Respite Index

Respite Care Guidelines……………...……………………………………………………………3

Admission Criteria ……………………………….………………………………………4

Required Documentation for Admission ……………………………………………………………5

Life Threatening Emergency Policy…………………………………………………………...….6

Infection Control Policies……………………………………………………………………………7

Bloodborne Pathogens Exposure Policy…………………………………………………………17

Positive Covid-19 Case Policy……………………………………………………………...…29

Assessment and Reassessment of Guests Policy……………………………………………...32

Medication Policy and Procedure…………………………………………………..……33

LTHC Respite Confidentiality Agreement………………………………………………………34

After hours on-Call Protocol…………………………………………………………………..35

Discharge Policy……………………………………………………………………………………36

Grievance Policy……………………………………………………………………………………37

Unusual Events Reporting Policy……………………………………………………………..38

Referral Questions to Ask Flowsheet……………………………………………………………39

Respite Occupancy Agreement Form……………………………………………………….....41

Intake Checklist Form……………………………………………………………………………42

Guest Valuables Form……………………………………………………………………………43

Hep B Vaccine Declination Form……………………………………………………..……44

Sharps Injury Log……………………………………………………………..…………45

Lab Draw Consent Form following critical exposure……………………………………………46

Incident Report Form……………………………………….……………………………………47

Grievance Form…………………………………………………………………..……………48

Discharge Summary Form……………………………………………………………………49

Discharge Questionnaire for Guests…………………………………………………..……50

Job Role Flowsheet for LTHC Medical…………………….…………………………………52

LTHC HOMELESS SERVICES PROGRAM GUIDELINES: General Information

What is Respite Care?

Respite Care is a program operated & staffed by LTHC Homeless Services. Medical respite care is acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from an illness or injury on the streets or in shelter, but who do not require hospital level care. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows individuals experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services.

Who can make a referral?

A social worker, registered nurse, or healthcare provider (doctor, NP, or PA-C) may call to initiate a referral and check on bed availability. **PATIENTS MAY NOT SELF-REFER**.

When to make a referral:

Referrals are accepted from 8AM-4PM Monday thru Friday

Making referral:

Contact the Respite Care Coordinator at 765-767-4094 or 765-423-4880. If a bed is available and the referral is thought to be appropriate, the referring medical provider must complete the Recuperative Care Provider Referral Form. The completed form should be faxed to 765-420-7027.

What happens next?

Once the Provider Referral Form is received, The Respite Coordinator will determine if the patient meets the Respite Care admission criteria. After review, the referring agency or provider will be notified (within a few hours) of PRELIMINARY ACCEPTANCE or denial. If approved, the remainder of the Respite Care Referral Packet including history & physical, medication reconciliation form, where the patient was residing before hospitalization occurred, disease disclosure form, **AND FOLLOW-UP APPOINTMENTS** for primary and specialty care will need to be faxed to the Respite Coordinator. The Respite Coordinator will review the additional information and finalize the approval for acceptance into the program and determine placement location. The Coordinator will then arrange the date and time for Respite admission. Clients to be admitted to the Respite Unit must arrive by 4:00 PM Mon-Fri.

Of Note:

1. If a client is deemed medically inappropriate or requiring a higher level of care, does not have required medications upon arrival to our Respite Care Unit, **he/she will be returned to the referring facility.**
2. Patients **MUST BE PROVIDED** a 30-day supply of all necessary medication unless a shorter course of administration is needed.
3. Patients **MUST BE PROVIDED** with shoes upon discharge from referring facility. Patients will be returned otherwise.
4. Patients **MUST BE PROVIDED** with assistive device for ambulation if prescribed by referring facility.

LTHC HOMELESS SERVICES PROGRAM GUIDELINES: Criteria

Admission Criteria:

Referrals are screened and evaluated by the Respite Care Coordinator or a healthcare provider from Phoenix Paramedic Solutions upon receiving the faxed Provider Referral Form which MUST BE COMPLETED by the responsible referring provider. A preliminary approval will be determined in a timely manner.

Patient must:

- Be homeless
- Have an acute medical illness
- Be independent in the Instrumental Activities of Daily Living (IADL) and medication administration
- Be willing to meet with Respite Coordinator daily and comply with medical recommendations
- Be bowel and bladder continent
- Be medically and psychiatrically stable enough to receive care in our Respite Care facility. Patient must not be suicidal or homicidal.
- Have a condition with and identifiable end point of care for discharge.

Exclusion Criteria:

- **Sex Offender**
- **Patient with unstable medical or psychiatric conditions that require inpatient level of care**
- **Trespassed from LTHC**
- **Patients unable to complete ADL’s**

LTHC HOMELESS SERVICES PROGRAM GUIDELINES: Required Documentation

STEP 1: Paperwork required to obtain preliminary approval of acceptance

From ALL Referring Agencies:

1. Provider Referral Form – Must be completed by REFERRING PROVIDER ONLY.
This is the only form needed to initiate the referral process and to obtain a preliminary approval for acceptance into the program.

STEP 2:

From Hospital/Inpatient:

- ❖ Respite Care Program Referral Form
- ❖ Initial History and Physical, and Discharge Summary
- ❖ Clinical Diagnosis at Discharge
- ❖ All Pertinent Social Services Information
- ❖ Follow up appointments for primary and specialty care
- ❖ Disclosure of any infectious diseases
- ❖ Homeless Verification
- ❖ Medication Reconciliation Form (with frequency and dosage of administration). Please list only medication with which patient will be provided upon discharge.
- ❖ Negative COVID lab result

From Emergency and Outpatient Department

- ❖ Respite Care Program Referral Form
- ❖ ER/Outpatient History & Physical Form
- ❖ All pertinent clinical information
- ❖ Follow up appointments
- ❖ Medication Reconciliation Form (with frequency and dosage of administration)
- ❖ Disclosure of any infectious disease
- ❖ Negative COVID lab result
- ❖ Homeless Verification

Life Threatening Emergency Policy:
LTHC will make every effort to ensure the respite area is safe and healthy for all guests and employees. In this effort we are establishing a protocol for action and who to contact in the event of a medical emergency at LTHC.

Procedure:
Below are the steps that need to be taken by an individual that witnesses or responds to the medical emergency.

1st Priority- **Call 9-1-1** for emergency services in the event of a possible life-threatening medical condition. This may include but is not limited to, chest pain, loss of consciousness, violent behavior, or uncontrolled bleeding

2nd Priority- Contact First Responders on the premises of LTHC. This may include medical personnel in the Respite area, security, or individuals trained in CPR/First Aid.

3rd Priority- Meet the emergency medical personnel at the entrance of the building.

An incident report must be completed within 48 hours by the supervisor or the supervisor of the area in which the incident occurred if not an employee. Statements should be obtained by others involved and witnesses.

Infection Control Policies

POLICY: INFECTION CONTROL 8

POLICY: LIST OF INFECTIONS REQUIRING PRECAUTIONS…………………………..………12

POLICY: INFECTIONS THAT REQUIRE AIRBORNE TRANSMISSION PRECAUTION……....14

POLICY: PROTOCOL FOR AIRBORNE TRANSMISSION PRECAUTIONS.............................15

POLICY: MULTIDRUG RESISTANT ORGANISM 16

POLICY: INFECTION CONTROL

Isolation Precautions Rationale: Every reasonable attempt will be made to prevent the spread of infection at LTHC. A variety of infection control measures outlined below are used for decreasing the risk of transmission of organisms at the LTHC Respite Center. All blood and bodily fluids will be considered infectious regardless of the perceived status of the source individual.

Purpose: To control spread of infection.

Procedure:
A. Standard Precautions: used during interaction with all patients regardless of their diagnosis or presumed infection status.
Handwashing: Good handwashing using soap and water or waterless antiseptic before and after each patient contact, after using the bathroom, after handling soiled material, and after eating is mandatory for all staff. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items whether or not gloves are worn. It may be necessary to wash hands between tasks and procedures on the same patient to avoid cross contamination of different body sites. Patients are asked to use waterless antiseptic before and after restroom use and before eating meals to avoid infection.
Gloves: As mandated by the OSHA blood borne pathogens final rule: Gloves should be worn whenever contact with any of the following is expected to occur:

1. Blood
2. Any body fluids, secretions and excretions except sweat, regardless of whether or not they contain visible blood
3. Non-intact skin and/or
4. Mucous membranes

In addition, gloves should be worn even if not explicitly delineated above whenever:

1. a risk of gross contamination of the hands
2. special care to avoid contamination of patients during patient-care procedures, including, but not limited to suctioning, phlebotomy, dressing changes, nail clipping, injections, and wound irrigation or
3. the possibility of transmission from one patient to another exists
4. Handling of contaminated items is required. Wearing gloves and changing them between patient contacts DOES NOT replace the need for handwashing. Failure to change gloves between patient contacts is an infection control hazard.

Protective Eyewear and nose/mouth droplet prevention masks:
Protective eyewear and masks should be worn to protect mucous membranes of the mouth, nose and eyes whenever there is a risk of a splash or spray of blood or body fluids. This includes but is not limited to the performance of the following procedures: suctioning, nail clipping, wound irrigation and dental work.

Gown
Non-sterile gowns should be worn when splashes, sprays, or spills of blood or bodily fluids are

likely to come into contact with the caregiver's body or clothes. Remove the soiled gown as promptly as possible and wash hands.

Patient care equipment
Handle soiled patient care equipment in a manner to prevent skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other patients and environments. Do not reuse patient care equipment until it has been cleaned and reprocessed appropriately. Discard single use items properly.

Environmental control
Please see separate policy on maintenance of clinical areas regarding cleaning and disinfecting, restocking, disposing of outdated materials, equipment maintenance/inspection, separation of clean and dirty items and medical infectious waste disposal.

Linen
All clean linen is to be kept covered. All used linen is to be handled with gloves and deposited in the dirty linen area. Clostridium difficile – all cleaning supplies are dedicated to infected patients and supplies are disposed of in biohazard bags. No sponges are used.

Contaminated Sharps
Never recap needles. All sharps will be discarded in puncture resistant/ leak proof containers located in the clinics. Sharps containers will be inspected daily by the housekeeping staff. Full containers will be brought to the biohazard room and be replaced by empty containers.

Resuscitation
A one-way mask should be used whenever possible if the need for resuscitation arises. These items are located in emergency red carts in the clinic area.

Patient placement
When a concern about a patient's infectious status occurs the Medical Director or designee will be contacted to determine the need for a private room.

Blood and body fluid exposures/ needle sticks
If a possible exposure due to needle stick, splash, or other accident occurs please refer to policy on "Blood and Body fluid Exposures/Needle Sticks" for course of immediate action.

B. Transmission-based Precautions:
Transmission based precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard/universal precautions are needed to interrupt transmission. Precautions are determined based on the mode of transmission of the disease/pathogen involved. There are three types of transmission-based precautions: Airborne, Droplet, and Contact.

1. Airborne Precautions: Airborne precautions require special air handling and ventilation specifications that are not possible at LTHC. Therefore, anyone with a high suspicion of being an infectious carrier of an airborne pathogen cannot be admitted to the LTHC respite program. Airborne pathogens include pathogens that can be transmitted by "droplet nuclei" (residue from evaporated droplets 5um or smaller in size) or dust particles. Diseases that require airborne precautions include: measles, disseminated Varicella zoster (including primary infection), Varicella pneumonia, and pulmonary tuberculosis. Patients with the above diagnoses cannot be admitted to LTHC Respite Clinic until they are considered non-infectious, and the medical director or his/her designee has reviewed their case.

2. Droplet Precautions: Droplet transmission of diseases involves the contact of eyes, or the mucous membranes of the nose or mouth of a susceptible person with "large particle droplets" (larger than 5 um in size) containing microorganisms generated from who is infected by or a carrier of that pathogen. Droplets are generally formed during coughing, sneezing, talking, suctioning and other similar activities. Droplet Transmission requires close contact between source and recipient because droplets generally remain suspended in air for 3 ft or less. Special air handling and ventilation is not required. Diseases that require droplet precautions include, but are not limited to, MRSA pneumonia.

-In addition to standard precautions, patients known or suspected to be infected with microorganisms transmitted by droplets (see page 13) should be treated with the following precautions:

   a) Place the patient in a private room if available. If no private room is available, place the patient in a room with a patient with the same infection, but no other infection that is not shared. Shared roommates should not be immunocompromised.
   b) A mask should be worn within 3ft of the patient. Mask the patient when he/she leaves the room. Minimize travel of the patient from his/her room.

3. Contact Precautions: Transmission of disease can occur through direct and indirect contact. Direct contact transmission involves direct skin-to-skin contact and physical transfer of microorganisms from a source person to a susceptible host. Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object.

-In addition to standard precautions, patients known to be infected or colonized with an epidemiologically important pathogen that can be transmitted by direct or indirect contact (see attached list) should be treated with the following precautions.

   a) Place the patient in a private room if possible. Private room needed for patients with large wounds, copious drainage, drainage or body fluids not well contained, patients not able to manage their own hygiene sufficiently. When a private room is not available, place the patient in a room with a patient(s) who has similar infection and/or colonization. However, cohorted roommates should not be immunocompromised.
   b) Wear gloves when coming in direct contact with patients. Dispose of gloves before leaving the room. Change gloves after contact with material that may have a high microorganism count (fecal material, wound drainage etc.). Wash hands immediately after removing or use waterless antiseptic.

c) Wear a gown when entering the room if you anticipate substantial contact with the patient, environmental surfaces, or items in the patient’s room or if the patient has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing. Remove the gown before leaving the patient's room. After gown removal ensures that clothing does not contact potentially contaminated surfaces.
d) Parameters of patient movement will be decided based on the organism in question and the likelihood of environmental contamination by the patient.
e) When indicated, dedicate the use of patient care equipment (e.g., stethoscope, BP cuff, and thermometer) to the cohort of patients with a single pathogen. Adequately clean and disinfect it between uses with 60% isopropyl alcohol or with disinfectant spray.
f) A red Biohazard trash bag should be placed in the patient’s room for disposal of contaminated material (gloves, masks, etc.) A special laundry bag, marked appropriately should be used to bag bed linens and gowns. The room should be completely sanitized with disinfectant detergent surface cleaner followed by germicidal detergent when the patient is discharged. Used red biohazard bags are moved to the biohazard waste room.

<u>List of infections that require precautions in addition to Standard Precautions:</u>

Organism/illness:	Patients should remain on precautions until/for:
Infections that require droplet precautions:	
Pharyngeal Diphtheria	Off antibiotics 2 cultures taken 24 hours apart are negative
Influenza	Duration of symptoms or seven days, whichever is longer, avoid room sharing with high risk patients, cohort when possible
Haemophilius infuenzae, known or suspected	24 hrs after initiation of effective therapy
Neisseria meningtiidis (meningicoccal), known or suspected	24 hrs after initiation of effective therapy
Meningicoccal pneumonia	24 hrs after initiation of effective therapy
Meningicoccemia	24 hrs after initiation of effective therapy
Mumps (infectious parotitis)	For 9 days after onset of swelling
Mycoplasma pneumonia	Duration of illness
Pertussis (whooping cough)	5 days after initiation of effective therapy
Pneumonic plague	72 hrs after initiation of effective therapy
Adenovirus pneumonia	Duration of illness
Rubella	7 days after onset of rash
MRSA – respiratory infections	Resolution of cough
Infections that require comprehensive contact precautions:	
Methicillin/oxacillin resistant *Staph aureus* (MRSA) – skin infections	See separate protocol
Vancomysin resistant enterococcus (VRE)	See separate protocol
Cutaneous Diphtheria	Off antibiotic 2 cultures 24 hrs apart are negative
Ebola viral hemorragic fever	Call State Health Dept. and CDC for specific advice
Lassa fever	Call State Health Dept. and CDC for specific advice
Marburg Virus disease	Call State Health Dept. and CDC for specific advice
E coli 0157:h7 in a diapered or incontinent patient	Duration of illness
Rotavirus in a diapered or incontinent patient	Duration of illness
Shigella in a diapered of incontinent patient	Duration of illness
Hepatitis A in a diapered or incontinent patient	Duration of illness
Disseminated or severe primary mucocutaneous *Herpes simplex*	Duration of illness
Impetigo	24 hrs after initiation of effective therapy
Adenovirus pneumonia	Duration of illness
Clostridium difficile in a diapered of incontinent patient	Stool culture negative 1 week after last dose of treatment medication (flagyl or vancomycin)

Conditions that require Modified Contact Precautions (Precaution parameter orders to be written on a case by case basis and approved by medical director or designee):	
Lice (pediculosis)	
Scabies	
Clostridium difficile	
Acute viral (acute hemmorragic) conjunctivitis	
Body Surface Infections that are not contained by a dressing including: major draining abcess, significant weeping cellulitis, decubitus ulcer with major infection and major wound infections	

NOTE: Precautions that apply to infants and children only ARE NOT included in this list

POLICY: INFECTIONS THAT REQUIRE AIRBORNE TRANSMISSION PRECAUTIONS
Varicella Zoster (Chicken Pox and Herpes Zoster)

Primary (Chicken Pox): Patients with known or suspected chicken pox cannot be admitted to LTHC due to a lack of a negative pressure room. Infected employees, visitors, and volunteers are not allowed on the premises until they are not infectious. A person can be considered not infectious when all lesions are crusted.

Disseminated Herpes Zoster or Herpes Zoster affecting more than one dermatome should be treated as above. (Dissemination implies there is a viremia and therefore potential for transmission via respiratory droplets. This requires Airborne Precautions, negative pressure isolation, and intravenous antiviral treatment, which should occur in an acute inpatient facility.) Localized Herpes Zoster (one dermatome) in immunocompetent patients should be treated with Standard Precautions only. If it is possible for a non-susceptible caregiver to give care to the affected patient that is preferable, but not required.

Localized Herpes Zoster (one dermatome) in immunocompromised patients should be discussed with the Medical Director or referring provider on a case-by-case basis since they may or may not be considered viremic, based on their clinical picture. The Medical Director or referring provider will decide whether Airborne Precautions or Standard Precautions will apply in these cases.

Pregnant women who are already immune to varicella infection (either because of prior infection or vaccination) are not at risk of infection. Therefore, if a pregnant woman has already had varicella or vaccination, her fetus is not at risk. If a pregnant woman is not immune to varicella infection, she should not be involved in the care of patients with either primary infection (chicken pox) or Herpes Zoster.

Rubeola (Measles)
Patients with known or suspected measles (Rubeola) cannot be admitted LTHC Respite Care.

Tuberculosis (TB)
See separate TB policy and policy on Isolation of Potentially Infectious Patients.

POLICY: PROTOCOL FOR AIRBORNE TRANSMISSION PRECAUTIONS

A. Airborne Infection Isolation Rooms are not available at LTHC, therefore, guests with pathogens that are transmitted through an airborne manner will be denied care at LTHC due to lack of Airborne Infection Isolation Rooms. The pathogens that require airborne transmission precautions include Tuberculosis, Varicella and Measles. (See policy: Infections that Require Airborne Transmission Precaution).

B. Admission Criteria and Airborne Precautions:

1. Patients suspected of having TB because of positive PPD status and clinical symptoms and suspected of having Varicella and Measles.
2. Patients with active TB or clinically suspected TB, defined as: 'a condition in which the individual has acid fast bacilli in the sputum or other bodily fluid, or tissue as evidenced by a laboratory smear; or has chest x-ray findings interpreted as probable Tuberculosis by a qualified medical authority' cannot be admitted.
3. TB suspected patients need to be evaluated by a clinician and have a CXR prior to admission (if one has not been done in the past 1 month) to ensure that the patient doesn't have 'clinically suspected TB'.
4. TB suspected patients should be able to produce sputum for laboratory evaluation
5. If one AFB sputum sample is found to be positive for an airborne bacillus, the patient will be transferred to an inpatient medical facility (See Section D for transporting patient).

C. Admitting Protocol

1. Medical Director or their designees must be notified of all pending admissions.
2. Since Airborne Infection Isolation Rooms are not available at LTHC, any guest with a suspected disease that is spread through airborne transmission will decline the referral.

POLICY: MULTI-DRUG RESISTANT ORGANISM

Vancomycin Resistant Enterococcus (VRE)
In addition to Standard Precautions and Contact Precautions the following procedures will be followed for any patients with VRE infection or colonization:

Obtain cultures of stool or rectal swabs of roommates of patients newly diagnosed with VRE to determine their colonization status and apply isolation precautions as necessary.

Patients should remain on VRE precautions until VRE-negative results are found on three consecutive occasions at least 3 days apart from multiple body sites including: stool or rectal swab, perineal area, axilla or umbilicus, wound, Foley catheter and/or ostomy sites if applicable.

All patients colonized or infected with VRE will have access to a private bathroom or a bathroom shared with patients with the same organism when appropriate.

Patients are expected to use only that bathroom while at the LTHC Respite Clinic. Charts of VRE colonized patients will be recorded in the electronic medical record.

Methicillin/oxacillin Resistant Staph Aureus (MRSA)

In addition to following Standard and Contact Precautions for all patients known to have MRSA skin infections or colonizations, MRSA status will be recorded in the electronic medical record.

Patients with MRSA respiratory infections will be treated with Droplet Precautions.

Mattresses are wiped with a bactericidal cleanser, air dried, and linens are replaced.

BLOODBORNE PATHOGENS

Exposure Control Plan

Facility name: Lafayette Transitional Housing Center

Date of preparation: 05/24/2021

Date of annual review: 05/01/2022 *(Where applicable; must not be more than 12 months following preparation or previous review date.)*

In accordance with the OSHA Bloodborne Pathogens Standard, 29 CFR 1910.1030, the following exposure control plan has been developed.

A. Purpose

The purpose of this exposure control plan is to:

1. Eliminate or minimize employee occupational exposure to blood and/or certain other body fluids; and
2. Comply with the OSHA Bloodborne Pathogens Standard, 29 CFR 1910.1030 and its Appendix A.

B. Exposure Determination

OSHA requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., employees are considered to be exposed even if they wear personal protective equipment). The exposure determination must list all job classifications in which all employees may be expected to incur such occupational exposure, regardless of frequency. At this facility, the following job classifications are in this category:

Guest Services, Sanitation, Case Managers, Shelter Staff, Directors, Maintenance

Safety, Coordinators, Chief Officers, Kitchen, Respite Staff, Healthcare Clinic staff

In addition, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all the employees in these categories would be expected to incur exposure to blood or OPIM, tasks or procedures that would cause these employees to have occupational exposure must also be listed in order to understand clearly which employees in these categories are considered to have occupational exposure. The job classifications and associated tasks for these categories are as follows *(or place in appendix)*:

Job classification	Task/Procedure

Finance	Human Resources and Finance

C. Implementation Schedule and Methodology

OSHA requires that this plan include a schedule and method of implementation for the various requirements of the standard. The following complies with this requirement.

1. Compliance methods

Universal precautions will be observed at this facility in order to prevent contact with blood or OPIM. All blood or OPIM will be considered infectious, regardless of the perceived status of the source individual.

Engineering and work practice controls will be utilized to eliminate or minimize exposure to employees at this facility. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be utilized. At this facility, the following engineering controls will be utilized: *(List controls, such as sharps containers, biosafety cabinets, non-glass capillary tubes, safety lancets or syringes, needleless systems, dust pan and broom for picking up broken sharps, etc.)*

Sharps Containers, Spill Kit, Dust Pan and Broom for Broken Sharps, Can Liners

Neoprene

The above controls will be examined and maintained on a regular schedule. The schedule for reviewing the effectiveness of the controls is as follows: *(List schedule, such as daily, weekly, etc., and who has the responsibility for reviewing the individual controls, such as department supervisor, nursing director, etc.)*

Weekly examinations shall be conducted by Health & Wellness Director,

Day Center Director, or Facilities Director

The process for evaluating existing controls and potential changes in engineering controls and work practices involves consultation with non-management direct-care employees as follows: *(Describe the process, the products/devices and/or work practices evaluated, and how employees are involved in evaluation and selection.)*

Yearly evaluations shall be conducted by Health & Wellness Director,

Day Center Director, or Facilities Director

Hand washing facilities shall be made available to employees who incur exposure to blood or OPIM. These facilities must be readily accessible after incurring exposure. *(If handwashing facilities are not feasible, the employer must provide either an antiseptic cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. If these alternatives are used, the hands are*

to be washed with soap and running water as soon as feasible. Employers who must provide alternatives to readily accessible handwashing facilities should list the location, tasks, and responsibilities to ensure maintenance of these alternatives.)

Directors shall ensure that after the removal of personal protective gloves, employees wash their hands and any other potentially contaminated skin area immediately or as soon as feasible with soap and water.

Directors shall ensure that if employees incur exposure to their skin or mucous membranes, those areas shall be flushed with water as soon as feasible following contact.

2. Needles

Contaminated needles or other contaminated sharps will not be bent, recapped, removed, sheared or purposely broken. OSHA allows an exception to this prohibition if the procedure would require that the contaminated needle be recapped or removed and no alternative is feasible, and the action is required by the medical procedure. If such action is required, the recapping or removal of the needle must be done by the use of a mechanical device or a one-handed technique. At this facility, recapping or removal is permitted only for the following procedures: *(List the procedures, and specify either the mechanical device to be used or that a one-handed technique will be used.)*

Recapping is not permitted.

Where feasible, sharps with engineered sharps injury protection (such as self-sheathing needles or needleless systems) will be used.

3. Work Area Restrictions

In work areas where there is reasonable likelihood of exposure to blood or OPIM, employees are not to eat, drink, apply cosmetics or lip balm, smoke, or handle contact lenses. Food and beverages are not to be kept in refrigerators, freezers, shelves, cabinets, or on counter tops where there is blood or OPIM. Mouth pipetting/suctioning of blood or OPIM is prohibited.

All procedures will be conducted in a manner that will minimize splashing, spraying, splattering, and generation of droplets of blood or OPIM. At this facility, the following methods will be employed to accomplish this goal: *(List methods, such as covers on centrifuges, use of dental dams if appropriate, etc.)*

Medical Clinic

4. Specimens

Specimens of blood or OPIM will be placed in a container that prevents leakage during the collection, handling, processing, storage, and transport of the specimens. The container used for this purpose will be labeled or color-coded in accordance with requirements of the OSHA standard.

(NOTE: The standard provides an exemption for specimens from the labeling/color coding requirement, provided that the facility uses universal precautions in the handling of all specimens and the containers are recognizable as containing specimens. This exemption applies only while the specimens remain in the facility. If the employer chooses to use this exemption, it should be stated here.)

Not applicable.

Any specimens that could puncture a primary container will be placed within a secondary container that is puncture resistant.

If outside contamination of the primary container occurs, the primary container will be placed within a secondary container that prevents leakage during handling, processing, storage, transport, or shipping of the specimen.

5. Contaminated Equipment

Facilities Director is responsible for ensuring that equipment which has become contaminated with blood or OPIM shall be examined prior to servicing or shipping, and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible.

6. Personal Protective Equipment (PPE)

PPE Provision

Facilities Director is responsible for ensuring that the following provisions are met.

All PPE used at this facility will be provided without cost to the employee. PPE will be chosen based on the anticipated exposure to blood or OPIM. The PPE will be considered appropriate only if it does not permit blood or OPIM to pass through or reach the employee's clothing, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time while the protective equipment will be used. *(Indicate how clothing will be provided to employees, such as who has responsibility for distribution. You may also list procedures that would require use of PPE and the type of PPE required; this could also be listed in an appendix to this program.)*

PPE is provided in the storage room located at the corner of the Day Room.

This room is available to all employees and staff.

PPE Use

Directors shall ensure that the employee uses appropriate PPE unless the supervisor shows that the employee temporarily and briefly declined to use PPE when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or posed an increased hazard to the safety of the employee or co-worker. When an employee makes this judgment, the circumstances shall be investigated and documented to determine whether changes should be instituted to prevent such occurrences in the future.

PPE Accessibility

Directors shall ensure that appropriate PPE in appropriate sizes is readily accessible at the work site or is issued (without cost) to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to employees who are allergic to the gloves normally provided.

PPE Cleaning, Laundering and Disposal

All PPE will be cleaned, laundered, and/or disposed of by the employer at no cost to employees. All repairs and replacements will be made by the employer at no cost to employees.

All garments that are penetrated by blood or OPIM shall be removed immediately, or as soon as feasible. All PPE shall be removed before leaving the work area. When PPE is removed, it shall be placed in an appropriately designate area or container for storage, laundering, decontamination or disposal.

Gloves

Gloves shall be worn where it is reasonably anticipated that employees will have hand contact with blood, OPIM, non-intact skin, and mucous membranes; when performing vascular access procedures; and when handling or touching contaminated items or surfaces.

Disposable gloves used at this facility are not to be washed or decontaminated for re-use, and are to be replaced as soon as practical when they become contaminated or if they are torn, punctured, or their ability to function as a barrier is compromised. Utility gloves may be decontaminated for re-use, provided that the integrity of the glove is not compromised. Utility gloves will be discarded if they are cracked, peeling, torn, punctured, or show other signs of deterioration or when their ability to function as a barrier is compromised.

Eye and Face Protection

Masks, in combination with eye protection devices such as goggles or glasses with solid side shields, or chin length side face shields must be worn whenever splashes, spray, splatter, or droplets of blood or OPIM may be generated and eye, nose, or mouth contamination can be reasonably anticipated. The following situations at this facility require such protection:

Cleaning a spill of blood, vomit, or other bodily fluids.

Additional Protection

Additional protective clothing (such as lab coats, smocks, gowns, aprons, clinic jackets, or similar outer garments) shall be worn when gross contamination can reasonably be anticipated (e.g., autopsies and orthopedic surgery). The following situations at this facility would require that such protective clothing be used:

Tyvek suit shall be available for use when cleaning larger spills.

7. Housekeeping

This facility will be cleaned and decontaminated according to the following schedule:

Area	Schedule	Cleaner
Day Room/Kitchen	Daily	Sanitation
Shelter/Medical	Daily	Sanitation
Administration	Weekly	Sanitation

Decontamination will be accomplished by using the following materials: *(List the materials which will be utilized, such as bleach solutions or EPA registered germicides. Make sure a tuberculocidal disinfectant is used.*

Member's Mark Commercial Disinfectant Cleaner, Sani Professional Disinfecting

Multi-Surface Wipes, Victoria Bay Disinfectant Spray, Claire Disinfectant SprayQ

Clorox Bleach

All contaminated work surfaces will be decontaminated after completion of procedures, and immediately or as soon as feasible after any spill of blood or OPIM, as well as at the end of the work shift if the surface may have become contaminated since the last cleaning. *(Add in any information on protective coverings, such as plastic wrap, which the employer may be using to assist in keeping surfaces free of contamination.)*

All bins, pails, cans, and similar receptacles shall be inspected and decontaminated on a regularly scheduled basis Daily by Safety/Sanitation.

Any broken glassware that may be contaminated will not be picked up directly with the hands.

8. Regulated Waste

Disposable Sharps

Disposable sharps shall be discarded immediately (or as soon as feasible) in containers that are closable, puncture resistant, leak proof on sides and bottom, and labeled or color-coded. This applies to all contaminated sharps, regardless of whether they are designed with sharps injury prevention features.

During use, containers for contaminated sharps shall be easily accessible to personnel and located as close as feasible to the immediate area where sharps are used or can reasonably be anticipated to be found (e.g., laundries). The containers shall be kept upright throughout use and replaced routinely, and not be allowed to overfill.

When moving containers of contaminated sharps from the area of use, the containers shall be closed prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

The container shall be placed in a secondary container if leakage of the primary container is possible. The second container shall be closeable, constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping. The second container shall be labeled or color-coded to identify its contents.

Other Regulated Waste

Other regulated waste shall be placed in containers that are closeable and constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping. The waste container must be labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

NOTE: Disposal of all regulated waste shall be in accordance with all applicable federal, state and local regulations.

9. Laundry Procedures

Laundry contaminated with blood or OPIM will be handled as little as possible. Such laundry shall be placed in appropriately marked bags (biohazard labeled or color-coded red) at the location where it was used or placed directly into a washing machine with disinfectant. The laundry shall not be sorted or rinsed in the area of use.

Laundry from this facility will be cleaned at Day Room or Shelter Laundry.

10. Hepatitis B Vaccine and Post-Exposure Evaluation and Follow-up

General

Lafayette Transitional Housing Center shall make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure follow-up to employees who have had an exposure incident.

LTHC Chief Financial Officer shall ensure that all medical evaluations and procedures including the Hepatitis B vaccine and vaccination series and post-exposure follow-up including prophylaxis are:

a) Made available at no cost to the employee;

b) Made available at a reasonable time and place;

c) Performed by, or under the supervision of, a licensed physician or other licensed healthcare professional; and

d) Provided according to the recommendations of the US Public Health Service.

Hepatitis B Vaccination

The Health and Wellness Director is in charge of the Hepatitis B vaccination program.

Hepatitis B (HB) vaccination will be made available after the employee has received the training in occupational exposure (see "Information and Training" section), and within 10 working days of initial assignment to all employees who have occupational exposure unless: the employee has previously received the complete HB vaccination series; antibody testing has revealed that the employee is immune; or the vaccine is contraindicated for medical reasons.

Participation in a pre-screening program shall not be a prerequisite for receiving HB vaccination.

For employees who complete the HB vaccination series, antibody testing will be made available at no cost to the employee, one to two months after completion of the series, as recommended by the US Public Health Service.

Employees who decline the HB vaccination shall sign the OSHA-required declination form indicating their refusal. Any employee who initially declines HB vaccination, but later decides to accept vaccination while still covered by the standard, shall be provided the vaccination series as described above.

If, at a future date, the US Public Health Service recommends a routine booster dose of HB vaccine, such booster doses shall be made available.

Post-Exposure Evaluation and Follow-up

All exposure incidents shall be reported, investigated, and documented. When an employee incurs an exposure incident, it shall be reported to Chief Financial Officer and Facilities Director.

Following a report of an exposure incident, the exposed employee shall immediately receive a confidential medical evaluation and follow-up, including at least the following elements:

a) Documentation of the route of exposure, and the circumstances under which the exposure incident occurred. If the incident involves percutaneous injury from a contaminated sharp, appropriate information should be entered in the sharps injury log. *(Must also be entered on the OSHA 300 form).*

b) Identification and documentation of the source individual, unless it can be established that identification is infeasible or prohibited by state or local law;

c) The source individual's blood shall be tested as soon as feasible, and after consent is obtained, in order to determine HBV and HIV infectivity. If consent is not obtained, Health and Wellness Coordinator shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the blood (if available) shall be tested and the results documented.

d) When the source individual is already known to be infected with HBV or HIV, testing for the source individual's HBV/HIV status need not be repeated.

e) Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

Collection and testing of blood for HBV and HIV serological status will comply with the following:

a) The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained;

b) The employee will be offered the option of having her/his blood collected for testing of the employee's HIV serological status. The blood sample will be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV status.

Any employee who incurs an exposure incident will be offered post-exposure evaluation and follow-up in accordance with the OSHA standard. All post-exposure follow-up will be provided by a healthcare profession.

Information Provided to the Healthcare Professional

Chief Financial Officer shall ensure that the healthcare professional (HCP) responsible for the employee's Hepatitis B vaccination is provided with a copy of the OSHA Bloodborne Pathogens standard (29 CFR 1910.1030).

Chief Financial Officer shall ensure that the HCP who evaluates an employee following an exposure incident is provided with the following:

a) A copy of the OSHA Bloodborne Pathogens standard; *(The standard outlines confidentiality requirements, but the employer should ensure that the HCP is aware of these requirements.)*

b) A description of the exposed employee's duties as they relate to the exposure incident;

c) Documentation of the route(s) of exposure and circumstances under which exposure occurred;

d) Results of the source individual's blood testing, if available; and

e) All medical records relevant to the appropriate treatment of the employee, including vaccination status.

Health Care Professional's Written Opinion

Chief Financial Officer shall obtain and provide the employee with a copy of the evaluating HCP's written opinion within 15 days of completion of the evaluation. For HBV vaccination, the HCP's written opinion shall be limited to whether vaccination is indicated for an employee, and if the employee has received such vaccination.

For post-exposure follow-up, the HCP's written opinion shall be limited to the following:

a) A statement that the employee has been informed of the results of the evaluation; and

b) A statement that the employee has been told about any medical conditions resulting from exposure to blood or OPIM which may require further evaluation or treatment.

NOTE: All other findings or diagnosis shall remain confidential and shall not be included in the written report.

11. Labels and Signs

Facilities Director will ensure that biohazard labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or OPIM, and other containers used to store, transport or ship blood or OPIM. The universal biohazard symbol shall be used. Labels shall be fluorescent

orange or orange-red and shall be affixed as close as feasible to the container by string, wire, adhesive, or other method which prevents loss or unintentional removal. Red bags or containers may be substituted for labels.

Labels for contaminated equipment shall comply with the previous paragraph and shall state which portions of the equipment are contaminated.

The following are exempted from the labeling requirement:

a) Containers of blood products that have been released for transfusion or other clinical use;

b) Containers of blood or OPIM that are placed in a labeled container for storage, transport, shipment or disposal; and

c) Regulated waste that has been decontaminated.

12. Information and Training

Chief Financial Officer shall ensure that training is provided at the time of initial assignment to tasks where occupational exposure may occur, and that training is repeated within 12 months of the previous training. Training shall be tailored to the education and language level of the employee, and offered during the normal work shift. Training will be interactive, and will cover the following:

a) A copy of the standard and an explanation of its contents;

b) A discussion of the epidemiology and symptoms of bloodborne diseases;

c) An explanation of the modes of transmission of bloodborne pathogens;

d) An explanation of the organization's bloodborne pathogens Exposure Control Plan (this program), and the method for obtaining a copy;

e) The recognition of tasks that may involve exposure;

f) An explanation of the use and limitations of methods to reduce exposure, such as engineering controls, work practices, and personal protective equipment (PPE);

g) Information on the types, use, location, removal, handling, decontamination, and disposal of PPE;

h) An explanation of the basis of selection of PPE;

i) Information on the Hepatitis B vaccination, including efficacy, safety, method of administration, benefits, and that it will be offered free of charge;

j) Information on the appropriate actions to take and persons to contact in case of an emergency involving blood or OPIM;

k) An explanation of the procedures to follow if an exposure incident occurs, including the method of reporting and medical follow-up;

l) Information on the evaluation and follow-up required after an employee exposure incident, particularly incidents which involve needlesticks or contaminated sharps; and

m) An explanation of the signs, labels, and color-coding system used to identify biohazards, regulated waste, and other potential BBP hazards.

The person conducting the training shall be knowledgeable in the subject matter.

Employees who have received training on bloodborne pathogens in the 12 months preceding the effective date of this policy shall receive training only in provisions of the policy that were not covered in their previous training. Additional training shall be provided to employees when there are changes in tasks or procedures that affect occupational exposure.

13. Recordkeeping

Medical Records

Chief Financial Officer is responsible for maintaining medical records as indicated below. These records will be kept in the Chief Financial Officer's Office. *(NOTE: If you contract for post-exposure follow-up and Hepatitis B vaccination evaluation, make sure the contract language includes provisions for recordkeeping that are consistent with the requirements of 29 CFR 1910.1020.)*

Medical records shall be maintained in accordance with OSHA standard 29 CFR1910.1020. These records shall be kept confidential and must be maintained for the duration of employment plus 30 years. The records shall include the following:

a) The employee's name and social security number;

b) A copy of the employee's HBV vaccination status, including the dates of vaccination <u>OR</u> a signed declination form;

c) A copy of all results of examinations, medical testing (including post-vaccination antibody testing), and follow-up procedures; and

d) A copy of the information provided to the healthcare professional, including a description of the employee's duties as they relate to the exposure incident, documentation of the route(s) of exposure, and circumstances of the exposure.

14. Training Records

Chief Financial Officer is responsible for maintaining BBP training records. These records will be kept in the Chief Financial Officer's Office.

Training records shall be maintained for 3 years from the date of training, and shall document the following information:

a) The dates of the training sessions;

b) An outline describing the material presented;

c) The names and qualifications of persons conducting the training; and

d) The names and job titles of all persons attending the training sessions.

15. Sharps Injury Log

For cases that involve percutaneous injury from contaminated sharps, Chief Financial Officer is responsible for maintaining a sharps injury log. Information shall be entered on the log so as to protect the confidentiality of the injured employee. At a minimum, log entries shall document the following:

a) The type and brand of device involved in the incident;

b) The department or work area where the incident occurred; and

c) An explanation of how the incident occurred.

The sharp injury log is required in addition to the OSHA 300 log.

Availability

All employee records shall be made available to the employee in accordance with 29 CFR 1910.1020.

All employee records shall be made available to the Assistant Secretary of Labor for Occupational Safety and Health (OSHA) and the director of the National Institute for Occupational Safety and Health (NIOSH), or their representatives, upon request.

Transfer of Records

If this facility is closed and/or there is no successor employer to receive and retain the records for the prescribed period, the Director of NIOSH shall be contacted for final disposition.

16. Evaluation and Review

Chief Financial Officer and Facilities Director is responsible for annually reviewing this program and its effectiveness, and for updating this program as needed. This review shall include and document:

a) Consideration and implementation, where feasible, of commercially available safer medical devices designed to eliminate or minimize occupational exposure; and

b) Input from non-management direct care staff who are potentially exposed to injury from contaminated sharps on identification, evaluation and selection of engineering and work practice controls.

17. Outside Contractors

(While the written exposure plan does not have to address information obtained from and/or provided to outside contractors, you may wish to establish standard operating procedures for these situations and append them to this document.)

POSITIVE COVID-19 CASE PROCEDURES

Testing persons with signs or symptoms consistent with COVID-19

Persons experiencing homelessness who have COVID-19 signs and/or symptoms should be escorted to the respite room, until they can be tested by a CHW. If Respite is not available, have the guest wait in an office or other empty and isolated space. If the guest is quarantined outside of respite, the shared bathroom must be cleaned immediately after use by potentially infected guest.

The client should wear a mask covering the nose and mouth and possibly be sent to a healthcare facility, depending on the severity of symptoms. Testing can be performed in accordance with the emergency use authorization to determine if the individual is infected with SARS-CoV-2 by antigen test or NAAT.

POSITIVE CASE PROCEDURE FOR GUEST

1. Notify Health Department that you have a guest in need of isolation: **765-423-9221**
2. Explain the following to guest:
    a. Since they have tested positive, the must go into quarantine. share with them the plan for isolation established by the health department. If they have not already been placed in an isolation room, do so now.
    b. Explain the expected duration of Isolation (see table) in clear terms and verify they understand
    c. In the event the health department is unable to isolate the guest outside of LTHC, they may need to be isolated in medical respite.
    d. Equip guest with any supplies they may need while isolated:
        i. toiletries
        ii. Towels/washcloths
        iii. Socks/underwear

*If health department is unable to provide transportation/hotel that evening and respite is unavailable, LTHC is then to put that guest in a hotel.

The need for a confirmatory test for a positive result is to be determined by the health department

3. Interview guest to identify close contacts and common locations the person visited starting from 48 hours before their symptoms began
4. Test unvaccinated close contacts of positive guest:
    a. *A close contact is defined as someone who has been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes in one day). An infected person can spread SARS-CoV-2 starting from 2 days before they have any symptoms (or, for asymptomatic patients, 2 days before the positive specimen collection date)*
    b. LTHC will mandate testing of close contacts if they are refused to be tested. A guest that refuses will be asked to leave for 2 weeks.
    c. Follow-up testing of close contacts is recommended for anyone who was not tested or tested negative if they develop symptoms of COVID-19 at any time.

d. If a close contact of a person with COVID-19 has a negative test result, the person may be tested again 2–10 days after last exposure or immediately if symptoms later develop.

5. Notify Guests and Staff that there has been a positive case and offer testing to anyone who could have potentially been exposed

POSITIVE CASE PROCEDURE FOR STAFF:

1. Instruct staff member on the recommended duration of isolation (see below), and notify or have them notify their supervisor
2. Interview staff member to identify close contacts and common locations the person visited starting from 48 hours before their symptoms began
    a. *A close contact is defined as someone who has been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes in one day). An infected person can spread SARS-CoV-2 starting from 2 days before they have any symptoms (or, for asymptomatic patients, 2 days before the positive specimen collection date)*
3. Encourage to get PCR test and give information for nearest testing (CVS)
    a. **CVS -** 1725 Salem Street, Lafayette, IN 47904
    b. **Walgreens -** 1801 South St, Lafayette, IN 47904
    c. **CVS -** 3630 S 18th St, Lafayette, IN 47909
4. Test unvaccinated close contacts of positive staff member
5. If the staff member utilizes a shared space, make sure that is cleaned

Duration of Isolation and Precautions for Adults with COVID-19
• For most adults with COVID-19 illness, isolation and precautions can be **discontinued 10 days after symptom onset*** and after resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. • Some adults with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; severely immunocompromised patients** may produce replication-competent virus beyond 20 days and require additional testing and consultation with infectious diseases specialists and infection control experts. • For adults who never develop symptoms, isolation and other precautions can be discontinued **10 days after the date of their first positive RT-PCR test result for SARS-CoV-2 RNA.** • ***Role of viral diagnostic testing (RT-PCR or antigen)***to discontinue isolation or precautions:*** For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the strategy outlined in Part 1, above.

Note Recovered adults can continue to shed detectable but non-infectious SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset, albeit at concentrations considerably lower than during illness, in concentration ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely.

Assessment and Reassessment of Guests

Purpose:
Assessment and Reassessment will be made on guests staying in the LTHC Respite area to continue to ensure that adequate treatment and care is being administered in the LTHC Respite area. The assessment will be performed at the initiation of service and reassessments will be made periodically depending on the guest's health status.

Who is Responsible:

Registered Nurses
EMTs
Paramedics
Physicians
Advanced Practice Nurses

Policy:
A practitioner (physician or nurse practitioner) will make the initial assessment in a clinical setting (hospital or clinic) and will assess to deem if the guest is eligible and in need of LTHC Respite Care. If unsure if guest will qualify for LTHC Respite Care see the Referral Questions flowchart.

Reassessment will review and evaluate the guest's status of previously identified conditions and evaluate any newly identified conditions. Reassessment will address pain, functionality, and discharge planning. Data will be documented in the patient's EMR. Diagnostic testing may be made by a practitioner or made through a follow-up clinical appointment after being discharged from LTHC Respite care. Reassessment frequency is indicated by guest's needs.

Medication Policy and Procedure

Policy

LTHC is committed to serving people experiencing homelessness that are ill or injured and in need of medical recovery. The residents are responsible for obtaining their own medications prior to arrival and throughout their stay. Guests are not permitted to share their prescribed medications with other guests. LTHC staff members are able to minimally assist guests in LTHC Respite care with their medications, but ultimately, the guests are responsible for their own prescribed medications.

Procedure

Each guest is required to arrive with a 30-day supply of medication. Obtaining medication is the responsibility of the guest and his/her health-care provider. While at LTHC, the guests will be given a medication locker with a key assigned to their locker. The guests are able to access the key from the Front Desk staff. The guests are responsible for following the prescribing providers instructions for taking their medication. Medication refills or new medications needed are also the responsibility of the guest; however, Community Health Workers at LTHC may help the guest acquire the medication refills if necessary. All medications must be put away after use in the guest's dedicated med locker as assigned upon admission. Discontinued or expired medications will be removed by Staff and safely disposed of using a deactivation system.

LTHC Respite Confidentiality Agreement

Guest Privacy

The health insurance portability and Accountability Act Privacy Rule created the national standard to protect individuals' personal health information.

Any information, whether spoken, electronic or written relates to the health of the individual, the health care provided to that individual or payment for health care provided is considered protected.

Guests have the rights to:

- Know who has accessed his/her health information
- Access his/her medical record
- Request an accounting of all disclosures of the past six-years
- A patient or patient representative has the right to ask the Health and Wellness director to place restrictions on the use and disclosure of the patient's protected health information
- Choose recourse if his/her rights are violated

Your Role in Protecting Patient Rights

No information that relates to a patient's health may be disclosed unless authorized by the patient or patient's representative unless permitted by HIPAA regulation. LTHC will limit access to only those individuals who need the information for a legitimate purpose.

Any information that is shared should be limited to the minimum necessary; the least amount of information to accomplish the request is optimal. However, this does not apply to the sharing of the medical record for treatment purposes.

You are accountable for:

- Appropriate disposal of materials containing patient identifiable health information
- Understanding the consequences for disclosing confidential patient information

- Inappropriate access to or disclosure of patient health information can lead to denied access, disciplinary action by your employer and potential legal action.

After Hours On-Call Protocol

Purpose:

In order to maintain a safe and quality experience for our guests receiving medical respite care at LTHC, there will be a nurse on-call 24 hours a day, 7 days a week through Physio Care, a home health agency. This nurse will be able to answer questions that guests may have outside of normal operational clinic hours, and if necessary, will come to LTHC to deliver in person care. Additionally, Phoenix Paramedic Solutions will be available 24/7 for more emergent cases, refer to LTHC Medical Conditions Protocol manual. In addition to a 24/7 on-call nurse, LTHC non-clinical staff will be on-site 24 hours a day, 7 days a week to provide assistance to guests and if needed, connect them with outside emergency services. If an unusual event occurs, defined in the Unusual Events Reporting Protocol, outside of normal operational hours, the LTHC Health and Wellness Director and the Shelter Director should both be contacted.

Contact Information:

PhysioCare-

Phoenix Paramedic Solutions-

LTHC Health and Wellness Director, Jodie Hicks-

Shelter Director, Robyn Krueger-

Discharge Policy

The LTHC Medical Respite area is available to individuals experiencing homelessness that are too ill to go without care, but healthy enough to be treated outside of a hospital setting. With the help of a home health organization, guests will be treated 24 hours a day in order to allow them to recuperate to return to functioning independently. Once deemed healthy enough by a medical provider, guests will be informed of the discharge order from the LTHC medical respite area while given adequate information on the next steps to take to maintain independence.

Procedure

Assess the guest to ensure they are healthy enough to leave Respite care. Guests who have been medically cleared to leave the Respite care of LTHC, will be informed 24 hours prior to discharge.

Ensure that guest has a primary care physician whom they can follow up with or find a care team for a follow-up. Inform guest's primary care provider of care given at LTHC, including admitting diagnosis, medications administered, and other care administered over the course of their time at LTHC. Forward discharge summary generated at LTHC to primary care provider. A post discharge appointment in 7-14 days will be set up with a primary care provider.

Upon discharge, a discharge summary is made available to guests containing discharge instructions including follow-up appointments, medication refill information, medical problem list, allergies, indications of worsening condition that may indicate readmission or hospital admission, special medical instructions relevant to guest's condition, and how to access relevant community resources.

Proper education will be provided prior to discharge on proper medication administration and dosing. Additionally, the guest will be given an explanation on how their medications are relevant to their condition. LTHC will perform follow-up phone calls based on guest's severity of their condition while at LTHC, this call will include reminder of upcoming appointments, and confirmation of acquisition of new medications when applicable.

LTHC Homeless Services has a list of expectations of conduct that applies to all guests receiving services, these policies will apply to the Respite Care area as well. These rules include but are not limited to the prohibition of weapons, drugs or alcohol on the premises. Guests who break the rules will be discharged immediately. A discharge summary will be formed and given to the guest prior to discharge; however, the guest will not be given the standard 24-hour notice, and the guest will have to arrange their own plans following their immediate discharge.

In the event of a Self-Discharge, the case manager of the guest should be notified as well as the community health worker on-site if available. The normal discharge procedure will be conducted if the guest allows, and a discharge summary will be given to the guest prior to leaving.

LTHC Respite Center Guest Grievance Policy

If a guest has a conflict with LTHC Respite personnel, or he/she/they feels as if they are being treated unfairly the following process will be followed:

<u>Grievance Procedure</u>

1) Whenever possible, talk things over directly with the person you are having a conflict with- Respite staff or Case Manager
2) If the matter cannot be resolved between the guest and the staff member, a grievance form should be filled out by the guest, and the employee's direct supervisor should be contacted in writing within five days of the issue being contested
3) If the matter cannot be resolved by the direct supervisor, the issue should be reported to an LTHC administrator in writing within the next five days
4) If there are still questions about the matter, they shall be submitted to the Chief Executive Officer of LTHC. The CEO will review the case and respond in writing within 10days of receiving the concerns
5) Any matter that cannot be resolved by step 4 will be referred to the Board of Directors for review and decision. The Executive committee may respond in writing within thirty days of receiving the concerns.

Unusual Events Reporting Policy

LTHC strives to improve the quality of care provided to guests, thus a system of procedures to document unusual events has been established. This system is designed to define unusual events, assure unusual events are reported in a timely and accurate manner, and to assure corrective actions will be made in order to improve the care administered at LTHC.

Unusual Events Definition and Procedure:

Unusual Events are occurrences that result in unexpected outcomes not consistent with routine LTHC operations. The event may be one that has occurred or might occur, an accident or a situation that might result in an accident, or any other unusual events that the staff wishes to report. Examples of such events are:

- Unexpected outcomes of medical treatment
- Treatment related injuries
- Deviations from procedure
- Medication errors
- Equipment/facility problems
- Needle-stick injuries
- Personal threat to staff
- Physical injuries
- Lost LTHC keys
- Lost LTHC equipment

The staff member who witnesses, discovers, or is involved in a reportable event is responsible for reporting to a supervisor or filling out an Incident Report Form. The Incident Report should be completed by the end of shift and given to a member of the management team. If an Incident involves violence, or a threat of violence, inform the manager immediately in addition to completing the Incident Report Form. A member of management should document any actions taken or investigations made as a result of the Incident Report Form.

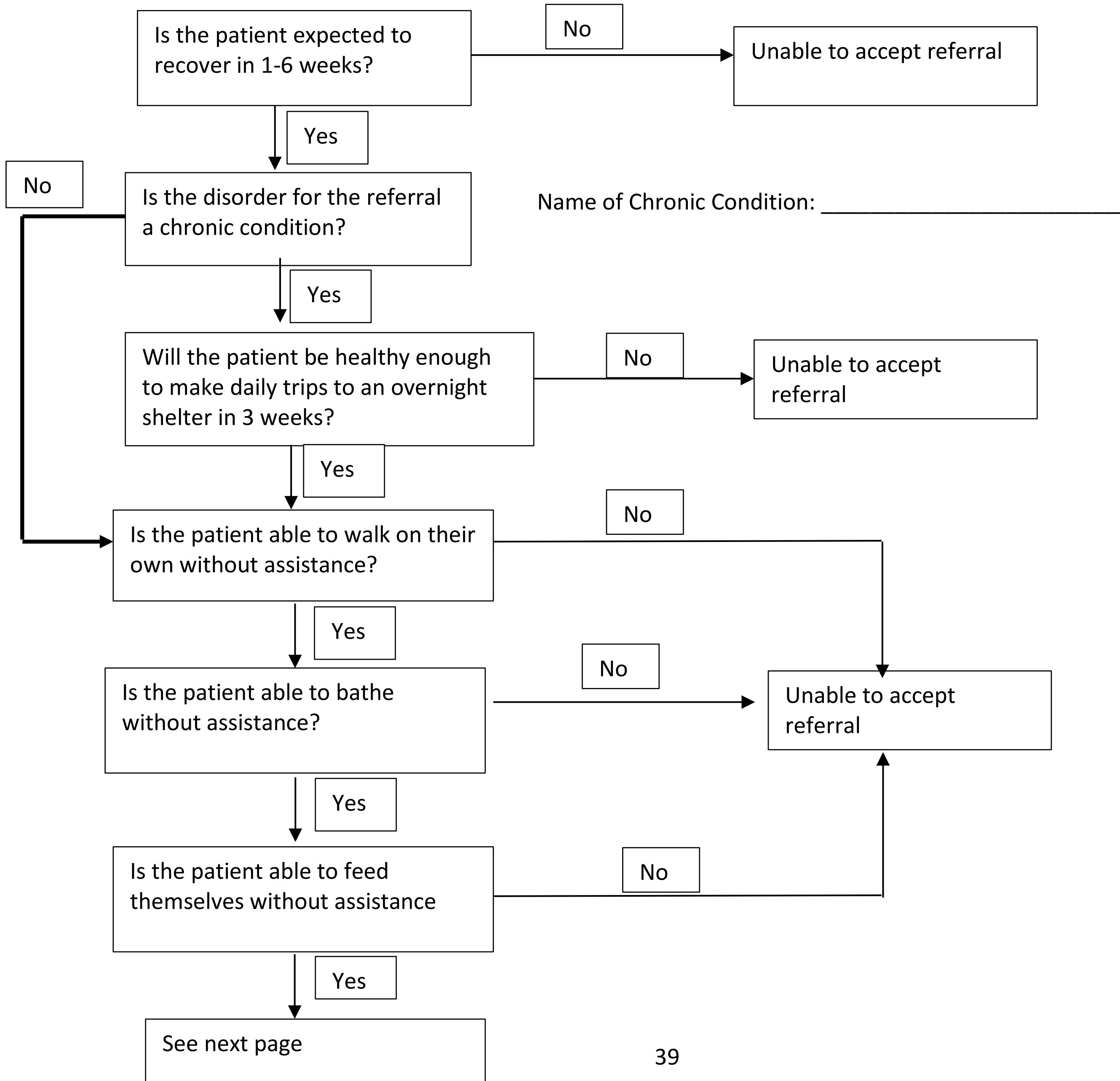
Guidelines

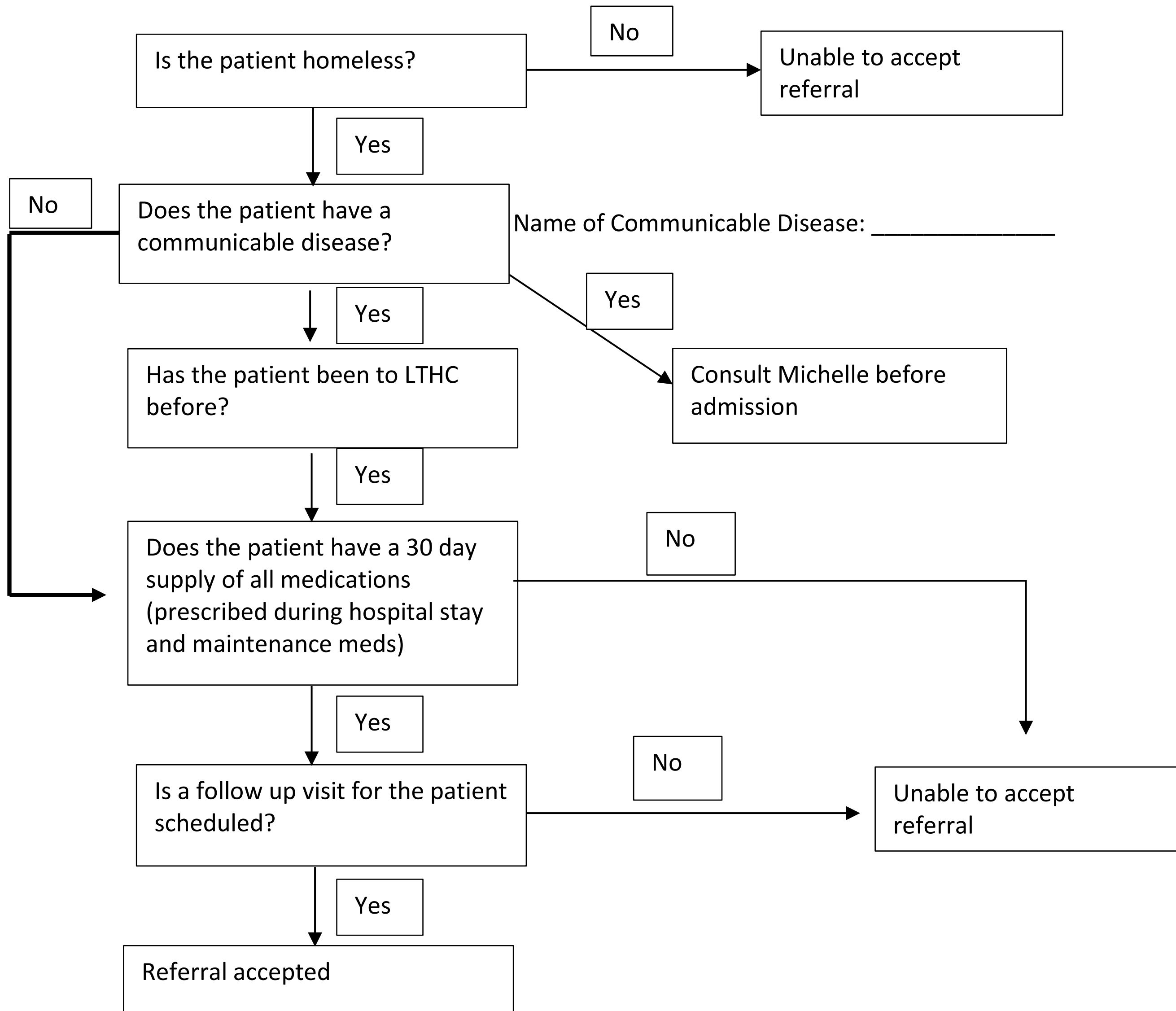
Completed Incident Report forms should not be photocopied except for purposes of organizational review.
Copies of incident reports should be shredded.
Reports should not be displayed publicly or placed in patient records.
Incident Reports should not be the subject of “public” discussion.
Incident Reports should be limited to quality improvement and risk management.
Incident Reports are the Property of LTHC and should not be distributed.

LTHC
HOMELESS SERVICES

Questions to ask hospitals when referring a patient for respite care

What is the patient name? ____
Date of Birth? ____





Check the sex offender website to make sure they aren't on there.
https://www.icrimewatch.net/index.php?AgencyID=54758&disc=54758

LTHC Conditions of Respite Residency
Occupancy Agreement

Welcome to LTHC Respite Care! This is a brief description of the conditions that our guests are expected to follow in order to receive care at LTHC. These conditions allow us to ensure that safety and quality care is provided during your stay in the LTHC Respite Area.

1. Alcohol and illegal drugs interfere with treatment, so the possession or use of alcohol and drugs is not allowed while you are a guest. If found in possession or under the influence of said drugs, the emergency discharge procedure will be conducted.
2. For the health of guests and staff, cigarette smoking is only allowed during free time outside; smoking anywhere else inside the facility is prohibited
3. Upon admission, we ask you to shower and put on clean clothes to help us promote a healthy environment in our respite area, we will also provide a means for you to wash and dry clothing you have brought in with you
4. In order to meet with a member of the health services team and a case manager, you are required to remain in the building (excluding medical and other social service appointments), until you have been cleared and discharged from Respite Care
5. Sexual Activity is prohibited on the premises.
6. To maintain a community of care and respect, violence, threats, verbal harassment, and crude language are not allowed.

I understand the above conditions and by signing below I accept and agree to follow these conditions of Respite Care at LTHC:

____________________________________ ____/____/_____

Resident Date

____________________________________ ____/____/_____

Witness Date

Respite Program
Intake Checklist

Resident Name: ____
HMIS #:______________________ Date: _________________________

- ☐ Orientation Complete
- ☐ Medication Locker Assigned
- ☐ Guest Agreement Signed
- ☐ Medical Assessment Completed
- ☐ Lock/Key for black locker
- ☐ Toiletries/Towels Given
- ☐ Intake Paperwork Complete

Guest Valuables Form

Guest Name: ________________________________ HMIS # __________________
Enrollment Date: _______________

I acknowledge that LTHC Homeless Services is not responsible for items that you keep in your possession. This includes medications, jewelry, money, bank cards, wallets, and any important documents. You are supplied with a locker box and the key is your responsibility to keep track of.

After your discharge from the LTHC Respite Program, you have 30 days to pick up your belongings or they will be discarded. LTHC Homeless Services will not be responsible for the items after that date.

Guest Signature: ___________________________ Date: ___________________________

Staff Signature: ____________________________ Date: ___________________________

Revised May 2021

Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccine series at no charge to me.

____
Employee's name (print)

____
Employee's signature

____
ECP Administrator signature

____
Date

Establishment/Facility Name: ______________________________ Year 2_____

Sharps Injury Log

Date / Time	Report No.	Type of Device (syringe, needle, etc.)	Brand Name of Device	Work Area where injury occurred (Lab, etc.)	Brief description of how injury occurred and what part of body was injured

Retain until: ___/___/___ (which is five years after the end of the current calendar year).

You are required to maintain this Sharps Log if the requirement to maintain an OSHA 300 log form applies to your company. See 29 CFR 1904 for details. The purpose of this Sharps Log is to aid in the evaluation of devices being used in healthcare and other facilities and to identify problem devices or procedures requiring additional attention and/or review. This Sharps Log must be kept in a manner which preserves the confidentiality of the affected employee(s).

Re: 29 CFR 1910.1030(h)(5).

PATIENT LAB DRAW CONSENT FORM AFTER CRITICAL EXPOSURE

I ____________________________________ **CONSENT / DO NOT CONSENT** to have blood drawn for the purpose of determining:

HIV status ________
Hepatitis status ______
RPR status ______

INCIDENT REPORT FORM

Person completing the report

_______________________________ _____________________ ______________
Name Job Title Date of report

Guest information

________________________________ Female Male
Name (First, Middle, and Last)

____
Date of Birth

Facts of Accident/Unusual Event

Date of Incident ____/____/_____

_____Illness ______Injury Did fatality occur? Yes No

Did incident occur on LTHC premises? Yes No

If yes, where on the premises did it occur?____

If no, where did the incident occur?____

Describe the event (including location, timeframe, actions taken, and witnesses)

____

____

____

____

____

_______________________________ _____________________________
Staff signature Witness signature (if applicable)

GUEST GRIEVANCE FORM

All guests are encouraged to complete this form to communicate information believed to be valuable to staff in order to improve the quality of service.

Client Name______________________________________ Date______________________

Facility Involved: ____

Staff Involved: ____

Other Guest(s) Involved: ____

Nature of information: ___ Idea ___Concern ___Complaint ___Lost item ___Behavior

BRIEFLY DESCRIBE YOUR ISSUE: ____

____

____

____

____

If APPROPRIATE BRIEFLY DESCRIBE YOUR EXPECTED RESULT TO THIS REPORT:

____

____

SIGNATURE: ____ DATE: _______________

Your signature here is consent for release of information provided herein to LTHC

RETURN THIS FORM TO THE FRONT DESK STAFF OR YOUR CASE MANAGER. YOU MAY REQUEST AN ENVELOPE THAT YOU CAN PLACE IT INSIDE AND SEAL IT. ALL FORMS WILL BE GIVEN TO THE ENGAGEMENT CENTER OPERATIONS DIRECTOR WHO WILL SET UP A TIME TO DISCUSS WITH YOU.

This space is reserved for meeting/response notes:

LTHC Discharge Summary

Guest's Name_________________________________ DOB_________________

Case Manager________________

Date of Referral__________________ Discharge Date____________________

Admitting Condition____

Condition Stabilized: Yes No Comments_______________________________________

Medications Given During Stay:

Medication Refills Needed:

Last set of vitals:

HR ___________ BP _________/_______ Weight ________________ Temp_____________

Sp O_2 __________%

Follow up appointments:

Primary Care____

Specialist____

Mental Health____

Respite Discharge Questionnaire

1. When you had important questions to ask medical personnel, did you get answers that you could understand?

2. Sometimes in a hospital, one doctor or nurse will say one thing and another will say something quite different. Did this happen to you at LTHC?

3. If you had any anxieties or fears about your condition or treatment, did an LTHC medical staff member discuss them with you?

4. Did you want to be more involved in decisions made about your care and treatment?

5. Overall, did you feel you were treated with respect and dignity while you were in LTHC Respite Care?

6. If you had any anxieties or fears about your condition or treatment, did an LTHC medical staff member discuss them with you?

7. Did you find someone in the LTHC medical staff to talk to about your concerns?

8. Do you think the LTHC medical staff did everything they could to control your pain?

9. Did the LTHC medical staff give you all the information you needed to help you recover?

10. Did a member of staff explain the purpose of the medicines you were to take home in a way you could understand?

11. Did a member of staff tell you about medication side effects to watch for when you went home?

12. Did someone tell you about danger signals regarding your illness or treatment to watch for after you went home?

LTHC
HOMELESS SERVICES

LTHC Medical Job Roles Flowsheet