AFFORDABLE LANGUAGE SERVICES

CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER GUIDELINES

INTERPRETER'S GUIDELINES

AFFORDABLE Language SERVICES

The Right Words Mean Everything

Revised
5-6-2019

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DRESS CODE

1.0 PURPOSE

This policy sets forth Cincinnati Children's Hospital Medical Center's (CCHMC) uniform and dress code expectations.

2.0 POLICY

CCHMC employees are representatives of the Medical Center and are expected to maintain an appearance that is appropriate to the work environment and reflects a positive message of competence and safety.

3.0 DEFINITIONS

N/A

4.0 IMPLEMENTATION

4.1 General

4.1.1 Workplace attire should be appropriate to the work environment and not detract from the function or safety of the job being performed. Clothing should be neat, clean, in good repair, and fit properly.

4.1.2 Employees in certain roles may be required to wear uniforms or meet specific attire, grooming and hygiene standards that are generally invoked for health or safety reasons, customer/patient contact or other business-related considerations.

4.1.3 Departments may establish department-specific work attire guidelines that comply with this policy and are consistent and appropriate for the work setting and for the work being performed.

4.1.4 Failure to comply with the provisions of this and department-specific dress code policies may result in disciplinary action, up to and including termination of employment.

4.2 Jewelry

4.2.1 For business-related reasons, departments may prohibit employees from wearing facial jewelry (e.g., nose/tongue/chin studs, and eyebrow studs or hoops, etc.).

4.3 Tattoos

4.3.1 For business-related reasons, departments may require employees to cover tattoos.

4.4 Aftershave, Cologne, Perfume, Scented Lotions, Hair Products

4.4.1 Employees are expected to be respectful of patients' and employees' sensitivities to these products and use them sparingly.

4.5 Guidelines for Appropriate and Inappropriate Workplace Attire

4.5.1 The following is a general guideline of appropriate and inappropriate workplace attire. Departments, after consultation with HR, may have supplemental department-specific guidelines that are consistent with, or more stringent than, this guideline.

Item	Appropriate
GENERAL: To ensure the safety and protection of employees and patients, employees must comply with OSHA regulations and wear clothing and footwear appropriate for their position.	
Clothing, insignia, or other items with wording or illustrations which advertise commercial products or express political, suggestive, vulgar, controversial, or divisive viewpoints. (This policy and guidelines are not intended to interfere with rights under the NLRA or to unreasonably interfere with religion.)	No
Clothing worn on designated days to celebrate holidays, special Cincinnati or CCHMC events	Yes
FOOTWEAR:	
Crocs (or similar) with holes (Direct Patient Care or Contact/Clinical Facilities/Research Labs)	No
Crocs without holes which cover the entire top of the foot (Direct Patient Care or Contact/Clinical Facilities/Research Labs)	Yes
Sandals/open toe shoes (Direct Patient Care or Contact/Clinical Facilities/Research Labs)	No
Sandals/open toe shoes	Dept Specific
Flip Flops/shower shoes/house slippers	No
LOWER BODY ATTIRE:	
Skirts (maximum of 3" above the knee)	Yes
Jeans and/or denim-like material pants finished similarly to jeans	Dept Specific
Capri /cropped pants	Dept Specific
Dress shorts/culottes/skorts	No
Knit leggings, stretch pants, stirrup pants, tights worn as outerwear	No
Low rise pants	No
Pajama or "pajama-like" pant/sweatpants/exercise-like attire	No
UPPER BODY ATTIRE: Tops must be long and high enough to provide adequate coverage of the abdomen, back and chest during performance of duties, including bending, stooping and squatting	
Blue Denim or denim-like material shirts with CCHMC logo	Yes
Crop/Halter tops	No
Polo/golf shirts	Yes
Sleeveless blouses or shirts	Yes
Sweatshirts/Hoodies	Dept Specific
T-Shirts as outer garments	Dept Specific
T-Shirts that advertise commercial products or express political, suggestive, vulgar, controversial or divisive viewpoints	No
T-Shirts worn on a designated special occasion to celebrate holidays, special Cincinnati or CCHMC events	Yes
T-Shirts with CCHMC logo	Dept Specific
HEAD/HAND ATTIRE:	
Caps, hats, or athletic-type headbands, except where job-related or for religious reasons	No
Face coverings, except where job-related or for religious reasons	No
Gloves or hand coverings, except where job or medically related	No

4.6 Uniforms

4.6.1 CCHMC will supply uniforms in those departments where employees are required to wear them, and it is not a usual or customary professional practice to wear them. These departments must either provide and maintain the uniforms or reimburse employees for purchase and maintenance. Upon termination, uniforms owned by CCHMC, but not returned, will require a payroll deduction of $25.00 from the employee.

4.6.2 CCHMC will not supply or reimburse for uniforms in those departments where it is the usual and customary professional practice to wear a uniform. The employee will be individually responsible for its purchase and upkeep.

4.6.3 The decision to require uniforms in a department must be reviewed and approved by a Vice President.

4.7 Scrub Attire

4.7.1 CCHMC will supply and maintain scrubs worn in areas where employees are required to wear them by regulatory standards. These areas include: Operating Room, Anesthesia, IV Room in Hospital Pharmacy, IV Room in Home Care Pharmacy, Dialysis, Special Procedures in Radiology, Cardiac Catheterization Lab, and Sterile Processing Department.

4.7.2 Employees required to wear scrub attire are required to change into that attire at CCHMC. These employees may not leave the premises in scrubs.

4.7.3 Employees who are required by regulatory standards to wear scrubs may only wear those scrubs currently provided and laundered by CCHMC. These scrubs will be a designated color (teal green).

4.7.4 Employees and departments not required by regulatory standards to wear scrubs may not purchase scrubs in the designated color of the hospital laundered scrubs.

4.8 Category I employees: are those employees with potential for exposure to blood or body fluids or other potentially infectious materials during the performance of their daily duties.

4.8.1 Category I employees must wear only clothing that is washable in hot water and should maintain an extra set of personal undergarments, socks/stockings, and shoes in their work area in the event that significant contact with blood or body fluids or other potentially infectious materials occurs.

4.8.2 Category I employees who do not expect to be involved in direct patient care may wear non-washable clothing, but must maintain washable clothing on the premises so that they may change clothes before getting involved in patient care.

4.8.3 The donning of impervious covering is an acceptable alternative for limited activities where scrubs or similar attire are not required.

4.8.4 Clothing that is splattered or soaked by blood or body fluids or other potentially infectious materials must NOT be worn home and must be laundered in compliance with Infection Control & Prevention Program Policy 5.4: *Management of Soiled Healthcare Worker Clothing*.

5.0 OVERSIGHT

Human Resources will periodically review and update this policy as appropriate. Policies will be reviewed at least every three (3) years. Questions regarding this policy shall be directed to Human Resources at 513-803-HR4U (4748) or HR4U@cchmc.org. Authority over this policy resides with the Senior Vice President of Human Resources and Learning.

6.0 REFERENCES

6.1 CCHMC Human Resources Policy WE-05: *Identification Badges*

6.2 Infection Control & Prevention Program Policy 1.1: *Hand Hygiene*

6.3 Infection Control & Prevention Program Policy 1.2: *Standard Precautions*

6.4 Infection Control & Prevention Program Policy 5.4: *Management of Soiled Healthcare Worker Clothing*

6.5 Infection Control & Prevention Program Policy 5.5: *Prevention and Post-Exposure Management of Bloodborne Pathogen Exposures Among Health Care Workers*

REVISION HISTORY
Original Date
05/01/2010 (Formerly F-00)
Revision Date
10/30/2017
Review Date
10/30/2017

Dress Code for Interpreters at Cincinnati Children's

All interpreters must follow Cincinnati Children's Policy WE-04. Per section 4.1.3 of that policy, we have also established the following department-specific work attire guidelines.

The policy and these guidelines describe the expectation that interpreters "maintain an appearance that is appropriate to the work environment and reflects a positive message of competence and safety." No dress code can cover all contingencies so interpreters must exert a certain amount of judgment in their choice of clothing to wear. If interpreters are uncertain about what is appropriate, they should consult their supervisor.

Upon discussion with their supervisor and Cincinnati Children's, exceptions may be made for an individual interpreter's medical needs.

Hair

Nontraditional hair colors are not permitted.

Hygiene

Interpreters must practice personal hygiene and be free of offensive odor.

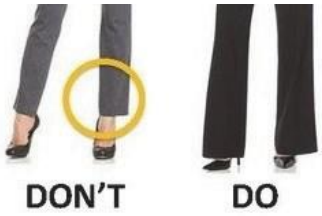
Scrubs

Scrubs are not appropriate since they may cause confusion.

Pants

Men must wear conventional, properly fitting long pants. Women may wear pants, skirts, or dresses (see below).

Jeans, capris, cropped pants, denim pants, overalls, cargo pants, pants with unfinished seams and pants with a drawstring waist are not appropriate.



The top of pants must be worn at the waist.

Men must wear belts.

Skirts and Dresses

Dresses should have sleeves and not be too tight, too short, or overly revealing. A sleeveless dress may only be worn if it is covered with a cardigan or blazer at all times.

Dresses and skirts must have finished seams and not be split above the knee.

Sun dresses and beach dresses are not appropriate.

Shirts, Tops, Blouses, and Jackets

Men must wear a properly fitting shirt with a collar and sleeves. Turtlenecks and mock turtlenecks are appropriate. Shirts must be tucked into the pants. Sweaters, suit jackets and sport coats may be worn over the shirt.

Women should wear blouses that have sleeves and are not sheer. As indicated in Policy WE-04, a sleeveless blouse may only be worn if it is covered with a cardigan or blazer at all times.

When not being worn, sweaters and jackets must not be tied around the waist.

Denim jackets are not **appropriate.**

Shoes and Footwear

Due to the constant exposure to diverse clinical settings, professional footwear with closed toe and closed heel must be worn.

Clogs, slippers, sneakers, military-type boots, boat shoes and athletic shoes are not appropriate.

Jewelry, Makeup and Perfume

Makeup must appear professional and natural, and should be conservative in style and color.

Facial jewelry must not be worn. Any jewelry that is worn must not be a distraction, visually or auditorily.

Due to employee and patient allergies, perfume and cologne must not be worn.

ACRONYMS BY LOCATION

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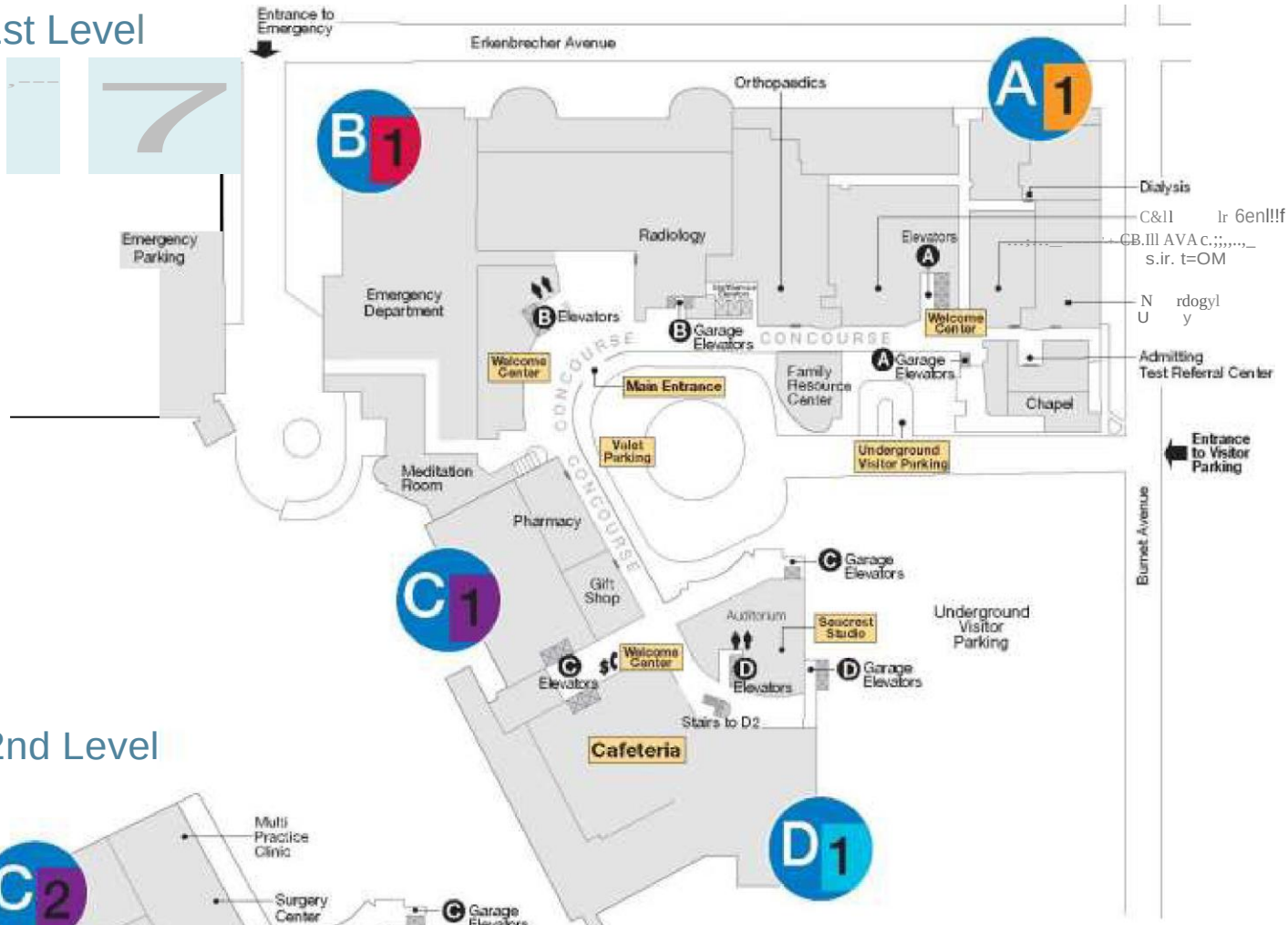
Please notice that these acronyms are organized by location to facilitate the ALS interpreters to locate the places where they need to go for their assignments, and to facilitate the understanding between the interpreters and the office of Interpreter Services.

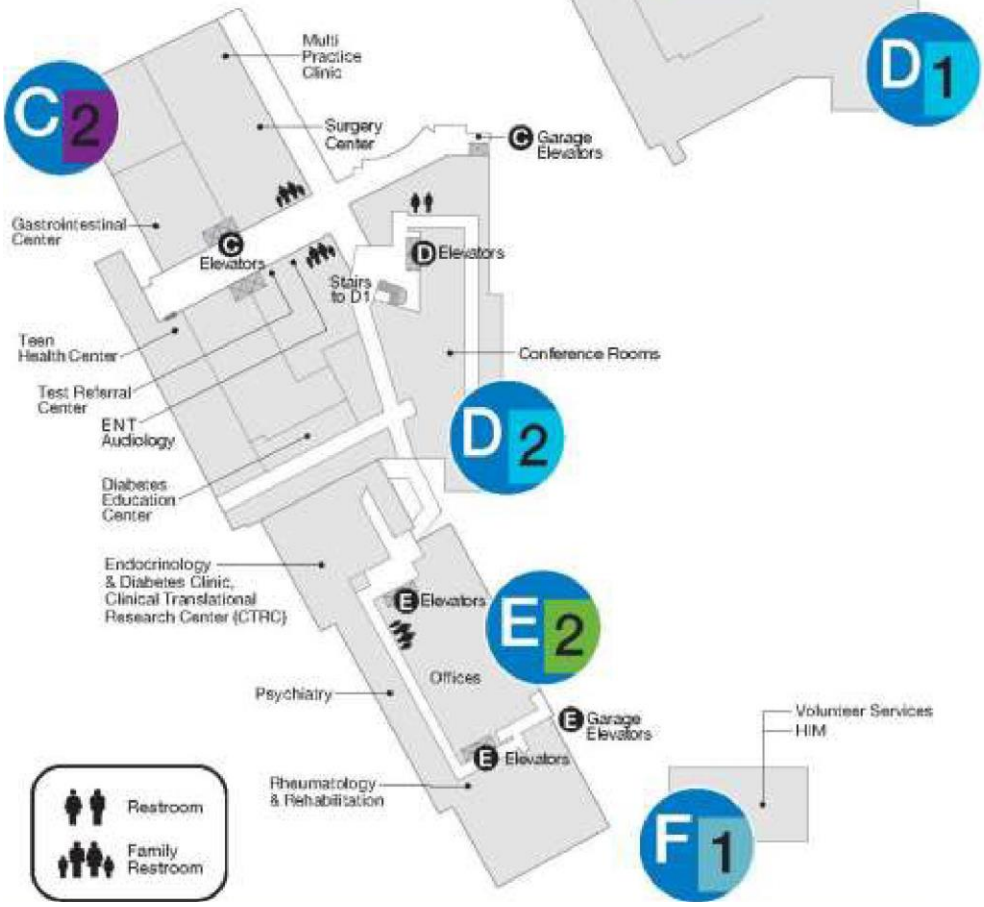
- CCHMC -Cincinnati Children's Hospital Medical Center
- ED-Emergency Department, located in building B, level 1, Base.
- ENT-Ears, Nose and Throat Clinic, located in building C, level 2, Base.
- BMT-Bone Marrow Transplant Clinic is located in building A, level 5, Base. It is part of Hematology/Oncology Unit (HEM/ONC)
- PPC-Pediatric Primary Care-a clinic where routine check-ups and non-urgent sick visits take place at Medical Office Building- 3430 Burnet Ave., 2nd floor.
- FCC-Fetal Care Center, located in building C level 4, Base
- GI -Gastroenterology Clinic, located in building C level 2 & D level 5, Base.
- HEME/ONC-Hematology/Oncology -Inpatient area located inbuildingA level 5, Base. Outpatient clinics are in A1.
- OT/PT/ST -Occupational, Physical, Speech Therapy, located at 3430 Burnet Ave., North Campus.
- ICU -Inpatient Care Unit, located in building B level 6W, Base.
- DDBP -Developmental Disabilities and Behavioral Pediatrics, located at 3430 Burnet Ave., North Campus
- PACU-PostAnesthesiaCareUnit,buildingBlevel3,SameDaySurgery.
- SDS-Same Day Surgery, locatedinbuildingBlevel3,Base.
- MPC-Multi-Practice Center-a clinic located in building C level 2 where several different types of appointments occur. When the Emergency Department is very full, the MPG is used as part of the ED.
- RCNIC -Regional Center for Newborn Intensive Care, located in building B level 4, Base
- BMCP – Behavioral Medicine and Clinical Psychology, located in different areas of thehospital
- CBHN-The Center for Better Health and Nutrition, located in North Campus, 2nd floor

Main Concourse at Cincinnati Children's Burnet Campus

1st Level



2nd Level



QBS-C & QBS

The Qualified Bilingual Staff (QBS) program was adopted by Cincinnati Children's Hospital Medical Center in 2014 with the purpose of creating a group of trained bilingual employees that could support the day-to-day linguistic operations of the hospital. The ultimate goal is to capitalize on the already existing bilingual resources disseminated throughout the organization; in order to ensure the best outcome when interacting with our non-English speaking families. In addition, the program allows employees of diverse backgrounds and linguistic skills to work and serve patients and families who have Limited English Proficiency.

Our qualified bilingual staff program is divided in two branches.

Branch #1:

Qualified Bilingual Staff - Clinicians (QBS-C)

The QBS-C program is designed to document and ratify a clinician's foreign-language skills. The examination is a functional performance test of the candidate's ability to perform the tasks of a clinician in a primary care setting in a foreign language.

Providers who pass the examination may communicate one-on-one with their patients and families in their language of expertise without the assistance of an interpreter. However, these providers are not considered interpreters and should refrain from offering this type of service to other providers unless they have received appropriate training as interpreters through Language Access Services. See the disclaimer notice on the badge backer.

Providers who have not passed the examination must always use a medical interpreter when communicating with patients and families who do not speak English.

What the interpreter should know:

If you are in a session and one of these provider is present without any other staff member you may step out and allow the provider communicate with the family. However, you must stay in the session if there are other team members that need interpretation.

Branch #2:

Qualified Bilingual Staff - I

This is the branch of our program that qualifies bilingual staff for interpretation. These qualified individuals serve different roles depending on the level of proficiency and training:

QBS-I Level I participants are invited to complete a thorough training (12 hours total, offered twice per year) which focuses on providing basic knowledge and tools to utilize linguistic skills during ***nonmedical interactions*** with non-English speakers.

QBS-I Level II participants must demonstrate superior proficiency and complete an additional 16 hours of training for a total of 28 hours. QBS Level II training focuses on providing the participant with the knowledge and tools to provide basic interpreting services. QBS Level II employees will be asked to provide interpreting services for pre-scheduled basic appointments in the hospital as agreed with their managers.

QBS-I Level III participants will follow a series of evaluations to prepare and qualify them for increasingly pre-scheduled complex interpreting appointments.

What the interpreter should know:

QBS-I are only allowed to interpret during emergency situations (when a qualified interpreter is not available) or during pre-scheduled interpreting encounters. Another thing to consider is that QBS-I are not allowed to interpret for a patient or family they are assisting. For example, a nurse in the PICU has gone through the QBS Program and she is now considered a level 2. The doctor asks her to interpret for the family she is taking care of. The nurse most decline the request because it could cause a conflict of interest.

INFECTION CONTROL PROGRAM

1.0 PURPOSE

To reduce the risk of transmission of epidemiologically significant microorganisms during the delivery of patient care.

2.0 POLICY

Patients known or suspected to be infected or colonized with one or more epidemiologically significant pathogens that are transmissible by direct contact with the patient or the patient's contaminated environment are to be cared for following CONTACT PRECAUTIONS in addition to *IC-1.2 –Standard Precautions*.

3.0 DEFINITIONS

3.1. **Health care workers**: All individuals including Patient Services employees, contractuals, members of the Medical and Dental Staff, students, volunteers and trainees, whose activities involve contact with patients

3.2. **Hand hygiene**: Either hand washing, use of an alcohol gel product, or use of alcohol wipes in a fashion that removes potential pathogens from hands in accord with *IC-1.1– Hand Hygiene*.

4.0 IMPLEMENTATION

4.1. Patient placement

4.1.1. Placement in a private room is preferred.

4.1.2. Patients with the same infection, but no other infection, may be cohorted with approval from Infection Control.

4.1.3. Patients MUST stay in their rooms. The door may remain open to facilitate care, BUT ONLY IF the patient is able to comply with staying in his/her room AND the placement of the isolation precaution sign is still clearly visible and evident to anyone who might enter the room.

4.2. **Hand hygiene** for **ALL** persons involved with the care of the patient is *ESSENTIAL* for the protection of the patient. Parents, other family members, and visitors must also be instructed on hand hygiene.

4.2.1. Hand hygiene must be performed BEFORE putting on gloves when entering the patient's room. It may be necessary to change gloves and practice hand hygiene between tasks and procedures on the same patient to prevent cross-contamination of different body sites.

4.2.2. Hand hygiene must be practiced AFTER glove removal and before exiting the patient's room.

4.3. **Health care worker restrictions** – None

4.4. Personal Protective equipment (PPE)

4.4.1. **Gloves** – Gloves must be worn to enter the patient's room. Gloves should be worn during all patient care. Gloves should be changed between tasks and procedures on the same patient. Gloves should be changed after contact with material that may contain a high concentration of microorganisms. Remove gloves and practice hand hygiene BEFORE leaving the patient's room.

4.4.2. **Gowns –** Gowns must be donned upon entering the room. Before leaving the patient room, gown must be removed and practice hand hygiene.

4.4.3. **Remove gloves and gown** before leaving the patient's environment, discard them in general trash unless grossly contaminated with blood or bloody body fluids or secretions/excretions capable of transmitting a disease for which the patient has been isolated. Use caution to avoid contaminating clothing after removal of gown. Perform hand hygiene before exiting the patient's room.

4.5. Medical equipment and other devices used in patient care

4.5.1. To prevent patient-to-patient transmission of infectious agents, dedicated medical equipment should be used whenever possible for care of patients.

4.5.2. Reusable medical equipment must be cleaned and disinfected upon removal from the patient's environment and before being used for any other patient in keeping with *IC-2.1– Maintaining Clean Patient Rooms and Equipment*.

4.5.3. Since many microorganisms may persist for prolonged periods of time on contaminated inanimate surfaces, these items should not be removed from the patient room to a storage area without first being cleaned and disinfected.

4.5.4. Nurse servers should be stocked with the necessary minimum number items needed for patient care.

4.5.5. Upon discharge, all medications and patient care items must be removed from the nurse server and inspected for package integrity and visible soiling. Medications must be managed in keeping with Pharmacy standards. Items may be used for the next patient if the package is intact and not visibly soiled; if otherwise, they may be sent home with the patient, as appropriate, or discarded. The nurse server should remain unlocked and empty until cleaned by Environmental Services.

4.6. Laundry management

4.6.1. All soiled linen and linen bags are processed as indicated for *Standard Precautions*.

4.6.2. Health care workers should wear appropriate PPE when handling soiled linen from patients in *Contact Precautions*.

4.7. **Waste management.** Refer to *IC- 1.3 – Infectious Waste and Sharps Waste Management.*

4.7.1. General trash is handled as described for *Standard Precautions*.

4.7.2. PPE (e.g., gloves, masks, gowns) used in the care of the patient should be discarded in general trash unless the item is moderately or grossly soiled with blood, bloody body fluids, or secretions/excretions likely to be contaminated with the infectious agent requiring the patient to be isolated; discard those items as infectious medical waste or "red bag" waste.

4.7.3. Any disposable item(s) that are moderately to grossly soiled with blood, bloody body fluids, or secretions/excretions likely to be contaminated with the infectious agent requiring the patient to be isolated must be discarded as infectious medical waste or "red bag" waste.

4.7.4. Sharps are managed as described in *Standard Precautions*.

4.8. **Laboratory specimen handling** is in accordance with *Standard Precautions*.

4.9. **Patient activities** are limited to in-room activities only.

4.9.1. Patient specific toys are preferred.

4.9.2. Durable toys (electronic, etc.) should be designated for this patient only during this stay and must be sanitized prior to subsequent use by another patient.

4.9.3. Patients requiring *Contact Precautions* are limited to in-room activities in general. When feasible, private Child Life activities may be arranged for patients who can cooperate in hand washing and general infection control measures.

4.9.4. Patients in *Contact Precautions*, who are cooperative and for whom ambulation is a necessary therapy(eg. Postop orders) must be accompanied by a HCW. Prior to leaving the room, patient should perform supervised hand washing with soap and water and wear clean clothes. Patient should ambulate in a low traffic area and have no contact with other patients or HCW.

4.10. **Visitors** are limited in order to minimize transmission within the medical setting

4.10.1. Parents/guardians or other primary care providers may visit at all times but should be instructed on the importance of hand washing to interrupt transmission of microorganisms and asked to perform hand hygiene whenever entering or exiting the room.

4.10.2. Donning of PPE is not required for parents/guardians or other primary care providers since they do not go from patient to patient. However, individuals who are not a part of the primary residence, and otherwise not exposed previously, may select to don PPE for their protection.

4.10.3. Parents/guardians or others visiting a patient in a cohort room should be instructed not to share items with or provide care for other patients within the cohort.

4.10.4. Visits by other individuals are at the discretion of unit leadership, but must be limited in time and scope, be deemed of significant importance to the wellbeing of the patient/parent during this hospital stay, not put the visiting individual at risk. These individuals must be counseled by the nursing leadership on the unit about and agree to abide by practices to prevent potential transmission including hand hygiene and use of PPE when appropriate (e.g., clergy or spiritual director who may also visit another patient).

4.10.5. Individuals visiting patients in isolation precautions without the use of PPE must not visit in other patients' rooms or other patient care areas.

4.11. **Work-stations on wheels (WOWs)** should be handled with clean hands and be protected from contamination.

4.12. **Food service delivery** personnel must not enter the rooms of patients in *Contact Precautions*. However, they may hand off the tray to a parent or other individual in the room who can come to the door to accept delivery. Nursing unit personnel should facilitate delivery to and removal from the patient's room.

4.13. **Patient transport** is limited to essential purposes only. Transporters should follow good hand hygiene practices and use gloves (and gowns) only if direct contact of transporter clothing is anticipated, for example, needing to hold the child.

4.14. Environmental Services (EVS)

4.14.1. Hand hygiene should be performed and gloves and gown donned before entering the room of a patient in *Contact Precautions*. Wear gloves for all re-stocking and cleaning duties. Remove gloves and gown and discard in general trash and wash hands before proceeding to the next bed space or room.

4.14.2. Cleaning procedures are the same as for *Standard Precautions* with the exception of privacy curtains, which must be removed and replaced.

4.14.3. Mop heads should be replaced after cleaning this room or bed space.

4.14.4. Disinfectant solutions do not need to be replaced since they are entered only by fresh cleaning cloths.

4.15. **Ancillary patient services** (e.g., Radiology, OT/PT/Speech Therapy, Operating Room, and other support services)

4.15.1. Services and procedures should be arranged in advance to minimize patient duration in a department.

4.15.2. Follow inpatient PPE practices.

4.15.3. Contaminated equipment and surfaces must be cleaned and disinfected prior to the next patient, in keeping with *IC-2.1 – Maintaining Clean Patient Rooms and Equipment.*

4.16. Outpatient settings

4.16.1. Those patients recognized to be colonized with MRSA/ORSA or other Infection Control alert pathogens should be placed in an exam room as soon as possible to limit contact in public areas.

4.16.2. For brief out-patient encounters, hand hygiene should be practiced and gloves donned to provide patient care.

4.16.3. **Gowns** should be worn.

4.16.4. All horizontal and high-touch surfaces should be cleaned and disinfected between patients regardless of barrier use.

5.0 OVERSIGHT

This policy will be reviewed every three years or whenever deemed necessary, by the Infection Control Program. Policy authority for this document resides with the Infection Control Officer.

6.0 REFERENCES

2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Healthcare Infection Control Practices Advisory Committee (HICPAC). Centers for Disease Control and Prevention (CDC).

REVISION HISTORY
Original Date
09/03/2009
Revision Date
4/28/2016

1.0 PURPOSE

To reduce the risk of transmission of epidemiologically significant microorganisms during the delivery of patient care.

2.0 POLICY

Patients known or suspected to be infected or colonized with one or more epidemiologically significant gastrointestinal pathogens that are transmissible by direct contact with the patient or the patient's contaminated environment are to be cared for following CONTACT-ENTERIC PRECAUTIONS in addition to *IC-1.2 –Standard Precautions*.

3.0 DEFINITIONS

3.1. **Health care workers**: All individuals including Patient Services employees, contractuals, members of the Medical and Dental Staff, students, volunteers and trainees, whose activities involve contact with patients

3.2. **Hand hygiene**: Either hand washing, use of an alcohol gel product, or use of alcohol wipes in a fashion that removes potential pathogens from hands in accord with *IC-1.1– Hand Hygiene*.

4.0 IMPLEMENTATION

4.1. Patient placement

4.1.1. Placement in a private room.

4.1.2. Patients MUST stay in their rooms. The door may remain open to facilitate care, BUT ONLY IF the patient is able to comply with staying in his/her room AND the placement of the isolation precaution sign is still clearly visible and evident to anyone who might enter the room.

4.2. **Hand hygiene** for **ALL** persons involved with the care of the patient is *ESSENTIAL* for the protection of the patient. Parents, other family members, and visitors must also be instructed on hand hygiene.

4.2.1. Hand hygiene must be performed BEFORE putting on gloves when entering the patient's room. It may be necessary to change gloves and practice hand washing between tasks and procedures on the same patient to prevent cross-contamination of different body sites.

4.2.2. Hand washing with soap and water must be practiced AFTER glove removal and before exiting the patient's room.

4.2.3. Hand washing with soap and water is required of ALL persons, prior to leaving patient room; alcohol gels are not effective against infectious diarrhea producing pathogens including but not limited to *Clostridium difficile, Norovirus and Rotavirus.*

4.3. **Health care worker restrictions** – None

4.4. Personal Protective equipment (PPE)

4.4.1. **Gloves** – Gloves must be worn to enter the patient's room. Gloves should be worn during all patient care. Gloves should be changed between tasks and procedures on the same patient. Gloves should be changed after contact with material that may contain a high concentration of microorganisms. Remove gloves and practice hand washing with soap and water BEFORE leaving the patient's room.

4.4.2. **Gowns –** Gowns must be worn to enter patient's room. The gown is worn to protect the health care worker's clothing from becoming contaminated by the patient, patient items, medical equipment, and/or environmental surfaces, all of which must be considered colonized with the patient's microorganisms.

4.4.3. **Remove gloves and gown** before leaving the patient's environment, discard them in general trash unless grossly contaminated with blood or bloody body fluids or secretions/excretions capable of transmitting a disease for which the patient has been isolated. Use caution to avoid contaminating clothing after removal of gown. Perform hand washing with soap and water before exiting the patient's room.

4.5. Medical equipment and other devices used in patient care

4.5.1. To prevent patient-to-patient transmission of infectious agents, dedicated medical equipment should be used whenever possible for care of patients.

4.5.2. Reusable medical equipment must be cleaned and disinfected, with bleach, upon removal from the patient's environment and before being used for any other patient in keeping with *IC-2.1– Maintaining Clean Patient Rooms and Equipment*.

4.5.3. Since many microorganisms may persist for prolonged periods of time on contaminated inanimate surfaces, these items should not be removed from the patient room to a storage area without first being cleaned and disinfected.
4.5.4. Nurse servers should be stocked with the necessary minimum number items needed for patient care.
4.5.5. Upon discharge, all medications and patient care items must be removed from the nurse server and inspected for package integrity and visible soiling. Medications must be managed in keeping with Pharmacy standards. Items may be used for the next patient if the package is intact and not visibly soiled; if otherwise, they may be sent home with the patient, as appropriate, or discarded. The nurse server should remain unlocked and empty until cleaned by Environmental Services.

4.6. Laundry management
4.6.1. All soiled linen and linen bags are processed as indicated for *Standard Precautions*.
4.6.2. Health care workers should wear appropriate PPE when handling soiled linen from patients in *Contact-Enteric Precautions*.

4.7. **Waste management.** Refer to *IC- 1.3 – Infectious Waste and Sharps Waste Management*.
4.7.1. General trash is handled as described for *Standard Precautions*.
4.7.2. PPE (e.g., gloves, masks, gowns) used in the care of the patient should be discarded in general trash unless the item is moderately or grossly soiled with blood, bloody body fluids, or secretions/excretions likely to be contaminated with the infectious agent requiring the patient to be isolated; discard those items as infectious medical waste or “red bag” waste.
4.7.3. Any disposable item(s) that are moderately to grossly soiled with blood, bloody body fluids, or secretions/excretions likely to be contaminated with the infectious agent requiring the patient to be isolated must be discarded as infectious medical waste or “red bag” waste.
4.7.4. Sharps are managed as described in *Standard Precautions*.

4.8. **Laboratory specimen handling** is in accordance with *Standard Precautions*.

4.9. **Patient activities** are limited to in-room activities only.
4.9.1. Patient specific toys are preferred.
4.9.2. Durable toys (electronic, etc.) should be designated for this patient only during this stay and must be sanitized, with bleach, prior to subsequent use by another patient.
4.9.3. Patients requiring *Contact-Enteric Precautions* are limited to in-room activities in general. When feasible, private Child Life activities may be arranged for patients who can cooperate in hand washing and general infection control measures.
4.9.4. Patients in *Contact-Enteric Precautions,* who are cooperative and continent of stool and for whom ambulation is a necessary therapy (eg. Postop orders) must be accompanied by a HCW. Prior to leaving the room, patient should perform supervised hand washing with soap and water and wear clean clothes. Patient should ambulate in a low traffic area and have no contact with other patients or HCWs.

4.10. **Visitors** are limited in order to minimize transmission within the medical setting
4.10.1. Parents/guardians or other primary care providers may visit at all times but should be instructed on the importance of hand washing to interrupt transmission of microorganisms and asked to perform hand hygiene whenever entering the room and hand washing with soap and water whenever exiting the room.
4.10.2. Donning of PPE is not required for parents/guardians or other primary care providers since they do not go from patient to patient. However, individuals who are not a part of the primary residence, and otherwise not exposed previously, may select to don PPE for their protection.
4.10.3. Parents/guardians or others visiting a patient in a cohort room should be instructed not to share items with or provide care for other patients within the cohort.
4.10.4. Visits by other individuals are at the discretion of unit leadership, but must be limited in time and scope, be deemed of significant importance to the wellbeing of the patient/parent during this hospital stay, not put the visiting individual at risk. These individuals must be counseled by the nursing leadership on the unit about and agree to abide by practices to prevent potential transmission including hand washing with soap and water and use of PPE when appropriate (e.g., clergy or spiritual director who may also visit another patient).
4.10.5. Individuals visiting patients in isolation precautions without the use of PPE must not visit in other patients’ rooms or other patient care areas.

4.11. **Work-stations on wheels (WOWs)** should be handled with clean hands and be protected from contamination.
4.12. **Food service delivery** personnel must not enter the rooms of patients in *Contact-Enteric Precautions*. However, they may hand off the tray to a parent or other individual in the room who can come to the door to accept delivery. Nursing unit personnel should facilitate delivery to and removal from the patient's room.
4.13. **Patient transport** is limited to essential purposes only. Transporters should follow good hand hygiene practices and use gloves (and gowns) only if direct contact of transporter clothing is anticipated, for example, needing to hold the child.

4.14. Environmental Services (EVS)

4.14.1. Hand hygiene should be performed and gloves and gown donned before entering the room of a patient in *Contact-Enteric Precautions*. Wear gloves and gown for all re-stocking and cleaning duties. Remove gloves and gown and discard in general trash and wash hands with soap and water, before proceeding to the next bed space or room.
4.14.2. Cleaning procedures include utilizing bleach to clean the entire room, for those individuals in Contact-Enteric Precautions with the exception of privacy curtains, which must be removed and replaced.
4.14.3. Mop heads should be replaced after cleaning this room or bed space.
4.14.4. Disinfectant solutions do not need to be replaced since they are entered only by fresh cleaning cloths.

4.15. **Ancillary patient services** (e.g., Radiology, OT/PT/Speech Therapy, Operating Room, and other support services)

4.15.1. Services and procedures should be arranged in advance to minimize patient duration in a department.
4.15.2. Follow inpatient PPE practices.
4.15.3. Contaminated equipment and surfaces must be cleaned and disinfected prior to the next patient, in keeping with *IC-2.1 – Maintaining Clean Patient Rooms and Equipment.*

4.16. Outpatient settings

4.16.1. Those patients recognized as having infectious diarrhea or other Infection Control alert pathogens should be placed in an exam room as soon as possible to limit contact in public areas.
4.16.2. For brief out-patient encounters, hand hygiene should be practiced and gloves and gowns donned to provide patient care.
4.16.3. All horizontal and high-touch surfaces should be cleaned and disinfected with bleach between patients regardless of barrier use.

5.0 OVERSIGHT

This policy will be reviewed every three years or whenever deemed necessary, by the Infection Control Program. Policy authority for this document resides with the Infection Control Officer.

6.0 REFERENCES

2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Healthcare Infection Control Practices Advisory Committee (HICPAC). Centers for Disease Control and Prevention (CDC).

REVISION HISTORY
Original Date
06/10/2015
Revision Date
4/28/2016

1.0 PURPOSE

To provide a safe work environment for health care workers by preventing or minimizing their exposure to bloodborne pathogens.

2.0 POLICY

To prevent or minimize the risk for occupational exposure to blood and other potentially infectious materials; to ensure appropriate treatment and counseling in the event of exposure; and to comply with the Occupational Safety & Health Administration (OSHA) regulations.

3.0 DEFINITIONS

3.1 **Bloodborne Pathogen** – A pathogen present in blood that can be transmitted to an individual who is exposed to the blood or body fluids of an infected individual.

3.2 **Other Potentially Infectious Material (OPIM)** – Includes amniotic fluid, cerebrospinal fluid, pericardial fluid, peritoneal fluid, pleural fluid, saliva during dental procedures, semen, synovial fluid, vaginal secretions, unfixed tissues/organs, and any body fluid visibly contaminated with blood.

4.0 IMPLEMENTATION

4.1 Employee Exposure Risk Determination.

4.1.1 The potential for occupational exposure to bloodborne pathogens is determined at the time of employment or transfer based on employee job title and description of work duties provided by Human Resources. Using this information, Employee Health will evaluate each employee and administer hepatitis B vaccine as appropriate.

4.2 Infection Control Procedures to Prevent or Minimize Exposure.

4.2.1 Hand hygiene practices are the most important means of controlling the transmission of microorganisms. Refer to policy *IC-1.1– Hand Hygiene* for specific procedures.

4.2.2 All personnel must adhere to Standard Precautions when providing patient care and during each patient contact. Refer to policy *IC-1.2 –Standard Precautions* for specific procedures.

4.3.3 Health care workers must select personal protective equipment (PPE) based on the anticipated exposure to blood or other potentially infectious materials. Refer to policy *IC-1.2 – Standard Precautions, Appendix A – Minimum Requirements for the Wearing of Personal Protective Equipment During Common Procedures*.

4.3 Engineering and Work Practice Controls to Prevent or Minimize Exposure.

4.3.1 Needles and other sharp devices must be handled carefully to prevent accidental injury during use and disposal. Refer to policy *IC-1.3 – Infectious Waste and Sharps Waste Management* for guidance.

4.3.2 Sharps with engineered sharps injury protection (SESIP) must be utilized whenever possible. Refer to policy *IC-6.1 – Appendix A: Sharps with Engineered Sharps Injury Protection (SESIP)*.

4.3.3 Regulated or infectious medical waste and sharps must be segregated from general trash at the point of generation. Refer to policy *IC-1.3 – Infectious Waste and Sharps Waste Management* for guidance.

4.3.4 All spills of blood or body fluids must be considered potentially contaminated with a bloodborne pathogen and the spill area must be contained, cleaned and disinfected as soon as possible by personnel wearing the required Personal Protective Equipment (PPE). Refer to policy *IC-1.3 – Infectious Waste and Sharps Waste Management, Appendix E Blood/Body Fluid Spill Cleanup Procedure* for guidance.

4.3.5 All soiled patient linens, regardless of patient diagnosis or isolation status, are considered contaminated and must be handled and laundered in keeping with required laundering procedures before use by another patient. Refer to policy *IC-1.5 – Linen Management* for guidance.

4.3.6 All patient laboratory specimens are to be collected in appropriate containers and securely closed to prevent leakage following collection and then placed within a second container to prevent leakage during handling, processing, storage, transport or shipping. EXCEPTION: Large quantity specimen containers constructed of heavy duty plastic that are puncture and spill resistant.

- Specimen containers that remain within CCHMC must be clearly recognizable as containing specimens or labeled biohazardous. Specimen containers that leave CCHMC must have the outside container labeled as biohazardous.
- The external surfaces of containers must be disinfected, if contaminated.
- Needles must be removed from syringes before being sent to the laboratory.
- If the specimen could puncture the primary container, the primary container must be placed with a puncture resistant secondary container.
- Glass slides must be placed into a cardboard envelope and securely closed before being placed into a biohazard labeled bag.

4.3.7 Eating, drinking, chewing gum, applying cosmetics/lip balm and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure to blood or OPIM. In general, health care worker consumption of food and drink should be separated from patient care areas by a wall or similar barrier. Food and beverages are not to be stored in refrigerators, freezers, shelves, cabinets or on countertops where blood or OPIM are present.

4.3.8 Health care workers must perform all procedures involving blood or other potentially infectious materials in such a manner as to minimize splashing, spraying, splattering and generation of droplets. Mouth pipetting and suctioning of blood or OPIM is prohibited.

4.3.9 Health care workers who have exudative lesions, weeping dermatitis, or otherwise non-intact skin may be at increased risk for exposures to blood and body fluids. If these conditions are present, Employee Health or the supervisor should be consulted for an evaluation for work restrictions. In the event these skin conditions are present on the hands, forearms, or face, health care workers are required to refrain from all direct patient care until the condition resolves.

4.3.10 Equipment that may be contaminated with blood or OPIM must be examined and decontaminated as necessary prior to servicing by either Cincinnati Children's Hospital Medical Center (CCHMC) staff or being packaged for shipment to the manufacturer. If portions of the equipment remain contaminated, a readily observable biohazardous label must be attached stating which portions of the equipment remain contaminated. If possible, this information should be conveyed to all affected employees prior to handling, servicing or shipping so that appropriate precautions will be taken.

4.3.11 Contaminated instruments and medical devices to be reprocessed by Sterile Processing and Distribution must be transported as soon as possible after use in a covered or closed container that protects the instruments from damage and the transporter and environment from contamination.

4.4 Hepatitis B Vaccination

4.4.1 The principal route of transmission of Hepatitis B virus is through contact with infected blood or body fluids. Immunization interrupts transmission following inadvertent or accidental exposure. Refer to policy *IC-5.1 – Immunizations for Health Care Workers* for details.

4.5 Post Exposure Evaluation and Follow Up

4.5.1 Following any percutaneous, mucosal or non-intact skin exposure to blood or OPIM, the exposed employee must receive a confidential medical evaluation and follow-up by contacting Employee Health by dialing 803-SAFE (803-7233). An exposure risk assessment will be completed and recommendations for post-exposure management and follow-up will be arranged.

4.6 Housekeeping Procedures

4.6.1 Environmental Services shall implement and maintain an appropriate written schedule for cleaning and methods of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil that is present, and tasks or procedures being performed in the area.

4.6.2 Managers and health care workers shall ensure their worksite is maintained in a clean and sanitary condition.

- Contaminated equipment and work surfaces must be cleaned of visible soil and then decontaminated upon completion of procedures or when contaminated by blood, any bloody body fluid or OPIM and at the end of the work shift, if the surfaces have become contaminated since the last cleaning.
- When decontaminating surfaces, an EPA-approved tuberculocidal disinfectant must be utilized following the directions listed on the manufacturer's label that are sufficient to kill the likely

pathogens. (See *Infection Prevention and Control Guideline X-1.1* for current recommended cleaning products)

- Protective coverings for work surfaces shall be removed and replaced as soon as possible after they have become contaminated.
- All bins, pails, cans and similar re-usable receptacles must be decontaminated on a regular basis and immediately, or as soon as possible after visible contamination.

4.7 Communication of Hazards to Employees, Information and Training and Recordkeeping Requirements

4.7.1 Biohazard warning labels shall be affixed to containers of regulated waste; refrigerators and freezers containing blood or other potentially infectious materials; other containers used to store, transport or ship blood or other potentially infectious materials; and on soiled workroom doors to ensure employees can identify biohazardous materials. These labels shall be predominantly fluorescent orange or orange-red with lettering or symbols in a contrasting color. Labels shall include the following legend:

BIOHAZARD

4.7.2 EXCEPTIONS to the labeling requirements include:

- Red bags or red containers may be substituted for biohazard warning labels.
- Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use.
- Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal.

4.7.3 Information and Training: CCHMC shall provide training to all health care workers with occupational exposure to blood or other potentially contaminated materials at the time of initial assignment and at least annually thereafter. Additional training will be provided when assignments are changed that affect the employee's risk for occupational exposure. The training program shall be interactive, provided by a technically-qualified person, and include the following:

- How to access a copy of the OSHA Regulations. Refer to: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051
- The epidemiology, symptoms and transmission modes of bloodborne diseases.
- How to recognize bloodborne hazards.
- How to prevent or reduce exposures including how to minimize aerosolization, handling needles properly, and instruction on hand washing procedures.
- Information and instruction on PPE location, selection, removal, and disposal or decontamination.
- Information on the handling and disposal of regulated (infectious) waste.
- Information on hepatitis B vaccine.
- Explanation of the Bloodborne Pathogens Exposure Control Plan and the OSHA Bloodborne Pathogens Standard.
- Explanation of the post-exposure management procedures.

4.7.4 Record Keeping Requirements

- New employee orientation and annual Safety College records will be maintained by Health and Safety for a minimum of three years and contain the dates of training, the content or summary of the training session, the names and qualifications of the trainers. The names and job titles of all such records shall be made available, upon request, to OSHA and the National Institute for Occupational Safety and Health (NIOSH) representatives.
- Employee medical records shall be maintained for the duration of employment plus 30 years by Employee Health and include the name, social security number, hepatitis B vaccine status, and all

bloodborne pathogens post-exposure management records (e.g., test results, health care professional's written opinion, and source patient test results, if applicable).

4.7.5 Annual Employee Performance Evaluations

- Managers shall include an evaluation of the employee's compliance with this plan and specific safe work practices appropriate to each employee in the employee's evaluation at least annually, or as otherwise necessary.

4.8 Responsibilities

4.8.1 Health care workers are responsible for attending the bloodborne pathogens training sessions, participating in their department's orientation program, knowing what tasks they perform that have occupational exposure, and employing safe work practices in the performance of their duties. Lack of compliance with safe work practices may lead to disciplinary action up to and including termination.

4.8.2 Managers and Supervisors are responsible on a day-to-day basis for maintaining practices that eliminate or reduce task-associated risks in keeping with the Bloodborne Pathogens Exposure Control Plan's methods of control and proper work practices (e.g., use of personal protective equipment, practice of Standard Precautions, compliance with the post-exposure management procedures, proper cleanup of blood and body fluid spills).

4.8.3 Department Directors have the responsibility for oversight and implementation of the Bloodborne Pathogens Exposure Control Plan in their respective areas and for reviewing compliance on the employee's annual evaluation.

4.8.4 Employee Health has the responsibility for implementation and management of the hepatitis B vaccination program and for post-exposure incident medical evaluation, follow-up, and collection and reporting of employee exposures to bloodborne pathogens.

4.8.5 The Bloodborne Pathogen Committee has the responsibility for evaluating sharps and selecting an appropriate product that is safety engineered to protect health care workers from bloodborne pathogen exposures.

4.8.6 The Environment of Care Committee has the responsibility for oversight of implementation of the Bloodborne Pathogens Exposure Control Plan.

4.8.7 The Infection Control Program has the responsibility to review at least every 3 years and update as necessary to the Bloodborne Pathogens Exposure Control Plan.

5.0 OVERSIGHT

The Infection Control Program will periodically review and update this policy as appropriate. Policies will be reviewed at least every 3 years. Questions regarding this policy shall be directed to, and authority over this policy shall vest with, the Infection Control Officer.

6.0 REFERENCES

6.1 OSHA Bloodborne Pathogen Standard
http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

7.0 APPENDICES (follow on subsequent pages)

Appendix A – Sharps with Engineered Sharps Injury Protection (SESIP)

REVISION HISTORY
Original Date
07/16/2004
Revision Date
09/26/2017

	Product Use	Name	Sizes	PS Order Number
1	Puncture-resistant containers for disposal of used/contaminated sharps	Sharps Containers [Tyco Healthcare]	1 Quart	102799
			2.2 Quart	114372
			5 Quart	114368
			3 Gallon	114370
			8 Gallon	114371
			8 Gal Hinged	102792
			18 Gallon	114373
2	To start a peripheral intravenous (IV) route	Eclipse™ Catheter [Bectin-Dickinson]	18 G x 1.5”	105950
			21G x 1.5”	105946
			22 G x 1.5”	105947
			23 G x 1”	105948
			25 G x 1”	105949
			25 G x 1.5”	105951
		Huber ™	19 G x 1.5”	111961
			22 G x 1.25”	111962
3	Lancets for finger sticks and heel sticks	Tenderfoot™ Lancets	Infant	105304
			Premie	105305
4	Single patient use for blood draws	Safe T Wing™ [Smiths Medical]	21 G x .75”	121908
			23 G x .75”	121909
			25 G x .75”	121910
5	Needles to access implanted IV ports	Huber ™	19 G x 1.25”	105959
			20 G x 1.25”	105960
			22 G x 1.5”	105961
6	Needles for percutaneous medication administration	Eclipse™ Safety Needle [Bectin-Dickinson]	19 G x .75”	105964
			19 G x 1”	105968
			20 G x .75”	105965
			20 G x 1”	105969
			20 G x 1.5”	105967
			22 G x .75”	105966
			22 G x 1”	105970
9	Surgical Scalpel	Safety Scalpel [BD]	No. 10	107671
			No. 11	107672
			No. 15	107670
10	Other Safety Engineered Devices	Multidose Cap [Alaris Products]		104358
		PICC Insertion Kit [Clinical Technology]		121914
		Click Lock [Clinical Technology]	21 G x 5/8”	111838
		Safety Insulin Pen [Novo Nordisk]		124195

What Is Infection Control???

- Prevent the spread of germs from patient to patient
- Prevent Health Care Workers from acquiring germs from patients

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Isolation Precautions

WHAT NOT TO WEAR !

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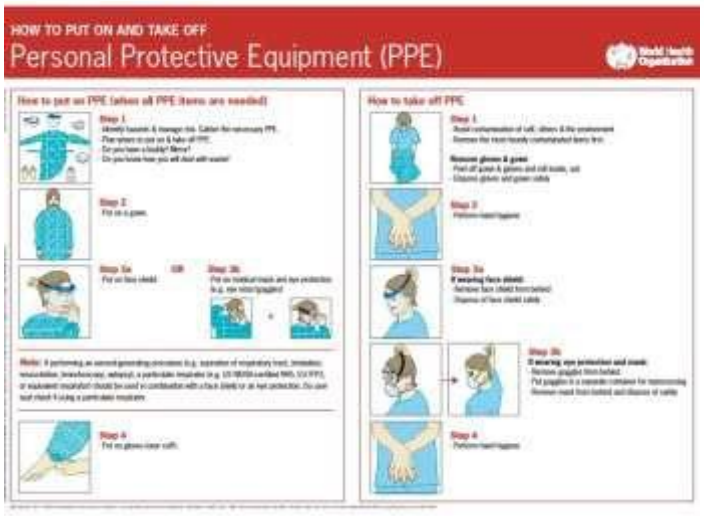
PERSONAL PROTECTIVE EQUIPMENT
PPE

- Barriers and equipment such as gowns, masks, face shields and gloves are used to protect you and the patients you provide care

BE SMART!

BE PREPARED!



Hand washing (aka Hand Hygiene)

- *...is the most effective means of preventing the spread of infection...and you can do it!*

-Hand washing
soap and water

-Hand hygiene
alcohol hand gel

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ISOLATION GUIDELINES

- *Transmission-based Isolation Precautions*
  -Precautions recommended by the CDC
  -Selected modifications unique to CCHMC
  -Supported by the AAP

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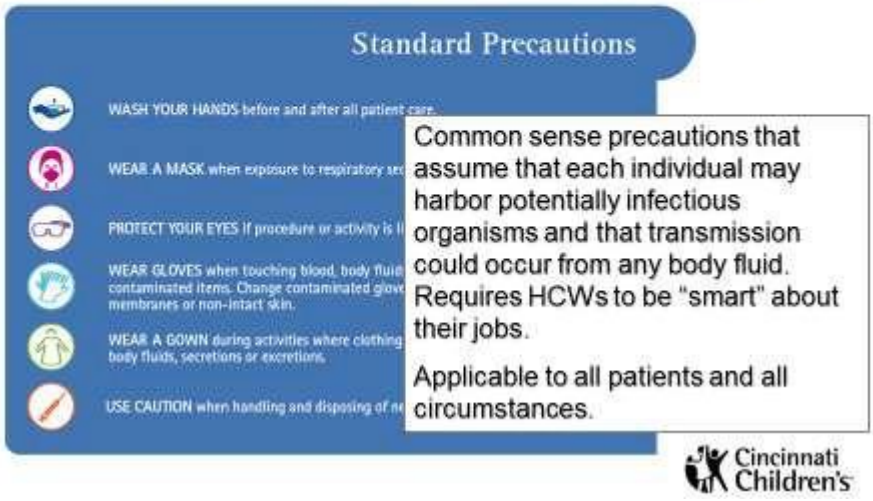
IC policy 1.2 - Standard Precautions ...



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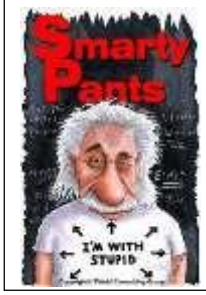
Preventing the Spread of Infection

- *Standard Precautions are the Foundation*
  -Common sense precautions that assume each individual may harbor potentially infectious organisms.



REQUIRES HCWS TO BE
"*SMART*"
ABOUT THEIR JOBS

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FOR ALL PATIENT CARE:

- **Wear a mask** to protect your nose and mouth ***every time*** there is the potential for a patient's secretions to reach those mucosal sites.
- **Wear eye protection** (protective glasses, goggles, eye-shields) ***every time*** there is the potential for a patient's secretions to be sprayed into your eyes. This may include children who are coughing, sneezing or crying.


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FOR ALL PATIENT CARE:

- **Wear gloves** if your hand will come in contact with a patient's secretions or mucous membranes.
- **Wear a gown** to protect your clothing (that you will wear from patient to patient) if your clothing is likely to become soiled with a patient's secretions or excretions.

*If there's a chance it *can* happen, it probably *will* happen!

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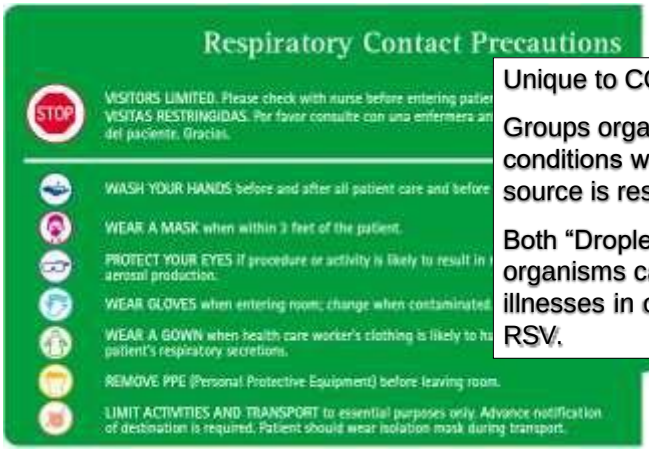
IC policy 4.2 - Respiratory/Contact Precautions ...



Unique to CCHMC

Groups organisms and conditions where the "shared" source is respiratory secretions.

Both "Droplet" and "Contact" organisms can cause similar illnesses in children such as RSV.

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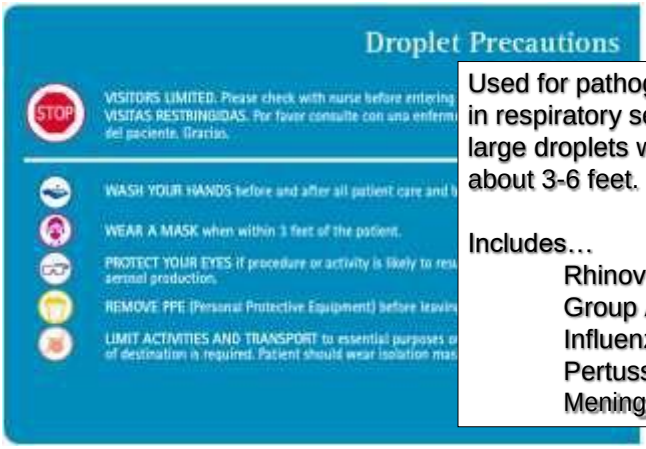
IC policy 4.4 - Droplet Precautions ...



Used for pathogens transmitted in respiratory secretions via large droplets which travel about 3-6 feet.

Includes…

- Rhinoviruses
- Group A strep
- Influenza
- Pertussis
- Meningococcemia

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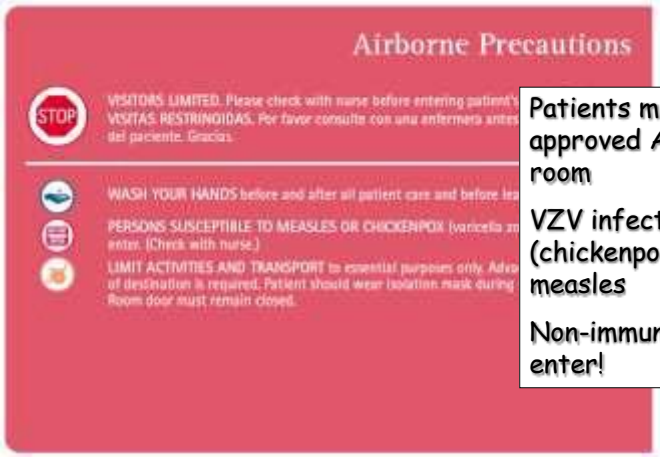
IC policy 4.5 - Airborne Precautions ...



Patients must be in an approved AI designated room

VZV infections (chickenpox, shingles) & measles

Non-immune HCWs cannot enter!

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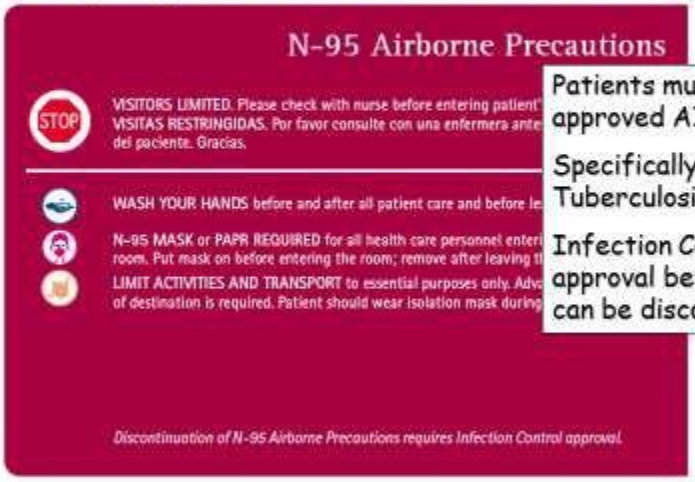
IC policy 4.7 N-95 Airborne Precautions ...



Patients must be in an approved AI/TB room

Specifically intended for Tuberculosis

Infection Control MUST give approval before this isolation can be discontinued

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IC policy 4.2 Contact Precautions

A private room is preferred, but not required.

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IC policy 4.8 Strict Contact Precautions

Specific to CCHMC:

Patients with history of VRE, Multi-drug resistant organisms (MDRO)

Needs private room

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LONG TERM PRECAUTIONS

CONTACT PRECAUTIONS

- ORSA/MRSA
- ESBL
- MDRO
- CF

STRICT CONTACT PRECAUTIONS

- VRE
- MDRO

* Long term categories can only be managed by Infection Control

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IC policy 4.9 - Protective Precautions ...

CCHMC specific

Patient "protection" provided through HEPA filtered air, hand washing, and avoidance of ill contacts.

Can be applied to any patient

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IC policy 4.10 - STRICT Protective Precautions ...

Unique to CCHMC Blood and Marrow Transplant (BMT) patients, particularly SCIDS.

Designed to create uniformity for patients requiring care outside the Hem/Onc area.

You must NOT enter these rooms if you are acutely ill.

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Click on…
Infection Control Policies and Resources

Cincinnati Children's

Policy Manuals

- Infection Control & Prevention Program
  - 1 - Routine Practices
  - 2 - Cleaning, Disinfection and Sterilization
  - 3 - Medical Center Environment
  - 4 - Isolation Precautions
    - IC-4.1 - Transmission-Based Isolation Precautions for Selected Agents, Diseases or Syndromes
    - IC-4.2 - Contact Precautions
    - IC-4.3 - Respiratory-Contact Precautions
    - IC-4.4 - Droplet Precautions

IC- 4.1
Transmission-Based Isolation Precautions for Selected Agents, Diseases or Syndromes

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CCHMC Infection Control & Prevention Program	Policy Number	IC-4.1
	Effective Date	5/10/2012
Transmission-Based Isolation Precautions for Selected Agents, Diseases or Syndromes	Page	1 of 40

1.0 PURPOSE

To assist healthcare workers in applying transmission-based guidelines for isolation precautions at CCHMC. STANDARD PRECAUTIONS are applicable to ALL patient care and for any agent, disease, or syndrome not listed here.

2.0 POLICY

CCHMC adheres to the transmission-based precautions recommended by the Centers for Disease Control and Prevention (i.e., Contact, Droplet, and Airborne) and to additional agent and disease-specific precautions applicable to the pediatric setting (e.g., RSV, Influenza, Rotavirus, Strep Pneumo., Strict Contact, and Respiratory-Contact).

Agent, Disease or Syndrome	Precautions	NOTE S	Duration or Comments
Abscess, draining/Wound	Contact	[6]	Until pathogen identified. If not a multi drug resistant bacteria or no growth, until drainage ceases or wound is drained and is easily covered
Actinomycosis	Standard		
Adenovirus, conjunctivitis	Contact	[2]	Until drainage ceases
Adenovirus, gastroenteritis	Contact - for patients <5 yrs. of age, incontinent, uncooperative or immune suppressed	[2] [7]	Duration of illness
Adenovirus, respiratory infection	Respiratory-Contact	[2]	Duration of hospitalization
Aeromonas	Contact - for patients <5 yrs. of age, incontinent, uncooperative or immune suppressed	[2]	Duration of illness
AIDS	Standard		Other precautions may be appropriate for associated conditions
Alcaligenes, xylosoxidans	Respiratory-Contact	[9]	Duration of hospitalization; vary test for special precautions relative to CF patients
Amebiasis	Standard		
Anthrax, cutaneous	Standard		
Anthrax, inhalation	Standard		
Antibiotic associated colitis	Contact	[2]	See Clostridium difficile
Arboviral or (arthropod encephalitides)	Standard		
Ascariasis	Standard		
Aspergillosis (pulmonary, cutaneous, disseminated)	Standard		

Voila!
An alphabetically arranged list of diseases, agents, syndromes that can be easily scrolled through to find the information needed

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HCW Food and Beverages

- Staff food and beverages are NOT permitted in locations where patient specimens, medications, or clean and sterile supplies may be present. Also the application of cosmetics such as lip balm and the chewing of gum are NOT permitted in these areas.

Not in the charting area or at the nursing station.

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Take-Home Message

- Wash your hands!
- Check with staff regarding the patient's isolation
- Make smart decisions about appropriate PPE
- Protect yourself!

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Guideline

1.0 SCOPE

This guideline is developed in collaboration with the Infection Control and Prevention Program and is intended to provide a standard process regarding infection control guidelines for Bone Marrow Transplantation and Immune Deficiency Program patients.

2.0 DEFINITIONS

N/A

3.0 GUIDELINES

3.1. Hand washing is the single most important way to prevent the spread of infection. It is preferable to wash hands with soap and running water for 15 seconds, rinse well, and use a paper towel to turn off the faucet (do not re-contaminate your hands). When working with children, a good measure of time is to sing the alphabet song completely while washing hands.

3.2. All persons prior to entrance to the BMT unit are to wash their hands at the sink station with soap and water for 15 seconds, rinse well, and use a paper towel to turn off faucet and swipe badge to enter the unit. Prior to entrance into the CBDI outpatient area everyone are to wash their hands with alcohol sanitizing wipes.

3.3. Educate and encourage patients/parents/legal guardians/caregivers that the safest place is in the patient's room. Locations used by multiple people may be contaminated with the germs of others.

3.4. Upon admission, patient should be placed in Strict Contact Precautions and screened for Vancomycin Resistant Enterococcus (VRE) and Oxacillin Resistant Staphylococcus Aureus (ORSA). If negative, patient should be placed in appropriate precaution and screened for VRE once a week. Once a patient is known to be VRE positive the patient does not need to be further screened on each admission or on a weekly basis.

3.5. Protective Precautions

3.5.1. Patient Rooms

3.5.1.1. Diligent hand washing is required each time you enter and exit the patient's room.

3.5.1.2. Everyone (including the patient) should wash their hands before and after eating, drinking, handling food, bathing, toileting/changing diapers, blowing their nose, and covering a cough or sneeze.

3.5.1.3. All rooms on the BMT unit are private rooms and double high-efficiency particulate absorption (HEPA) filtered on the BMT unit with the exception of 533, 534, 535, and 556 which do not have the use of a second HEPA filter.

3.5.1.4. Patient's room should only be visited by designated members of the patient's family/caregivers. It is not permitted for other patients and/or their family members/caregivers to visit another patient's room, handle supplies, or participate in another patient's care.

3.5.1.5. Approval should be obtained for a patient to leave the room for any reason other than testing.

3.5.1.6. Patients should wear N95 masks when outside of their room. Attending approval needed for requests to not wear N95 mask.

3.5.1.7. Clean mat/blanket should be placed on the floor when patient plays/has physical therapy on the floor.

3.5.1.8. Every patient room should be cleaned daily. Patients/parents/legal guardians/caregivers should keep personal belongings/toys contained in one bin to decrease clutter. If a patient's stay has been longer than a month, the patient should expect to be moved to another room in order to accommodate an extensive cleaning process. Patient length of stay per BMT room should be tracked on a monthly calendar found on the unit.

3.5.1.9. When the patient's stay approaches the 30 day time frame, the Charge Nurse should initiate a plan to get the patient's room cleaned per the Total Critical Care Room Cleaning with Environmental Services.

3.5.1.9.1. To implement this cleaning process, the following questions should be answered:

3.5.1.9.1.1. Is there an open and empty room on the BMT Unit to transfer the patient into?

3.5.1.9.1.2. Is the patient nearing their designated discharge date?

3.5.1.9.1.3. Is the patient medically stable and able to be transferred to another room on the BMT Unit?

3.5.2. Once the plan for Total Critical Care Room Cleaning is identified, the HUC should call Environmental Services to set up the day and time of the Total Critical Care Room Cleaning process. Plant Engineering should be contacted to inspect room for Preventative maintenance.

3.5.2.1 Description of the Total Critical Care Room Cleaning and cleaning records are documented and maintained by Crothall Healthcare in review with Cincinnati Children's Hospital Medical Center.

3.5.3. Food

3.5.3.1. Only patients should be permitted to eat in the patient room on the BMT unit.

3.5.3.2. Food and drinks should not be stored in the patient's room on the BMT unit. A separate kitchen area is provided.

3.5.3.3. Nutrition Guidelines should be followed for the patient.

3.5.3.4. Parents/legal guardians/caregivers may eat in the Parent Lounge. Approval for parents/legal guardians/caregivers to eat in a patient room should be reviewed and obtained by Nursing Leadership and Attending Physician.

3.5.4. Bathrooms

3.5.4.1. Only patients should use the bathroom in the patient room on the BMT unit (no visitors should use the patient bathroom)

3.5.4.2. Parents/legal guardians/caregivers may use the bathroom in the Parent Lounge.

3.5.4.3. Parents/legal guardians/caregivers may use the bathroom in the patient room if the patient is in diapers full-time and has not started toilet training prior to admit to the BMT unit.

3.5.4.4. For parents/legal guardians/caregivers who are allowed to use the bathroom in the patient room:

3.5.4.4.1. Parents/legal guardians/caregivers should flush the toilet after each use.

3.5.4.4.2. Parents/legal guardians/caregivers should wash their hands after each time using the bathroom.

3.5.4.4.3. No personal care items should be near the diaper scale.

3.5.4.4.4. Bathrooms should be kept free of clutter so daily cleaning can occur by Environmental Services.

3.5.4.4.5. Parents/legal guardian/caregivers should place dirty personal clothing/towels/washcloths in personal wash bin. If hospital issued towels/washcloths are used, then place in the dirty linen hamper.

3.5.4.4.6. If bathroom becomes visibly soiled, please have Environmental Services contacted.

3.5.5. Toy/ Movie/ Electronic Device Care

3.5.5.1. Only toys that can be safely cleaned and disinfected should be used. Toys that soak up water or retain water when cleaned should be avoided.

3.5.5.2. All toys should be cleaned/disinfected before entering or exiting a patient room. Toys remaining at the time of patient discharge should be placed in a bin in the dirty utility room.

3.5.5.3. Toys should remain in patient room unless removed to be sanitized. Toys are to be used by one patient at a time.

3.5.5.4. Quantity of toys in patient's room should be limited to one bin to facilitate daily cleaning.

3.5.6. Parent Lounge
3.5.6.1. A place where parents/legal guardians/caregivers can eat, drink, and relax.
3.5.6.2. When entering and exiting the Parent Lounge, proper hand hygiene should be completed.
3.5.6.3. Patients and visitors are not permitted in the Parent Lounge.

3.6. Strict Protective, Contact or Strict Contact Precautions (the following should apply in addition to the above Protective Precautions)
3.6.1. There may be an anteroom where everyone should wash their hands.
3.6.2. Staff should wash their hands, and don appropriate PPE as needed before entering the patient room. PPE should be put into the trash before leaving the room and hand washing before exiting.
3.6.3. Parents/legal guardians/caregivers are not required to wear PPE while in the patient room
3.6.4. For epidemiologically significant pathogens, parents/legal guardians/caregivers toileting and dining needs may be cohorted in the patient's room with approval of Infection Control.
3.6.5. Individuals, including parents/legal guardians/caregivers who are ill should not visit.
3.6.6. Parents/legal guardians/caregivers should limit the time outside their child's room and in the Parent Lounge
3.6.7. Toys coming from the room of a patient with VRE and/or C-Diff should be placed in a labeled bag and put in the dirty utility room for Child Life to clean.

4.0 REFERENCES

5.0 APPROVALS

All revisions of this guideline are approved by Bone Marrow Transplantation and Immune Deficiency Unit. This guideline is reviewed every three years or sooner if deemed necessary. Policy authority for this document resides with the Bone Marrow Transplantation and Immune Deficiency Unit. This guideline is approved by Clinical Director, Bone Marrow Transplantation and Immune Deficiency Unit, Medical Director, Division of Bone Marrow Transplantation and Immune Deficiency, Director Infection Control and Prevention, Evidence Based Practice Mentor, Director, Patient Services Compliance, and Assistant Vice President of Patient Services.

HISTORY

Original Date
4/23/2001
Revision Date
9/94, 4/95, 5/98, 5/00, 4/01, 1/02, 2/03, 3/02, 2/20/03, 4/8/04, 2/17/05, 2/20/06, 2/03/07, 2/05/08, 2/02/09, 2/02/11, 2/24/12, 2/19/14, 2/18/16
Review Date
2/18/18

GUIDELINES FOR PREGNANT WOMEN

1.0 PURPOSE

To provide health guidance for individuals who are pregnant or may become pregnant so that they can any minimize risk of acquiring infections in the workplace that may have adverse impact on the developing fetus.

2.0 POLICY

Pregnant persons are not excluded from the care of any patient for whom following standard and pathogen/disease related isolation precautions are considered appropriate to prevent disease transmission.

3.0 DEFINITIONS

N/A

4.0 IMPLEMENTATION

Because patients with diagnosed infections represent only a fraction of those individuals who may potentially harbor transmissible agents, pregnant persons must be immunized against vaccine preventable diseases and must practice diligent hand hygiene and STANDARD PRECAUTIONS for ALL patient encounters as the principal means of protecting themselves from unrecognized infectious agents in the healthcare setting.

The following sections address the most common pathogens that raise concerns for pregnant women; however, covering all potential agents of concern is beyond this scope. If personnel need more information, contact Infection Control.

4.1 **Parvovirus B19**: *This is the only common pathogen for which a pregnancy related restriction may apply*

4.1.1 Prevalence: Approximately 3/4 of individuals have been infected by the time they reach adulthood and are likely immune.

4.1.2 Disease: Erythema Infectiosum (EI) or "Fifth Disease" is generally self-limited and no longer contagious by the time it is recognized. B19 may precipitate aplastic crises in patients with sickle cell disease or other hemoglobinopathies, or result in chronic infection of immunocompromised, both with high titer.

4.1.3 Impact on developing fetus and/or newborn: Infection in the first 20 weeks of pregnancy, or 1st trimester is associated with early fetal demise in 2-6% of cases; NO associated congenital anomalies

4.1.4 Vaccine: None

4.1.5 Prevention: Hospitalized patients who may be shedding parvovirus B19 should be cared for following DROPLET PRECAUTIONS in addition to STANDARD PRECAUTIONS. Health care workers in early pregnancy should consider not providing direct care for patients with parvovirus B19 associated aplastic crisis or immunocompromised hosts with chronic parvoviral infection.

4.2 Hepatitis B:

4.2.1 Prevalence: The estimated prevalence of chronic hepatitis B in the United States is 0.3%–0.5%; ~ 40 new cases are diagnosed annually at CHCMC

4.2.2 Disease: Women who acquire hepatitis B virus infection during pregnancy and are HBsAg positive at delivery risk transmission to their infant.

4.2.3 Impact on developing fetus and/or newborn: Newborns who acquire hepatitis B are at higher risk of chronic hepatitis B viral infection and its complications; universal immunization of infants at birth helps minimize this risk

4.2.4 Vaccine: Hepatitis B vaccine is recommended for all pregnant women and REQUIRED for all CCHMC HCWs at risk for potential exposure to blood, body fluids or other potentially infectious materials during the performance of their duties. The vaccine can safely be administered during pregnancy.

4.2.5 Prevention: In addition to vaccine, practice STANDARD PRECAUTIONS including SHARPS SAFETY to minimize the potential inadvertent exposure to hepatitis B or other potentially blood-borne pathogens

4.3 Rubella:

4.3.1 Prevalence: Rubella occurs worldwide; uncommon in highly vaccinated populations

4.3.2 Disease: Self-limited childhood exanthema, rubella, aka, "German or three-day measles"

4.3.3 Impact on developing fetus and/or newborn: Infection in pregnancy is a risk for miscarriage, fetal death, or an infant born with congenital rubella syndrome (microcephaly, chorioretinitis, congenital heart

disease, hepatosplenomegaly, thrombocytopenia, and/or jaundice). Severity of damage is dependent on gestational age at acquisition.

4.3.4 Vaccine: Rubella vaccine (one component of MMR) REQUIRED for all CCHMC healthcare workers at hire and recommended for all women of childbearing age. The vaccine (live-attenuated virus) is not recommended during pregnancy.

4.3.5 Prevention: In addition to universal immunization, individuals with suspected rubella should be in DROPLET and STANDARD PRECAUTIONS for 7 days after the onset of rash. Congenitally infected infants may be contagious for several months. These infants should be cared for following CONTACT and DROPLET PRECAUTIONS in addition to STANDARD PRECAUTIONS for up to 1 year of age unless proven culture negative after 3 months of age.

4.4 Varicella virus infections (chickenpox or herpes zoster):

4.4.1 Prevalence: Prevaccine, 4 million cases each year; vaccine programs have reduced that by > 80%

4.4.2 Disease: Primary infection with varicella-zoster virus (VZV) causes chickenpox, a pruritic vesicular childhood viral exanthema that is contagious for up to 2 day before the rash appears, until all lesions are crusted. Herpes zoster (shingles) is the reactivation disease of VZV and is contagious until all lesions are crusted.

4.4.3 Impact on developing fetus and/or newborn: Although uncommon, a VZV embryopathy may occur in as many as 2% of primary VZV infections before 20 weeks gestation. After 20 weeks gestation, unapparent infection in the fetus is the rule with a risk of recurrence as zoster in early infancy. Women who acquire chickenpox during pregnancy are at risk of severe disease, including viral pneumonia with hypoxia that puts the fetus at risk.

4.4.4 Vaccine: A live-attenuated vaccine is routine in children. Non-immune adults should be immunized; however, the vaccine cannot be given during pregnancy. All CCHMC employees should have submitted proof of vaccine x2 and hx of physician documented disease at hire.

4.4.5 Prevention: Children are contagious for up to 48 hours prior to the appearance of the rash and until all lesions are crusted (usually another five to seven days). Women contemplating pregnancy should be VZV immune. The licensed VZV vaccine contains a live attenuated VZV strain and is NOT indicated in pregnant women. Only individuals considered varicella-immune may care for hospitalized children with VZV infection. For hospitalized children incubating or with active varicella–zoster virus infections, AIRBORNE PRECAUTIONS must be practiced in addition to STANDARD PRECAUTIONS. CONTACT PRECAUTIONS are also indicated when lesions are present.

4.5 Cytomegalovirus (CMV):

4.5.1 Prevalence: 50-70% of women are positive for CMV before pregnancy; 80-100% of children in daycare settings shed CMV at some time

4.5.2 Disease: Most infections are asymptomatic and undetected. Nonspecific febrile illness may occur as well as “infectious mono-like” syndromes; primary and reactivation disease in immunocompromised patients may result in pneumonitis, colitis, retinitis.

4.5.3 Impact on the developing fetus and/or newborn: CMV is the most common virus to infect the developing fetus. Most infected infants will know no sequelae; however, CMV is responsible for more long term morbidity than Down syndrome or fetal alcohol syndrome. Infants may have intrauterine growth retardation, microcephaly, intracranial calcifications, hepatosplenomegaly, thrombocytopenia, jaundice, and/or chorioretinitis. Infants apparently symptom-free at birth may manifest late hearing loss or developmental delay.

4.5.4 Vaccine: None

4.5.5 Prevention: Recognize that CMV is very prevalent and is frequently found in saliva and urine of infants and toddlers in particular. Those persons with recognized infections are the “tip of the iceberg” and serve to remind us that this virus is very common. Practicing hand hygiene and following STANDARD PRECAUTIONS are appropriate means of protection in the health care setting.

4.6 Respiratory viruses including influenza:

4.6.1 Seasonal outbreaks of respiratory infections in the community are common.

4.6.2 Disease: Agent specific, from upper respiratory infections to tracheobronchitis, to pneumonitis/pneumonia

4.6.3 Impact on the developing fetus and/or newborn: Congenital infections generally not a risk; severe lower respiratory disease (especially from influenza) in the mother may compromise oxygenation of the fetus.

4.6.4 Vaccine: All pregnant women should receive annual inactivated influenza vaccine regardless of trimester

4.6.5 Prevention: Hand hygiene as a part of consistent practice of STANDARD PRECAUTIONS and DROPLET PRECAUTIONS will minimize the risk of acquisition in the health care setting.

4.7 Pertussis

4.7.1 Prevalence: Pertussis continues to circulate in the community.

4.7.2 Disease: Can begin with cold-like symptoms (sinus, HA) advancing to lower respiratory infection associated with severe cough, inspiratory whoop, and pust-tussive vomiting

4.7.3 Impact on the developing fetus and/or newborn: Congenital infections are not a risk; infections in young infants can be severe and life threatening and are often traced back to a care provider.

4.7.4 Vaccine: All healthcare workers should receive Tdap. Pregnant women, who have not been previously vaccinated with Tdap, should receive one dose of Tdap during the second or third trimester or post-partum. In addition, all family members and caregivers of new infants should also get vaccinated with Tdap.

4.7.5 Prevention: Be suspicious of infants with cough or apnea and others with severe cough, post-tussive vomiting. DROPLET PRECAUTIONS in combination with hand hygiene and STANDARD PRECAUTIONS will minimize the risk of acquisition in the health care setting.

4.8 Other infectious agents that can pose a risk to women and their unborn children, such as *Treponema pallidum* (syphilis), *Chlamydia trachomatis*, herpes simplex virus, and group B streptococcus, are sexually transmitted and thus uncommonly acquired in health care settings. Infants infected with these agents can pose a risk for health care workers who fail to follow appropriate transmission-based precautions in addition to STANDARD PRECAUTIONS. Good hand hygiene practices and appropriate use of barriers minimizes any risk.

4.9 Caring for patients in N-95 AIRBORNE PRECAUTIONS: Changes in facial contours, which may occur during pregnancy, pose a potential for fit-failure of a disposable N-95 half-face respirator mask to which the individual was previously successfully fitted. For this reason, pregnant personnel are encouraged to consider being re-fit tested for safe use of a half-face N-95 respirator, if the need arises. Alternatively, pregnant personnel may find use of a purified air powered respirator (PAPR) more comfortable.

5.0 OVERSIGHT

The Infection Control Program will periodically review and update this guideline as appropriate. Policies and guidelines will be reviewed at least every 3 years. Questions regarding this guideline shall be directed to, and authority over this guideline shall vest with, the Infection Control Officer.

6.0 REFERENCES

6.1 Guideline for Infection Control in Healthcare Personnel, 1998. The Hospital Infection Control Practices Advisory Committee (HICPAC)

6.2 Vaccines for Pregnant Women at www.cdc.gov

REVISION HISTORY
Original Date
11/04/2003
Revision Date
6/02/2017

SMOKING VIOLATORS POLICY

1.0 PURPOSE

To provide uniform guidelines for the purpose of assuring that all hospital employees are in compliance with CCHMC smoking policy, and the general guidelines to use when a visitor is observed smoking on property.

2.0 POLICY

All CCHMC staff are responsible for enforcement of the Smoke and Tobacco Free policy. Protective Services will support CCHMC's efforts to encourage healthier lifestyles by prohibiting tobacco in or on all CCHMC properties.

3.0 DEFINITIONS

Tobacco Products – These include, but are not limited to, cigarettes, pipes, chewing or smokeless tobacco, cigars or snuff.

Electronic Cigarettes – An electrical device that simulates the act of tobacco smoking by producing an inhaled mist bearing the physical sensation, appearance, and flavor of smoking, cigarette or otherwise.

4.0 IMPLEMENTATION

4.1. **Employee and Contractor Violations.** For employees or contractors observed using or smelling of tobacco products or electronic cigarettes on CCHMC property, Protective Services Officers will:

4.1.1. Advise the employee that they are in violation of CCHMC policy.

4.1.2. Ask for their CCHMC ID badge to record their information.

4.1.3. Unit 1 will communicate this information via telephone or email to the employee/contractor's Supervisor, Manager or designee and report the infraction.

4.1.4. CCHMC employees will be subject to disciplinary action, up to and including termination, per Medical Center policy.

4.1.5. Non-CCHMC employees will be subject to their employers, sponsoring schools or organizations being notified by CCHMC and their services terminated.

4.2. **Visitor and Patient Violations.** For visitors observed smoking on CCHMC property, Protective Services will:

4.2.1. State the Tobacco Free policy: *For the health of our children, all buildings and grounds of Cincinnati Children's are Smoke and Tobacco-Free.*

4.2.2. Politely request that the person refrain from using any tobacco product while on property of CCHMC.

4.2.3. If the person will not stop using tobacco, politely request that they move away from the building as far as they feel comfortable.

4.2.4. Protective Services will not direct people to any area to smoke on or off campus.

4.2.5. **Electronic Cigarettes.** CCHMC staff and visitors are requested to refrain from the use of electronic cigarettes due to their visual similarity to tobacco and the Medical Center's desire to convey a completely smoke-free environment.

5.0 OVERSIGHT

The Senior Director, Protective Services will periodically review and update this policy as appropriate. Questions regarding this policy shall be directed to the Senior Director, Protective Services.

6.0 REFERENCES

Medical Center Policy 22 – Smoke and Tobacco Free Workplace

REVISION HISTORY
Original Date
01/01/07
Review Date
04/14/09, 10/21/11, 04/01/13, 10/15/15, 10/04/17

Language Access

Policy

CCHMC Medical Center Policy	*Policy Number*	MCP-F-106
	Effective Date	1/18/2019
Language Access	*Page*	1 of 4

1.0 PURPOSE

The purpose of this policy is to avoid discriminating against and ensure the safety of Cincinnati Children's Hospital Medical Center ("CCHMC") patients, parents and/or persons authorized to consent with limited English proficiency ("LEP") and/or communication disabilities, by ensuring accurate and timely communication with CCHMC personnel.

2.0 POLICY

CCHMC will provide language access services to patients, parents, or persons authorized to consent with LEP, hearing and/or visual impairments in order to ensure effective communication between these individuals and CCHMC.

3.0 DEFINITIONS

3.1. Vital Documents – Documents that are a key component of providing access to LEP persons, and to ensuring that LEP persons are informed of CCHMC's and of their own rights and responsibilities. By applying HHS guidance to CCHMC's programs activities, these are:
- 3.1.1. General consent form
- 3.1.2. Financial responsibility form
- 3.1.3. Notice of Privacy Practices
- 3.1.4. Visitation Rights and Responsibilities
- 3.1.5. Your Rights and Responsibilities
- 3.1.6. Financial Assistance Policy (formal and plain-language)
- 3.1.7. Financial Assistance Application
- 3.1.8. Handouts and flyers advertising financial assistance
- 3.1.9. Notices advising LEP persons of free language assistance
- 3.1.10. Short form consent to participate in research
- 3.1.11. Informed consent for surgical/medical procedure form

3.2. Significant Documents – All vital documents and any other significant publications or significant communications targeted to patients, families and members of the public

3.3. Individuals with Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English

3.4. Language access services, formerly referred to in CCHMC policy as Communication/language assistance – reasonable steps taken to provide meaningful access to individuals with LEP. These include, but are not limited to, interpreting, translation, the use of qualified bilingual or multilingual staff to communicate directly with individuals with LEP, and taglines (short statements written in non-English languages that indicate the availability of language assistance services free of charge).

3.5. Translation – communication of the meaning of text in one language by means of an equivalent text in another language

3.6. Interpreting – immediate communication of meaning from one language into another, orally or with sign-language
- 3.6.1. Electronic remote interpreting – interpreting provided by a remote or offsite interpreter via a device such as a telephone, videophone or web camera
- 3.6.2. On-site, face-to-face interpreting – interpreting provided by an interpreter who is physically present with the individual with LEP
- 3.6.3. Sight translation – oral communication of the meaning of text in one language by means of another language

3.7. Qualified bilingual Personnel (QBP) – CCHMC staff who Language Access Services has designated after training and testing to provide oral language assistance, and have demonstrated that they (1) are proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and (2) are able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages. Language Access Services keeps the official registry of qualified bilingual staff.

3.8. Qualified interpreter – a person providing interpreting who (1) adheres to generally accepted interpreter ethics principles, including client confidentiality; (2) has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and (3) is able to interpret effectively, accurately, and

impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. Language Access Services keeps the official registry of qualified interpreters.

3.9. Qualified translator – a person providing translation who (1) adheres to generally accepted translator ethics principles, including client confidentiality; (2) has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and (3) is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. Language Access Services keeps the official registry of qualified translators.

3.10. CCHMC personnel – all Cincinnati Children's employees, medical staff members, trainees, contractors or representatives

3.11. Communication Disabilities – vision, hearing, or speech disabilities

3.12. Auxiliary aids and services

3.12.1. Qualified interpreters, computer-aided transcription services, written materials, or other effective methods of making aurally delivered materials available to individuals with hearing impairments

3.12.2. Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments

3.12.3. Acquisition or modification of equipment or devices

3.12.4. Other similar services and actions

4.0 IMPLEMENTATION

4.1. Identification of Individuals Requiring Services

CCHMC will ask patients, parents and/or persons authorized to consent if they need language access services when the patient is scheduled and/or registered into CCHMC's clinical systems. Their preferred language for discussing health care will be documented in the patient's medical record, even when that language is English.

4.2. Covered Activities

CCHMC may provide language access services to identified individuals for any interaction with CCHMC personnel not specifically excluded below. Language Access Services will manage the provision of all language access services. CCHMC departments and units may need to cover the cost of these services.

4.2.1. Non-covered Activities.

4.2.1.1. For legal reasons, CCHMC will only provide interpreting services for Cincinnati Children's employees and vendors. Any exception must be approved in advance in writing by Language Access Services management.

4.2.1.2. For legal reasons, CCHMC will not translate documents for which CCHMC does not hold the copyright and which are not in the public domain unless the copyright holder gives us permission to do so.

4.3. Services

4.3.1. Interpreter Services

CCHMC staff will use an interpreter when speaking with individuals with limited English proficiency. The patient's or parent/persons authorized to consent's primary language, the name and ID number of the medical interpreter, the platform (in-person, telephonic or video) and the date will be documented in the appropriately designated places in the patient's medical record.

4.3.1.1. Acceptable interpreting methods

Due to the limited availability of face-to-face interpreters, CCHMC's preferred mode of interpreting will be electronic remote (telephonic and video remote) interpreting. While face-to-face interpreters will be available for limited situations and languages, the use of telephonic and video remote interpreting will be regarded as appropriate in most instances.

4.3.1.1.1. If the video remote interpreting device is producing lags, choppy, blurry, or grainy images, irregular pauses in communication, or unclear, inaudible transmission of voices, it is not an acceptable interpreting method.

4.3.1.2. Sight Translation

Interpreters may sight translate documents. They have an ethical and professional responsibility to

decline requests to sight translate documents when, in their professional opinion, it would not be an effective way of communicating the information. This is often the case with complex or critical documents such as consent forms.

4.3.1.3. Qualifications to interpret - Only qualified interpreters may provide interpreter services.

4.3.1.3.1. Adults accompanying an individual with limited English proficiency may only interpret or facilitate communication (i) in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.

4.3.1.3.1.1. It is not generally appropriate for adults accompanying an individual with limited English proficiency to interpret or facilitate communication for the purposes of informed consent or discharge.

4.3.1.3.1.2. Form J1011 will be completed whenever an adult accompanying an individual with limited English proficiency interprets or facilitates communication.

4.3.1.3.2. Minor children may only interpret or facilitate communication in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available.

4.3.1.4. Language Identification

If an individual with limited English proficiency is unable to verbally communicate their preferred spoken language to staff, staff will use a language identification card or contact the telephonic interpreter service for assistance.

4.3.1.5. Declining an Interpreter

An individual with limited English proficiency may decline a qualified interpreter. However, providers may use a qualified interpreter to assist in communicating with, and assuring appropriate treatment to, the individual.

4.3.2. Written Translation Services

CCHMC personnel may request the translation of any document needed for any Covered Activity.

4.3.2.1. CCHMC will provide written translations of vital documents for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons likely to be affected or encountered.

4.3.2.2. CCHMC will use the most recent census data applicable to its Primary and Secondary Services Area for persons who live in a household with children aged 17 or younger, and speak English less than very well.

4.3.2.3. CCHMC will regularly, no less frequently than every three years, assess factors such as requests for translations or interpreters, feedback received from persons and families with LEP, feedback received from patients and community organizations, and the like to determine whether vital documents should be translated into additional languages.

4.3.2.4. Qualifications to translate - Only qualified translators (3.9) may provide written translation services.

4.3.3. Direct Communication with Individuals with Limited English Proficiency - Only tested bilingual personnel (QBP), particularly clinicians, may communicate directly with individuals with limited English proficiency.

4.3.4. Taglines - CCHMC will include in all significant documents taglines in at least the top 15 languages (or top 2 languages for small-sized significant documents) spoken by individuals with limited English proficiency of the States where CCHMC has facilities and also on CCHMC's website.

4.3.5. Services for Individuals with Communication Disabilities

CCHMC will provide auxiliary aids and services to communicate with people who have communication disabilities.

4.3.5.1. Primary Consideration

CCHMC will give primary consideration to the choice of aid or service requested by the person who has a communication disability unless CCHMC can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental

alteration or in an undue burden. If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, CCHMC will provide an alternative aid or service that provides effective communication if one is available.

4.3.5.1.1. Advance Notice

CCHMC will require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service. “Walk-in” requests for aids and services will also be honored to the extent possible.

4.3.5.1.2. Undue Burden

In determining whether a particular aid or service would result in undue financial and administrative burdens, CCHMC will take into consideration the cost of the particular aid or service in light of all resources available to CCHMC and the effect on other expenses or operations. The decision that a particular aid or service would result in an undue burden must be made by a high level official, no lower than a Department head, and must include a written statement of the reasons for reaching that conclusion.

4.3.5.2. Website Accessibility

CCHMC will ensure that any Covered Activities provided through websites comply with the requirements of Title II of the ADA.

4.4. On a regular basis, no less frequently than every three years, CCHMC will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures.

5.0 OVERSIGHT

All revisions of this policy must be approved by the responsible department before being approved by the President and CEO. This policy will be reviewed every three years or sooner if deemed necessary. Policy authority for this document resides with Chief of Staff and Assistant Vice President Medical Operations.

6.0 REFERENCES

6.1. Executive Order 13166, 65 FR 50121 (August 16, 2000).

6.2. Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d and regulations.

6.3. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, Department of Health and Human Services

6.4. Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care Roadmap for Hospitals: Appendix C, New Joint Commission Standards, The Joint Commission, 2010

6.5. ADA Requirements: Effective Communication (January 31, 2014)

6.6. Nondiscrimination in Health Programs and Activities, A Rule by the Health and Human Services Department on 05/18/2016

HISTORY
Original Date
9/1/1978
Revision Date
1/2/2007, 10/27/2010, 8/27/2014, 7/7/2016,1/18/2019
Review Date

HEALTHCARE WORKERS RESTRICTIONS DUE TO ILLNESS

1.0 PURPOSE

To create a work environment where employees are encouraged to report conditions or illnesses that are potentially contagious in order to minimize the risk that staff will transmit an infectious disease to a patient, visitor, or other staff member. These guidelines place additional restrictions on direct care providers because their duties require face-to-face patient contact. However, any highly contagious condition could restrict any employee from their duties.

2.0 POLICY

CCHMC expects all individuals to understand and practice *Standard Precautions (see IC-1.2)* as a part of their routine duties. These practices will minimize the likelihood of acquiring a contagious illness in the workplace. It is also recognized that employees may become ill from infectious agents that we encounter at home or in the community. Individuals who may transmit infectious agents must not work. To allow for these circumstances, employees are considered for a reduction or exemption from recorded "occurrence of absence" in accordance with Personnel Policy WE-01.

3.0 DEFINITIONS

Occurrence - Absence

3.1 Under Personnel Policy WE-01, individuals will have one (1) "occurrence of absence" recorded if they miss three consecutive calendar days.

3.2 If absence beyond 72 hours (3 consecutive calendar days) is due to a continuing or recurring contagious condition, employees may request review by the Director of Infection Control for consideration of a reduction or exemption of recorded "occurrence of absence".

3.3 An occurrence will be recorded if an individual is sent home by their manager, Employee Health, or Infection Control because of an infectious condition.

3.4 In the event of a widespread community outbreak of an infectious disease, exemption of an occurrence may be considered in healthcare workers with an illness associated with the outbreak.

3.5 Individuals with acute infectious illnesses or conditions that prevent them from practicing *Standard Precautions (see IC-1.2)* should not work and must notify their manager/supervisor in keeping with departmental policy. Managers may assist such individuals with temporary alternative job assignments if appropriate and available.

3.6 Healthcare workers who are not ill but are absent from work because of exposure to a communicable disease (e.g., measles, pertussis, TB, varicella) that has resulted in furlough by Infection Control, may request that the absence be considered for a reduction or exemption from any recorded "occurrence of absence." These individuals must notify their managers/supervisors as soon as the condition is recognized. These individuals must file a "Request for Reduction or Exemption from Recorded Occurrence of Absence" with the Director of Infection Control within seven (7) calendar days of the last day of the absence.

4.0 IMPLEMENTATION

Reduction or Exemption of Occurrence of Absence

4.1 To be considered, employee must file a "Request for Reduction or Exemption from Recorded Occurrence of Absence" (see Appendix A) with the Director of Infection Control within seven (7) calendar days of the last date of absence. Incomplete, illegible, and late submissions will not be considered. Laboratory evidence of the specific disease may be requested. PTO, EIB, or FML rules may be applicable for an absence and should be discussed with the manager/supervisor.

4.2 A "doctor's excuse" does not result in a reduction or exemption from a recorded "occurrence of absence." Absences are still accrued as in Personnel Policy WE-01. A note from a treating physician can provide corroborating evidence for the reason for an absence, but it is not sufficient to justify a reduction or exemption.

4.3 The Director of Infection Control will review all requests and notify the employee and the employee's manager by e-mail whether or not an "occurrence of absence" has been reduced or exempted (see Appendix A).

4.4 A log of all requests and decisions made is maintained by Infection Control and shared with Employee Health.

The following table serves as a GUIDELINE to help individuals and their managers or supervisors minimize risks of infection transmission in the health care setting.

Note: Reduction or Exemption from recorded *"occurrences of absence"* requires review and approval by the Director of Infection Control.

Illness/Condition	*Work Restriction*	*Duration/Comment*
Casts or bandages that prevent effective hand washing	No direct patient contact.	Until effective hand hygiene can be established.
Conjunctivitis - non-allergic; with uncontrolled drainage watery, itchy eyes are most often allergy related)	No direct patient contact.	Until discharge ceases.
Dermatitis, hand (moderate to severe)	No direct patient contact.	Until effective hand hygiene can be established.
Diarrhea Acute infectious gastroenteritis (for bloody diarrhea, evaluation and culture are recommended)	No direct patient contact, no food handling--be considerate of co-workers.	Individuals should stay home until acute symptoms resolve. When returning to work ALL individuals must practice good hand hygiene.
Convalescent from culture confirmed Salmonella, Shigella, Yersinia, Campylobacter, Giardia or E. coli 0157:H7.	MUST be cleared by Employee Health to work in any clinical area. No high-risk patient care (NICU, PICU, CICU, Hem/Onc, BMT, solid organ transplant). NOTIFY Infection Control.	MUST be cleared by Employee Health (State of Ohio Health Department regulations may apply).
Enteroviral infections (febrile illness, seasonal, recognized by epidemiologic link to confirmed case)	No high-risk patient care (NICU, PICU, CICU, Hem/Onc, BMT or solid organ transplant).	Until symptoms resolve. Good hand hygiene is essential upon return to work.
Hepatitis A virus infection Laboratory-confirmed or epidemiologic link to confirmed case	No direct patient contact, no food handling and no childcare. Must NOTIFY Infection Control.	Until seven (7) days after onset of jaundice. MUST be cleared by Employee Health.
Herpes simplex virus infections		
Cold sores/fever blisters (for recurrent disease, individuals are encouraged to talk with their primary care provider about antiviral prophylaxis)	No high-risk patient care (NICU, other infants < 2 months of age, patients with widespread dermatitis, immunocompromised patients).	Until crusted.
Herpetic whitlow (herpes simplex infection involving fingers)	No direct patient contact.	Until lesions heal.
Impetigo (superficial skin infections with *Staphylococcus aureus* or *Streptococcus pyogenes*) See also Skin Lesions	No direct patient contact; no Operating Room duty.	Until 24 hours effective treatment; **NO** O.R. duty until lesions resolved.
Infectious mononucleosis	No restrictions.	
Lice (Pediculosis)	No direct patient contact.	Until effectively treated, generally until first application of pediculicide; for extensive disease, consult with Employee Health prior to return to work.
Measles (Rubeola)	**EXCLUDED from duty**; must NOTIFY Infection Control.	Until 4 days after rash appears.
Exposure (susceptible individuals only)	**EXCLUDED from duty**; must NOTIFY Infection Control.	Will be furloughed from 5th to 21st day after exposure.

Illness/Condition	*Work Restriction*	*Duration/Comment*
Mumps	**EXCLUDED from duty**; must NOTIFY Infection Control.	Until five (5) days after onset of parotid swelling.
Exposure (susceptible individuals only)	**EXCLUDED from duty**; must NOTIFY Infection Control.	Will be furloughed from 12th to 26th day after last exposure.
Pertussis (actively ill with cough, post-tussive emesis, or other signs of whooping cough)	**EXCLUDED from duty**; must NOTIFY Infection Control.	Until 6th day after effective therapy started or through 3rd week of paroxysmal stage.
Exposure history (symptomatic; runny nose, cough occurring in the incubation period)	**EXCLUDED from duty**; must NOTIFY Infection Control.	Will be furloughed until 6th day after effective therapy started. Regardless of immunization status, individuals who become symptomatic within the incubation period of 6 to 21 days following exposure must notify Infection Control; diagnostic testing may be indicated; furlough from duty may occur.
Exposure history (asymptomatic and/or Tdap immunized)	No restrictions; must NOTIFY Infection Control of exposure and any symptoms that subsequently develop.	Antibiotic prophylaxis is recommended for health care workers that have not been Tdap immunized.
Respiratory illness - acute (individuals are generally most contagious in the first few days of an acute respiratory illness)	Restrict from high-risk direct patient care, especially NICU and BMT; caution in PICU, CICU.	Until acute symptoms resolve (usually 2 to 3 days); an isolation mask and good hand hygiene are required for any symptomatic individual, regardless of care areas to which they are assigned.
Ringworm (involving hands and forearms)	No direct patient care.	Until effective treatment initiated and adequate hand hygiene can be accomplished.
Scabies	No direct patient care.	Until effectively treated (i.e., one application of scabicide and cleared by Employee Health or Infection Control).
Skin rashes suspicious for an infectious agent (e.g., measles, rubella, varicella, enterovirus)	No direct or indirect patient care. Individuals with febrile rashes should see primary care provider.	Until no longer considered contagious. MUST be cleared by Employee Health and NOTIFY Infection Control.
Skin lesions • Open or draining lesions (e.g., burns or poison ivy)	No direct patient care.	Unless lesions are easily covered and adequate hand hygiene can be accomplished.
• Active staphylococcal infections, ORSA/MRSA in particular (e.g., cellulitis, furunculosis, abscesses)	No direct or indirect patient care, no O.R. duty, no food handling, no child care contacts. Culture confirmation recommended.	Until lesions are no longer draining or otherwise active, any resolving lesions can be easily covered, and adequate hand hygiene can be accomplished.
• Recurrent staphylococcal infections, ORSA/MRSA in particular.	No direct or indirect patient care, or childcare and no food handling while lesions are active, as above.	Health care workers must consult Employee Health. Culture confirmed recurrences may be considered for exemption; use *IC-5.2-Appendix A* to report each event).
• Staphylococcal carrier state, either sensitive or resistant.	No restrictions (see comment).	Infection Control may restrict work activities if health care worker is linked epidemiologically to transmission; decolonization may be attempted.

Illness/Condition	*Work Restriction*	*Duration/Comment*
• Streptococcal skin infection, cellulitis or abscess	No direct patient contact and no O.R. duty.	Until 24 hours effective treatment and lesions are no longer draining or otherwise active; **NO** O.R. duty until lesions resolved.
Tuberculosis (TB)		
• Active TB disease	**EXCLUDED from duty**; must NOTIFY Infection Control.	Until proven non-infectious and cleared by Employee Health and Infection Control.
• PPD skin test converter, only*	No restrictions.	* Skin test status MUST be verified by Employee Health.
• Exposure to an active case of TB, including known community exposures	No restrictions; must NOTIFY Infection Control.	REPORT exposure to Employee Health as part of TB screening program.
Varicella zoster virus (VZV) infections		
• Chicken pox (varicella)	**EXCLUDED from duty**; must NOTIFY Infection Control.	Until lesions dry and crusted; MUST report to Employee Health before duty.
• Shingles (herpes zoster), localized in a healthy individual	If lesions can be adequately covered, may work but **NOT** in an inpatient area and **NOT** with high-risk outpatients (e.g., Hem/Onc and BMT patients, neonates). NOTIFY Infection Control.	Until lesions dry and crusted; MUST report to Employee Health before duty.
• Shingles (herpes zoster), localized or disseminated in an immunosuppressed individual	**EXCLUDED from duty**; must NOTIFY Infection Control.	Until lesions dry and crusted; MUST report to Employee Health before returning to duty.
• Exposure to individual with a VZV infection (susceptible individuals only)	**EXCLUDED from duty**; must NOTIFY Infection Control.	Furloughed from 8th to 21st day post exposure (day 28 if VZIG administered).

5.0 OVERSIGHT

The Infection Control Program will periodically review and update this guideline as appropriate. Guidelines will be reviewed at least every three (3) years. Questions regarding this guideline shall be directed to, and authority over this guideline shall vest with, the Infection Control Officer.

6.0 REFERENCES

6.1 CDC. Guidelines for Infection Control in Health Care Personnel, 1997. Recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC).

6.2 APIC Text of Infection Control and Epidemiology, 4th ed. Chapter 100 Occupational Health. Author: Sebazzo, Sue, RN, MBA, CIC. Publisher: APIC 2014

7.0 APPENDICES (follow on subsequent pages)

Appendix A – Request for Reduction or Exemption from Recorded Occurrence of Absence

REVISION HISTORY
Original Date
12/21/2005
Revision Date
12/06/2016

Request for Reduction or Exemption from Recorded Occurrence of Absence

IMPORTANT: Refer to policy *IC-5.2* for eligible conditions. A doctor's excuse DOES NOT exempt employees from recorded absences. Employees must file a **COMPLETED** form with the Director of Infection Control (fax 636-7598) within seven (7) calendar days of the last date of absence to be considered for any reduction in the number of recorded absences for a given condition. **Late, illegible, or incomplete forms will NOT be considered.**

PLEASE PRINT LEGIBLE

*Employee Name (PRINT):*_____ *Employee Number:*_____

*Employee Email (PRINT):*_____ *Department/Unit (PRINT):*_____

*Manager/Supervisor (PRINT):*_____ *Manager/Supervisor email (PRINT):*_____

*Date(s) of absence:*_____

(1st – last dates of contiguous absences)

Indicate below the condition(s) for which you request consideration for reduced recorded "occurrences"

- ☐ Chickenpox or shingles
- ☐ Pertussis
- ☐ Influenza or influenza—like illness
- ☐ Gastroenteritis (vomiting/diarrhea)
- ☐ Herpetic whitlow
- ☐ Other listed in policy (described below)
- ☐ Hepatitis
- ☐ Suspected measles or other contagious rash
- ☐ Condition preventing hand hygiene
- ☐ Specify: _____
- ☐ Orolabial herpes (cold sore)

Employee Comments (please do not exceed this space)

_____

_____

_____

_____

_____

FOR INFECTION CONTROL USE ONLY

Disposition:

- □ Not considered because □ Filed late –or– □ Form incomplete –or– □ Condition not applicable
- □ No occurrence
- □ One (1) occurrence applies

_____

Director Infection Control or designee Date

GUIDELINES ON CONSENT FORMS

Guideline

1.0 SCOPE

Obtaining and documenting consent when the individual giving consent (e.g. patient, parent or guardian) has limited English proficiency (LEP). Interpreters cannot provide written translation for consent purposes.

2.0 DEFINITIONS

2.1. Individual with LEP – Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP."
2.2. Informed Consent – see policy *MCP-G-107: Consent for Treatment and Informed Consent* for definition.
2.3. Translator – a professional who recreates a written message by writing it in a different language.
2.4. Interpreter – a professional who recreates a spoken or signed message by speaking or signing it in a different language. Interpreters cannot sign as the witness on consent forms.
2.5. Machine translation – use of software to automatically translate text from one language to another. To minimize safety and compliance risk, machine translation (e.g. Google Translate or Microsoft Translator) cannot be used at Cincinnati Children's.
2.6. Bilingual consent form – a consent form with English and a different language side-by-side.

3.0 GUIDELINE

3.1. Obtain consent from an individual with LEP by working with an interpreter for their preferred spoken or signed language per Policy MCP-G-107 and Policy MCP-F-106.
3.2. To document consent from an individual with LEP:
  3.2.1. Determine if a bilingual consent form is available in the preferred written language of the individual with LEP who is giving consent.
    3.2.1.1. They are stored in the forms repository.
    3.2.1.2. The form ID is the English form ID followed by the ISO 639-1 language code, e.g. J1194-AR for the Arabic translation of form J1194 and J1194-ES for the Spanish translation.
    3.2.1.3. Templated, filled-out, procedure-specific versions of consent forms for surgical/medical procedure will not be available initially. Use a standard, blank consent form for surgical/medical procedure instead.
  3.2.2. If a bilingual consent form is not available in the preferred written language of the individual with LEP who is giving consent, determine if there is time to request it.
    3.2.2.1. Language Access may need more than 24 hours to create a bilingual consent form.
    3.2.2.2. Per federal regulation, interpreters are not translators. They cannot provide written translation for consent purposes.
  3.2.3. If there is not time to request creation of a bilingual consent form, use the English consent form to document the individual's consent.
    3.2.3.1. Anyone required to sign the form (including the individual with LEP) should sign the English form.
    3.2.3.2. The interpreter cannot sign as the witness.
    3.2.3.3. If there is not a line for the interpreter to sign, write "Interpreter:" followed by their name and ID number at the bottom of the page.
    3.2.3.4. Electronic remote interpreters (video or phone) cannot sign forms. Instead document only the interpreter's name and ID number.
    3.2.3.5. Do not ask the interpreter to sight translate, i.e. read the English consent form aloud in another language. Instead discuss the contents of the form with the family through the interpreter.
  3.2.4. If there is time to request creation of a bilingual consent form, complete the Translation Request Form on CenterLink, attaching the PDF of the English consent form from the forms repository.

3.2.4.1. Language Access will advise you if the deadline you request is not feasible, in which case you may need to use the English consent form to document consent (see 3.2.3 above).

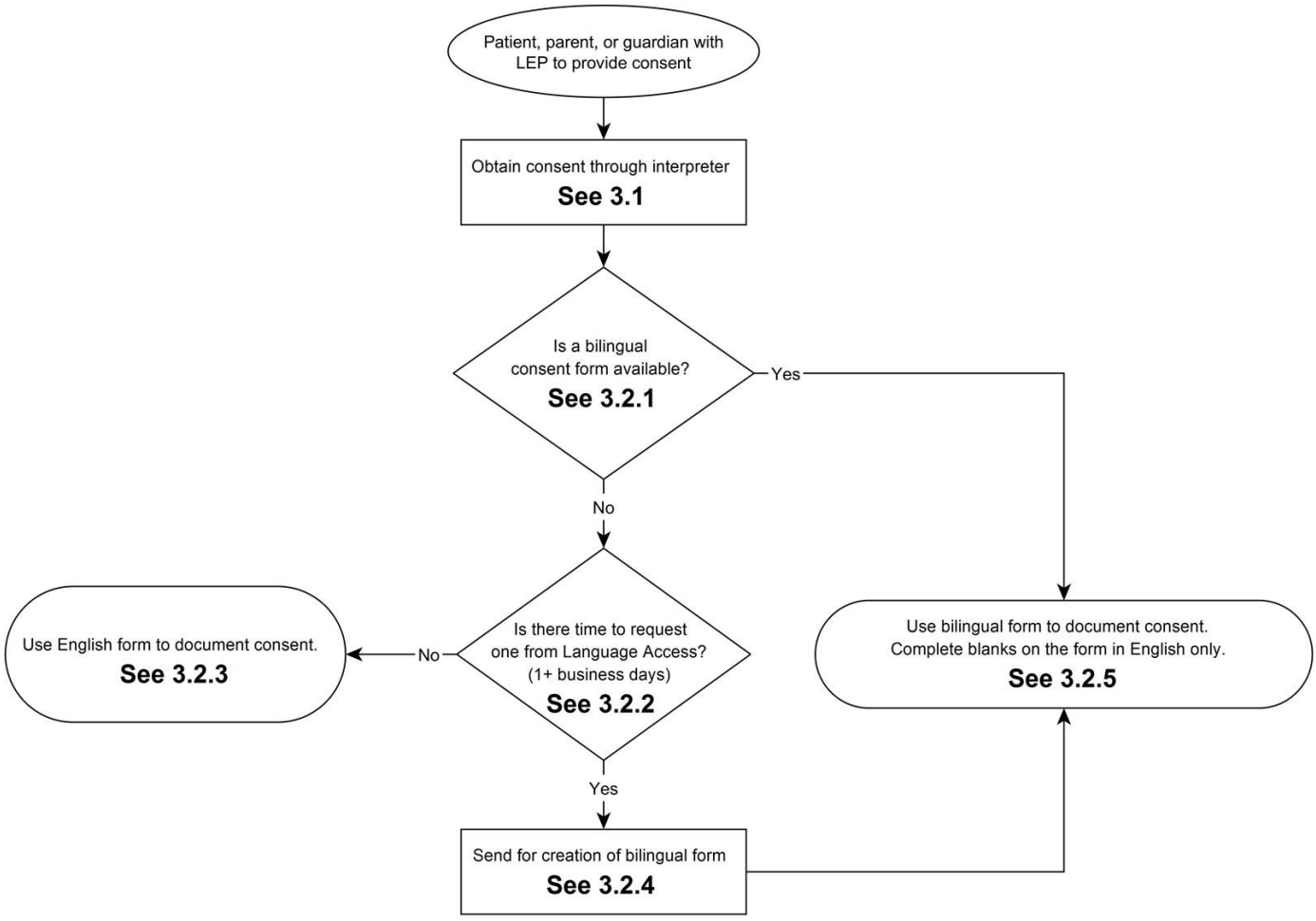
3.2.5. Once you have the bilingual consent form, use it to document consent, including consent obtained by telephone.

3.2.5.1. Complete the blanks on the form in English only, e.g. procedure, risks, benefits, alternatives, etc.

3.2.5.2. Electronic remote interpreters (video or phone) cannot sign forms. Instead document only the interpreter's name and ID number.

3.2.5.3. The witness is signing the form to indicate that they saw the individual sign it. The witness is not required to speak or read the individual's preferred language.

3.2.5.4. The interpreter cannot sign as the witness.



4.0 REFERENCES

4.1. MCP-F-106: Language Access
4.2. MCP-G-107: Consent for Treatment and Informed Consent
4.3. Nondiscrimination in Health Programs and Activities, A Rule by the Health and Human Services Department on 05/18/2016

5.0 APPROVALS

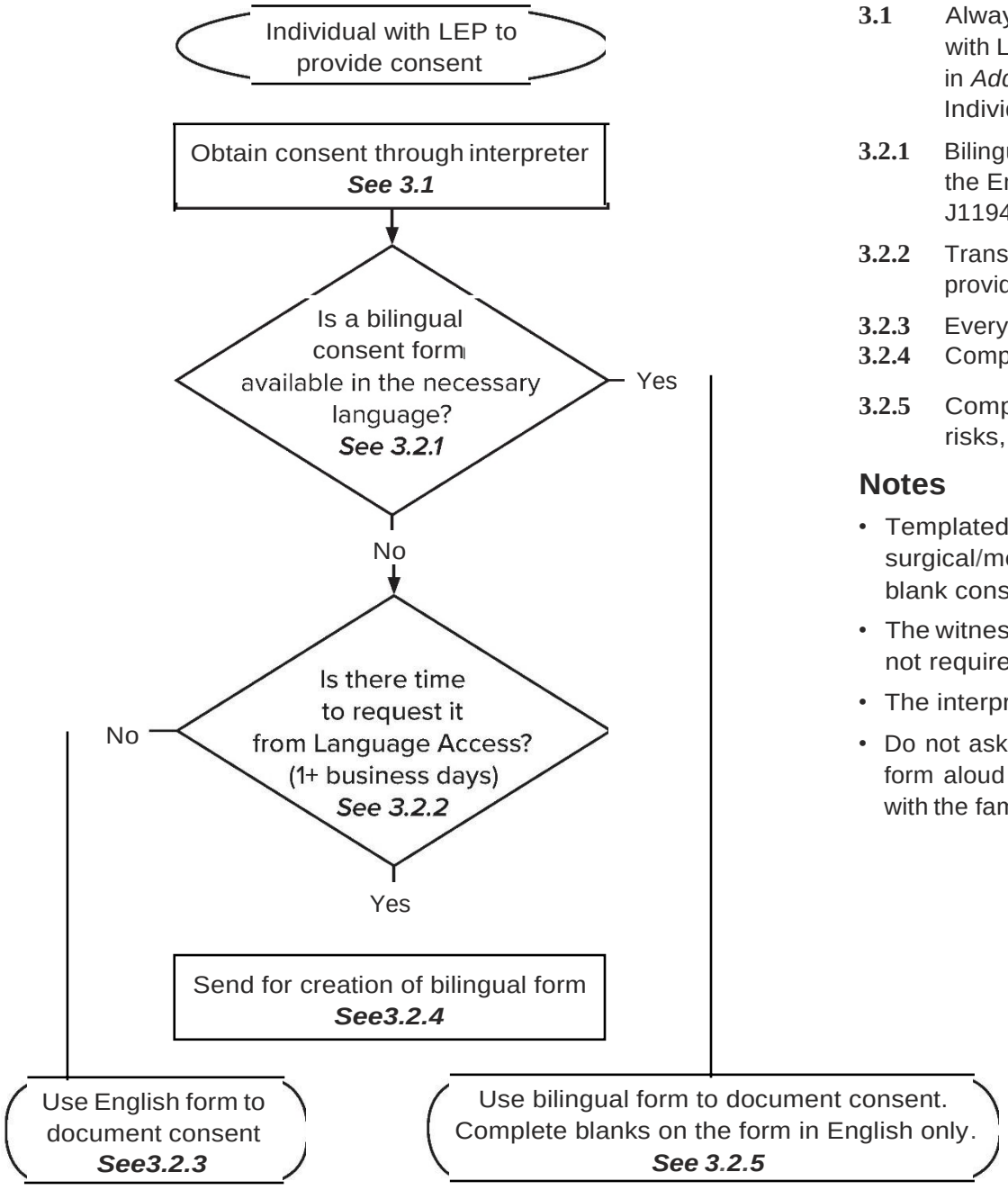
All revisions of this guideline are approved by the Chief of Staff Office, Assistant Vice President Medical Operations. This guideline is reviewed every three years or sooner if deemed necessary. Authority for this document resides with the Chief of Staff Office, Assistant Vice President Medical Operations.

HISTORY

Original Date
1/31/2017
Revision Date
3/2/2017, 9/20/2017
Review Date

Quick Reference for Medical Center Guide-OS

Obtaining and documenting consent from individuals with limited English proficiency (LEP)



3.1 Always use an interpreter to communicate with individuals with LEP. Preferred written and spoken languages are documented in *Additional Information* in the *Demographics* section in Epic. Individuals may change their preferred languages at any time.

3.2.1 Bilingual consent forms are in the forms repository, numbered like the English forms (e.g. J1194-AR for the Arabic translation of form J1194 and J1194-ES for the Spanish translation).

3.2.2 Translation may take more than 24 hours. Interpreters cannot provide written translation for consents.

3.2.3 Everyone signs the English form.

3.2.4 Complete the Translation Request Form on Centerlink.

3.2.5 Complete the blanks on the form in English only, e.g. procedure, risks, benefits, alternatives, etc.

Notes

- Templated, filled-out, procedure-specific versions of consent forms for surgical/medical procedure will not be available initially. Use a standard, blank consent form for surgical/medical procedure instead.
- The witness signs to indicate they saw the individual sign. The witness is not required to speak or read the individual's preferred language.
- The interpreter cannot sign as the witness.
- Do not ask the interpreter to sight translate, i.e. read the English consent form aloud in another language. Instead discuss the contents of the form with the family through the interpreter.

Updated 2017-09-11

SHADOWING GUIDELINES

Free 2-Hour Shadowing Sessions

We are pleased to continue offering our Interpreting Shadowing Program to contractor interpreters. Cincinnati Children's Language Access team in partnership with our vendors, offers this opportunity to advance your interpreting skills, learn new terminology, and help ensure we provide high-quality interpretation.

General Guidelines:

-The Interpreting Shadowing Program is intended for Interpreters level 2 moving up to level 3.
-The type of assignments are primarily in the Cancer and Blood Diseases Institute (CBDI), Neurology, Cardiology, and other level 3 clinics as well as rounds.
-Two sessions are available each Monday and Thursday, one in the morning (9:00 am to 11am) and one in the afternoon (1:00 pm to 3:00 pm).
-We request to have one interpreter per day per shift and to have the time requesting for shadowing 1 week in advance.
-Interpreter must follow proper protocol already set up with their agency by submitting the appropriate request by emailing Francisca.horner@cchmc.org
-Interpreters must arrive on-time at the scheduled location and must be present during the entire session.
-Electronic devices should be put away during their assignments, unless they are looking up medical terminology. Contractor interpreters should always be attentive to the encounters, body language should reflect their interest in what is being discussed. Therefore, they should never turn their backs and look like they are not a part of the encounter.

Key Reminders:

- We ask that the interpreter don't interfere with the session in progress nor engage in side conversations.
- If you have questions write them and ask those questions when the session in completed.
- Our staff has no control over the amount of time of the appointments, cancellations, unforeseen changes in the schedule. Please remind the interpreters that they might have some down time or might be dismiss earlier.

POINT COMPLAINT SYSTEM

Cincinnati Children's

Point System for Medical Interpreters

Attendance

Late	0.5	Arrival at the appointment location later than the scheduled appointment time.
No show	2	Failure to arrive for an appointment. In case of a snow day in the school district where the interpreter lives, this will be reduced to 1 point. No points will be assessed to the interpreter if the interpreter's agency finds another interpreter to cover the appointment.
Failure to notify	1	Failure to provide notification prior to *Late* or *No show*. Interpreter Services must be notified by the agency in writing 15 minutes prior to the scheduled appointment time.

Dress Code

Attire	1	Failure to follow Uniform and Dress Code Policy WE-04 or the Dress Code for Interpreters at Cincinnati Children's.
Accessories	1	Wearing facial jewelry or any jewelry that is a distraction, visually or auditorily.
Perfume/cologne	1	Wearing perfume or cologne.

Professionalism

Demeanor (respect, attitude)	2	Failure to treat all parties with dignity and courtesy, respecting the rights and duties of each individual, including those of the interpreter.
Other unprofessional behavior	2	Behavior which goes against the canons of the interpreting profession and does not fall into any other category listed here.

Interpreter Duty

Pre-session	1	Failure to briefly discuss with all parties, prior to the interpreting session, the most important points that will help make things go smoothly for the interpreter and all parties.
Fraternizing	2	Talking with a patient or family outside of the pre-session and interpreting session, or staying in the exam room without a provider present.
Compliance with policies, procedures and guidelines	2	Failure to comply with all applicable Cincinnati Children's policies, procedures and guidelines.
Positioning	1	Failure to arrange the spatial configuration to support direct communication between the participants.

Updated February 12, 2016

Cincinnati Children's

After Hours On-Call

Not answering phone	3	While on call, failure to answer the phone or respond to a voicemail within 5 minutes, except if the interpreter is in an interpreting session at Cincinnati Children's.
Late (on-call)	2	Arrival at the requested location more than 30 minutes after being called in.

Advising/Impartiality

Remaining unbiased	4	Allowing personal judgments or cultural values to influence objectivity, or not disclosing potential conflicts of interest.
Side conversations	3	Speaking directly with one party during the interpreting session, except for the purposes of clarification after first informing the other party.
Accepting gifts	4	Accepting any gift from any party.

Accuracy

Omitting	4	Not transmitting the entire message.
Adding	5	Transmitting more information than was included in the original message.
Polishing	3	Transmitting an improved or refined version of the message.
Summarizing	3	Transmitting only a brief statement of the main points of the message.
Misinterpretation	3	Transmitting a word and/or concept incorrectly during the message's rendition.

Confidentiality/HIPAA

Confidentiality/HIPAA	18	Written or oral disclosure of information outside the care team, except with the patient's consent or if required by law.

Implementation Measures

Interpreters who accrue 10 points during a period of 6 months will be suspended from working at Cincinnati Children's for 7 calendar days. Before the interpreter returns to work, the agency must provide proof of individualized coaching.

Interpreters who accrue 20 points during a period of 12 months will be terminated, i.e. permanently suspended from working at Cincinnati Children's.

At the time of suspension the interpreter's point balance will be set at 4.

Interpreters suspended twice during a period of 6 months will be terminated.

Suspensions will be made effective on the date a decision is made regarding the validity of the points assessed to the interpreter.

Scheduled quality control assessments (QCAs) will have no impact on the interpreter's point balance. Points will only be assessed during unscheduled QCAs.

E-cards

1 point will be deducted from the interpreter's point balance every time positive feedback is received from a Cincinnati Children's employee through the e-card system.

QUALITY CONTROL ASSESSMENTS

CCHMC QUALITY CONTROL PROGRAM

Dear Interpreter,

Welcome to Cincinnati Children's. We are pleased to have you join our team and look forward to our future collaboration. In order to ensure that we are providing high quality services, Language Access Services has created the Quality Control Assessment Program. As part of this program, you are going to be observed by one of our staff interpreters during an interpreting session. This staff interpreter will fill out a survey for the QCA session and the report would be sent to your agency in 5-7 business days. We hope the report helps you understand your strengths and weaknesses as an interpreter. Our staff is instructed to not interfere with the interpretation session or share any feedback with the interpreters during or after the session. Below you can find a list of areas that we will evaluate during the QCA session.

This program is divided in two types of assessments:

a. **Quality Assurance Assessment (QAA)** as part of the requirements to move to Level III

   1. Complete a minimum of 80 hours of reported interpreting time as a Level II interpreter through Cincinnati Children's.
   2. Complete a formal Interpreter Education Program
   3. After completing the required interpreting time at Cincinnati Children's, vendor will ensure the interpreter is exposed to specific terminology and concepts commonly found in Level III assignments. Cincinnati Children's will provide a glossary of these terms and concepts in English and will require proof that the interpreter documented a definition and a corresponding equivalent in their language of expertise.
   4. Successfully complete a QAA (Quality Assurance Assessment) conducted by a Cincinnati Children's staff interpreter during a Level III assignment, e.g. rounds, care conferences, or any type of assignment that involves complex care patients. QAA are scheduled in advance so you have time to prepare.

b. **Quality Control Assessment (QCA)** as a quality measurement tool

   These assessments are not pre-scheduled, may be conducted during any assignment. They're our tool to guarantee that the service we are providing is effective, accurate, and of the highest quality.

If an interpreter's performance is poor during:

- **QAA:** the interpreter would not move up to Level III. After additional training, another QAA would be scheduled.
- **QCA:** after additional training, another QCA would be performed. We want this to be an educational experience for all of us, with the goal of improving the quality of service we provide to our families. **Please keep on mind that points may be assigned in our Performance Point System during a QCA. When your agency meets with you to go over your QCA, they will notify you if any points were assigned to you during the QCA.**

Areas evaluated during Quality Assessments:

Introduction

- Dress code (see the Cincinnati Children's and Language Access Dress Codes)
- Arrives at least 15 minutes early
- Immediately informs a staff member of arrival (example: receptionist, CSR, nurse).
- Has the patient's information at hand in case it is requested
- Pre-session with providers and patient/family
- Has a dictionary, pen and paper. If using a phone or tablet as a dictionary and/or notepad, lets everyone know.

Conversation Flow

- Interpreter positions self appropriately, always encouraging eye contact between the individuals with LEP and the health care professionals
- Manages the flow of communication

Interpreting Session

- Knowledge of medical terminology. Writing skills will be evaluated if during the encounter the interpreter is required to translate discharge instructions
- Uses first person
- Maintains tone and register
- Cues health care professional and individual with LEP to return to direct communication.
- Interprets everything heard in the room, even curse words or conversations among health care professionals and patient (e.g. Child Life)
- Doesn't engage in side conversations, instead interpreting what's said or politely and transparently reminding the individual that the interpreter is there to interpret everything that is said
- Transmits message completely and accurately
- Switches modes of interpretation according to the situation
- Transparently asks for clarification
- Stops and corrects own mistakes
- Verifies meaning in ambiguous situations
- Picks up on verbal and nonverbal cues
- Knows when to withdraw from an assignment
- Remains calm in stressful situations or when there is conflict
- Keeps personal issues of the encounter
- Refrains from counseling or advising
- Appropriately addresses cultural issues
- Shows care and concern for patient needs by facilitating the use of appropriate resources
- Keeps track of time in order to follow personal schedule
- Follows Cincinnati Children's policies, procedures and guidelines

INSTRUCTIONS ON EMERGENCY DEPARTMENT COVERAGE

ED appointments at CCHMC

Please be advised that these are instructions for interpreters taking ED appointments at CCHMC:

1. Please be sure to advise the ESR if an additional ED patient has been given to you by the ED Department. We have to account for every patient that we interpret for in the ED Department, and the only way we will know for certain is if this is communicated through the appropriate resources.

2. If there is a long line at the Greeter desk, you are allowed to go to the front of the line and announce that you are the interpreter and you need to check in. They may ask for your cell phone - this is the only time you may ever give out your cell phone number to anyone.

3. If you are sent to any emergency appointment at any Children's Hospital satellite location (Liberty, Mason, Fairfield etc...) and the patient needs to be transferred to Main Base, please call the dispatcher to let her/him know about the situation. Your agency needs to contact either LAS as soon as possible or the Command Center to communicate the transfer.

4. If you are sent to an emergency appointment at any Children's Hospital location and you can only stay for a specific length of time, please communicate that to the dispatcher at the time of the dispatch. Then call the dispatcher at least 1 hour before you need to leave so he/she can start finding a replacement interpreter. Please don't wait until the last minute to tell the dispatcher that you need to leave.

5. You must check out with the ESR's (Emergency Services Representative) at the Team Coordinator Desk in each team (Do not go to the Greeter Desk). The ESR's are dressed in purple and sit behind the desk in each pod. This will allow Children's to accurately record the time the interpreter leaves and will help in guaranteeing quick processing of their internal paperwork.

6. Interpreters that cover any shift in the Emergency Department will use a Voalte phone to communicate with staff.

7. There should always be an "Interpreter needed" sign on the frame of the door of LEP families. Upon arrival, the interpreter will make sure that such sign is properly placed. If the sign is not placed, interpreter shall ask the Pod's ESR for assistance.

8. If you have to leave unexpectedly due to an emergency, advice staff to use the phone or VRI.

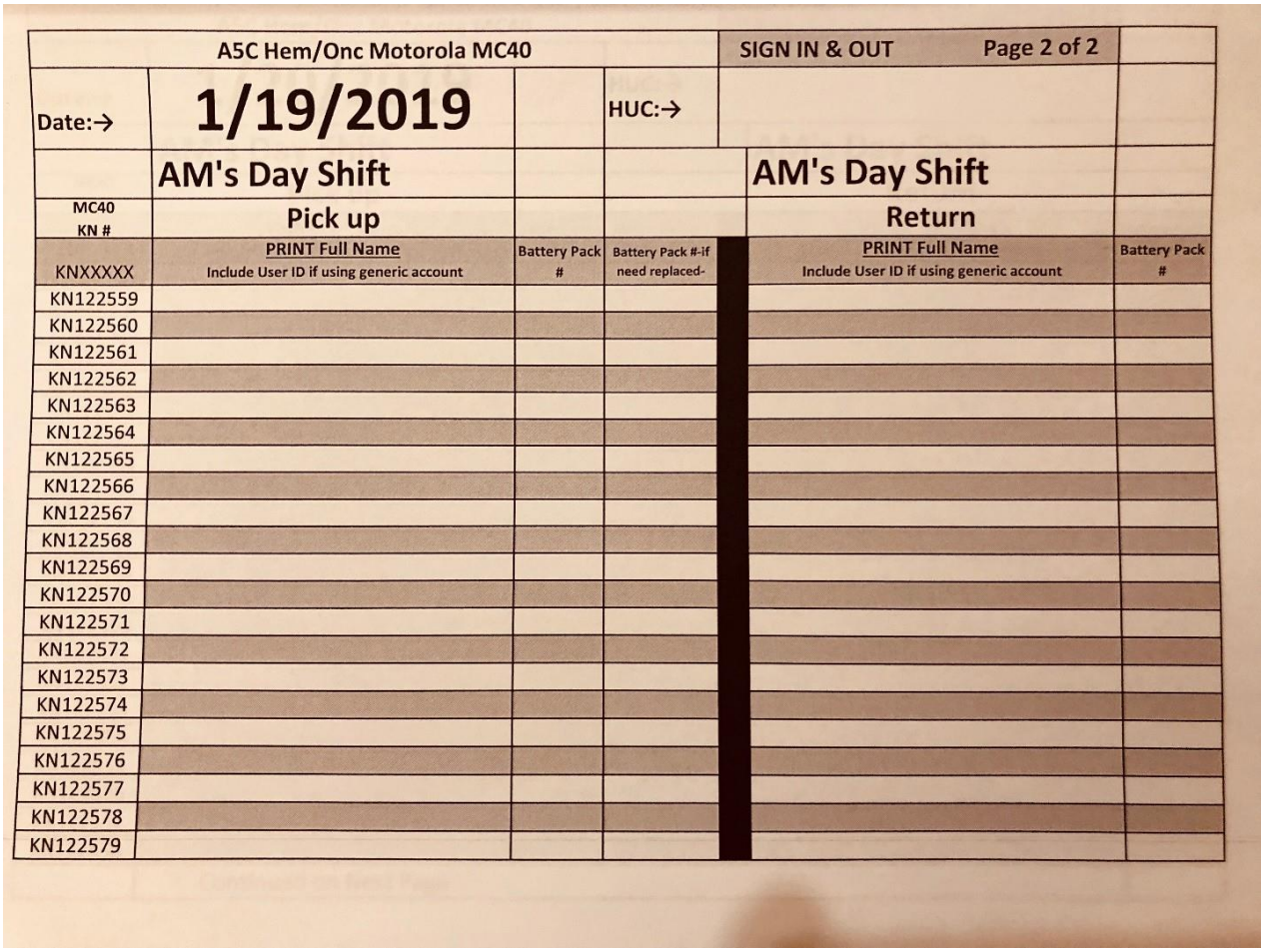
VOALTE INSTRUCTIONS

CBDI Protocol for Spanish Interpreters:

1) Interpreters that come to Cincinnati Children's to cover CBDI blocks Mon-Sunday between 9:00am-11:00 shall make use of a phone Voalte. This phone will become the main point of contact between the interpreter and CBDI staff.

LOGIN: cbdispanish
PASSWORD: cchmc

2) Voalte phones are located in A5C next to the HUC desk. Interpreters should arrive 5 minutes before their shift to make sure that they can log in to the Voalte phone in a timely manner. Interpreters need to choose a phone and a battery from the Voalte station, please make sure that the battery selected comes from the tray marked as “charged battery”. The interpreter must document the tag number of the phone selected and as well as the battery number in the Voalte Log. Make sure that you are documenting the phone use on the page that says A.M.



A5C Hem/Onc Motorola MC40				SIGN IN & OUT Page 2 of 2	
Date:→	1/19/2019		HUC:→		
	AM's Day Shift			AM's Day Shift	
MC40 KN #	Pick up			Return	
KNXXXXX	PRINT Full Name Include User ID if using generic account	Battery Pack #	Battery Pack #-if need replaced-	PRINT Full Name Include User ID if using generic account	Battery Pack #
KN122559					
KN122560					
KN122561					
KN122562					
KN122563					
KN122564					
KN122565					
KN122566					
KN122567					
KN122568					
KN122569					
KN122570					
KN122571					
KN122572					
KN122573					
KN122574					
KN122575					
KN122576					
KN122577					
KN122578					
KN122579					

3) The tag number of the phone can be located in the back on the phone, it is number that starts with KN.
4) Interpreter should keep their phone on available mode and answer request in a timely fashion. When called to a unit the interpreter shall inform the HUC that they have arrived and text the person that requested the service to confirm arrival.
5) On weekends, it is possible that other units will try to use the CBDI interpreter. Interpreters can help other units if you are not busy with a CBDI patient. It is also important to inform the unit that he/she can help, but that they have to leave as soon as CBDI puts in a request.
6) Interpreters shall return the phone to A5C at the end of their shifts. They should make sure that the phones are clean upon return. It is also of extreme importance that they document in the log that the phone has been returned.

Liberty Emergency Department Voalte Protocol

In Order to facilitate communication between the ED/Urgent Care staff and the Interpreter, all Interpreters covering a shift in the ED are required to use a Voalte phone to communicate with staff. Personal phones are not the preferred method of communication.

Voalte Phones Location

Before you start your shift get a Voalte phone from the Emergency Department's Service Center located in the corridor between the North and South side of the ED.

Voalte log

- At the Service Center request/take a Voalte phone
- Fill out the log book that is located in the Service Center. On the upper middle part of each log page, you will find the date, please make sure that you are signing in under the correct date.
- In the log book you will find a list with the codes assigned to each phone. Find the code assigned to your phone and fill out the information requested. In order to locate the code assigned to your phone; remove the battery of the phone. Please use the picture below as a reference:

- In the log book next to your code, you will have to fill out your name; Your initials will be filled in when you return the Voalte. **Be sure to enter your initials upon return of Voalte.**
- The Battery is located on the back part of the phone.

Voalte signing-In Process

- When you turn on the phone tap on the Voalte logo and enter username and a password.

    - Username for ED Liberty: **libedspanish**
    - Password: **cchmc**

- After you finalize the signing in process inform the ESR at the registration desk that you will be using the Voalte phone under the contact name **Spanish Interpreter**

Voalte One:

Spanish interpreters that work any shift at the Emergency Department shift, shall make use of a Voalte Phone. The use of this device facilitates communication among staff members.

You can find the Voalte One phone cart in room 305 of the Emergency Department. Once you locate the cart, retrieve a phone and a battery.

Connect the battery to the back of the phone, and the phone will turn on automatically.

Once on the main screen, click on the Voalte One icon, located in the left right bottom corner.

Enter the username b1interpreter and the passcode cchmc. The phone has been programed to have B1Emergency Dept.as its default connection. Proceed to click continue. You will be prompted to select a role; it should be set as Spanish interpreter. Double check that the correct role is showing on the screen, and then proceed to click on done at the upper right side of the screen. Completing this action will successfully log you the network.

HOME CARE VISITS

Cincinnati Children's

Home Health Care Interpreter

Interpreter ID#_____

Department of Linguistic Services
Cincinnati Children's Hospital Medical Center
513-636-1444

Cincinnati Children's

Home Health Care Interpreter

Interpreter ID#_____

Department of Linguistic Services
Cincinnati Children's Hospital Medical Center
513-636-1444