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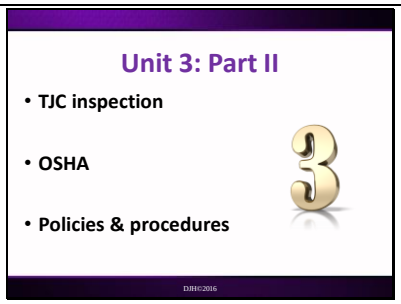
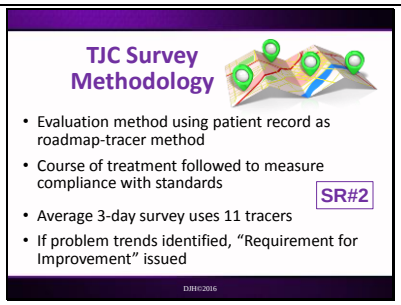
| 1. |  | This is Unit 3, Part II entitled "Compliance-Accrediting & Regulatory Agencies; Policies & Procedures. |
| 2. |  | In Part 1, we discussed the Joint Commission standards for Infection Prevention & Control. In this part, we will talk about the Joint Commission inspection, OSHA and their inspection process, and finally, policies & procedures. |
| 3. |  | The Joint Commission's on-site survey process includes tracer methodology. Tracer methodology is an evaluation method in which surveyors select a patient, resident or client and use that individual's record as a roadmap to move through an organization to assess and evaluate the organization's compliance with selected standards and the organization's systems of providing care and services. Surveyors retrace the specific care processes that an individual experienced by observing and talking to staff in areas that the individual received care. As surveyors follow the course of a patient's, resident's or client's treatment, they assess the health care organization's compliance with Joint Commission standards. They conduct this compliance assessment as they review the organization's systems for delivering safe, quality health care. While conducting tracer activities, the surveyor may identify compliance issues in one or more elements of performance. Surveyors will look for compliance trends that might point to potential system level issues in the organization. The tracer activity also provides several opportunities for surveyors to provide education to organization staff and leaders, as well as to share best practices from other similar health care organizations. The number of tracers completed depends on the length of the survey; however, the average three-day hospital survey with a team of three surveyors typically allows for completion of approximately 11 tracers. Tracer patients, residents or clients are primarily selected from an active patient list. Typically, individuals selected for the tracer activity are those who have received multiple or complex services. The surveyor may speak to the patient, resident or client during the tracer activity, if it is appropriate. As always, the surveyor asks for patient permission before speaking to him or her. If problem trends are identified, surveyors will issue the organization a Requirement for Improvement. The organization has 45 days from the end of the survey to submit Evidence of Standards Compliance and identify Measures of Success that it will use to assess sustained compliance over time. Four months after |

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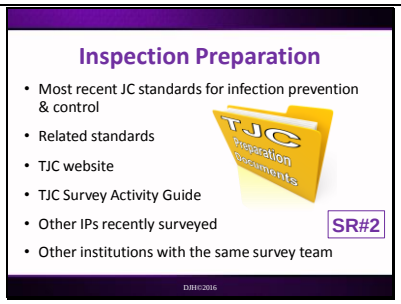
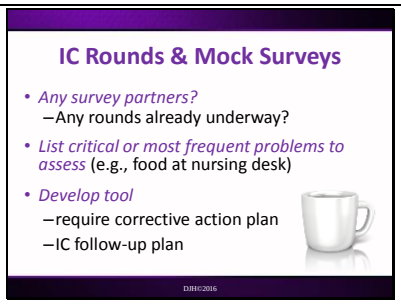
| | | approval of the Evidence of Standards Compliance, the organization will submit data on its Measure of Success to demonstrate a track record. Any exchange of information between the health care organization and The Joint Commission will meet HIPAA requirements. For more information about the tracer methodology, or other key components of the accreditation process, please review Supplemental Reading #2. |
| 4. |  | In order to prepare for an inspection, the most recent JC standards are necessary. As I mentioned earlier, the infection prevention and control standards are not the only JC standards that have infection control application. There are some in Leadership, Environment of Care, and Medical Staff Credentialing in TJC (JCAHO) manuals, that have infection control-related standards. One very good resource is the Joint Commission website itself. TJC has published a document entitled "Survey Activity Guide for Health Care Organizations" (Source: http://www.jointcommission.org/assets/1/18/2014_organization_sag.pdf) (Supplemental Reading #2). There is a JC publication called, "Perspectives", a newsletter-type document. There are also many other references that are listed on that website. Finding out what other infection preventionists have recently been surveyed is probably the very best thing that you can do if it has been recent. That is because they'll be using the most current guidelines for that inspection. You may be able to anticipate what the "hot spots" are to prepare ahead of time. It is helpful if you can find if you are getting the same survey team as another institution and find out what happened, what questions were asked. The last time I was involved in a JC inspection was September of 2000. We had the misfortune of having the survey leader be an ex-infection preventionist, making it especially challenging! |
| 5. |  | Many facilities will conduct what they call "mock infection control inspections". They may hire consultants to come in and inspect the facility. As an IP, you might survey the community and find any hospitals in your area already conducting mock rounds. These are good resources for finding out what happened during their mock inspections. You should list what you think are the most critical or most important problems to assess. One example is having food at the nursing desk, a practice that JC or OSHA often cite facilities for, especially if there are patient specimens or centrifuges (where you spin blood samples) located in the same area. That's just an example of one thing you could look at. You could also develop tools for survey preparation. There are many different ones available from colleagues or the Internet to look at what corrective actions you need to do at your facility and tools for completing those corrective actions. |

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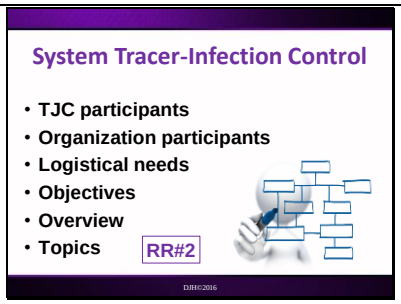
| 6. |  | Let's next outline the system tracer for infection control. The Joint Commission Participants include the surveyors. The organization's suggested participants include the infection control coordinator for each program being surveyed; physician member of the infection control team; clinicians from the laboratory; clinicians knowledgeable about the selection of medications available for use and pharmacokinetic monitoring, as applicable; facility or facilities staff; organization leadership; and staff involved in the direct provision of care, treatment, or services. The duration of this session is approximately 30-60 minutes.<br>The surveyor will:<br>• Learn about the planning, implementation, and evaluation of your organization's infection control<br>• program<br>• Evaluate your organization's process for the infection control plan development, outcome of the<br>• annual infection control evaluation process, and oversight of opportunities for improvement<br>• Understand the processes used by your organization to reduce infection<br>• The infection control session begins during one of the individual tracers where the surveyor identifies an individual patient with an infectious disease. This session is conducted in two parts. During the first part, surveyors meet with staff from all programs being surveyed to discuss your organization's infection control program. During the remaining time, surveyors spend their time where care, treatment, or services are provided.<br>• Topics of discussion include:<br>• How individuals with infections are identified<br>• Laboratory testing and confirmation process, if applicable<br>• Staff orientation and training activities<br>• Current and past surveillance activity<br>• Analysis of infection control data<br>• Reporting of infection control data<br>• Prevention and control activities (for example, staff training, staff and licensed independent<br>• practitioner vaccinations and other health-related requirements, housekeeping procedures,<br>• organization-wide hand hygiene, food sanitation, and the storage, cleaning, disinfection,<br>• sterilization and/or disposal of supplies and equipment)<br>• Staff exposure<br>• Physical facility changes that can impact infection control and<br>• Actions taken as a result of surveillance and outcomes of those actions<br>(Note: These topics are covered by surveyors during other activities on surveys that do not have a specific system tracer related to infection control.) Please review Required Reading #2 |

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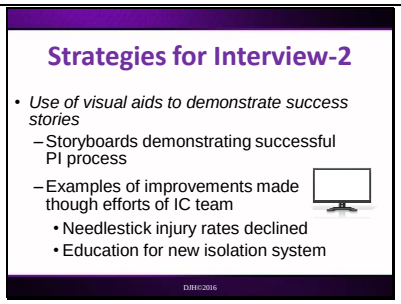
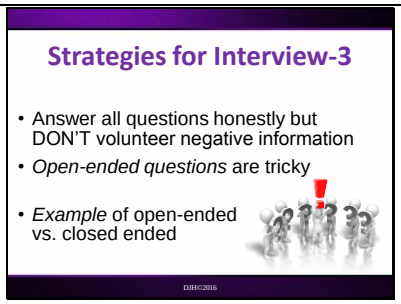
| 7. |  | During an inspection, it is really very important that as an IP, you keep in touch with your hospital inspection team (the persons from your facility assigned to accompany TJC survey team) on an hourly basis. They will be able to give you a "heads up" if any infection control issues arise, so that you can prepare before you meet with TJC. We always found that the best approach, when TJC did meet with us is to have the Infection Preventionists, the Hospital Epidemiologist, someone from the laboratory (the Micro lab), someone from Medical Administration and an Employee Health representative present. |
| 8. |  | One strategy that is helpful during JC surveys is the use of visual aids. Critically think about your program before Joint Commission comes, so that you can share success stories (e.g., decline in needlestick injuries in healthcare workers, successful educational program on new isolation systems). A presentation tool known as a storyboard could be used for this purpose. It is a poster with the issue, how you implemented interventions to deal with that issue and what the outcomes were. You would want to use a successful program to demonstrate with a storyboard. |
| 9. |  | Here are some additional strategies for the TJC infection control interview. First, of course, you are going to answer all questions honestly. However, you don't need to volunteer negative information, especially if NOT in response to a specific question. Open-ended questions are very tricky. So if a surveyor asks you, for example to, "Tell us about your isolation categories?" You could say, "Yes. We use these 4 categories but nobody follows them." You DON'T want to say that. There's a skill in answering an open-ended question. Instead, you could say, "We use these 4 categories and presented education to all employees when we started them". You could mention positive outcomes that you achieved. Now let's give an example of a closed-ended versus an open-ended question. The topic is tuberculosis exposures in the hospital. A closed-ended question would be, "Do you think you have an excess number of TB exposures at your facility? If the answer is Yes", then it doesn't really allow for you to expand. A related open-ended question might be, "Tell us what you think contributes to the large number of TB exposures at your facility." Here is your chance to expand, explain, or even justify your program, especially if they are not correct. An example of a response to this would be "We have a policy. The policy requires all new patients on admission, if they have an upper-lobe infiltrate, to be placed immediately in isolation. They do not come out of isolation until certain requirements are met. If a doctor does not write an order, a nurse can still put a patient in isolation. Our county has the highest number of TB cases in the country, so taking that into consideration, we do not really have an excess number of exposures." That would be a way to give the information you |

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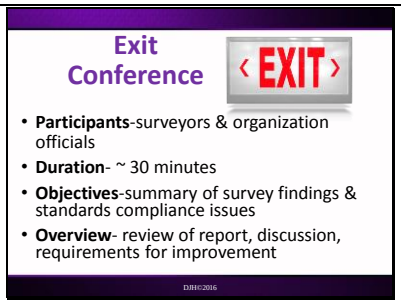
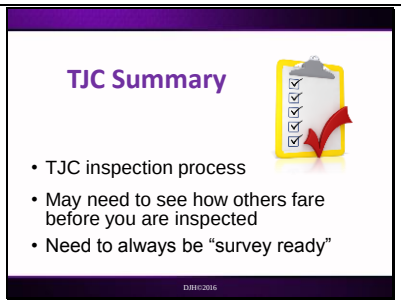
| | | want but not offer any negative information. Another strategy Joint Commission uses is to go around and ask employees questions to determine if they are familiar with infection control policies. One example would be to ask a laboratory worker, “Do you know what universal precautions or standard precautions are? When do you wear gloves? How do you clean up a blood spill?”. IPs need to make sure that the program is in place and that employees can answer the question correctly. The recommendation is that a facility always be survey ready. |
| 10. |  | Upon completion of the survey process, the exit conference is held. Participants include the JC surveyors and the organization’s participants (such as the CEO/Administrator or designee, senior leaders and staff as identified by the CEO/Administrator or designee). The suggested duration of this session is approximately 30 minutes and takes place immediately following the Exit Briefing. During the exit conference surveyors will verbally review the Summary of Survey Findings Report and review identified standards compliance issues. Surveyors will verify with participants that all documents have been returned to the organization. Discussion will include the Requirements for Improvement and any patterns or trends in performance revealed by the Priority Focus Areas and Clinical/Service Groups. If follow-up is required, the surveyors will explain the submission process |
| 11. |  | Let’s review what we’ve talked about regarding the Joint Commission. First, we have described the general JC inspection process using tracer methodology and then specifically described the infection control session. It is really important to see how other colleagues have fared before a facility is inspected by TJC because it may provide insight into areas that can be worked on ahead of time. Finally, the “continuous” nature of the accreditation process reinforces the need for IPs and their facilities to always be “survey ready”. |
| 12. |  | Let’s next discuss the Occupational Safety & Health Administration, or OSHA, which is a regulatory agency. OSHA is a division of the Department of Labor. Its programs are administered under the jurisdiction of the federal OSH Act and through approved state plans. The OSH Act of 1970 requires an employer to be responsible for providing a workplace free of occupational hazards. Probably the standard that is the most applicable to infection control practice is the OSHA Bloodborne Pathogens Standard (BBPS). It was first published in the early ‘90s. It was most recently revised in 2001 to include the 2000 Needlestick Safety and Prevention Act’s mandate about safer needle devices that we will talk about in Product Evaluation lecture. |

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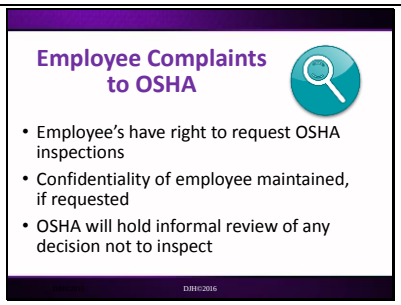
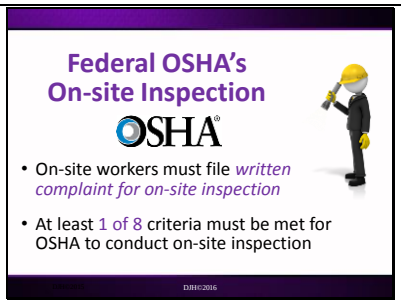
| 13. |  | What are some events that can trigger an OSHA inspection? Not all 6 million workplaces covered by the Act can be inspected immediately. The worst situations need attention first. Therefore, OSHA has established a system of inspection priorities. **Imminent danger** situations are given top priority. An imminent danger is any condition where there is reasonable certainty that a danger exists that can be expected to cause death or serious physical harm immediately, or before the danger can be eliminated through normal enforcement procedures. Second priority is given to investigation of **fatalities and catastrophes** resulting in hospitalization of three or more employees. Such situations must be reported to OSHA by the employer within 8 hours. Investigations are made to determine if OSHA standards were violated and to avoid recurrence of similar accidents. Third priority is given to **employee complaints** of alleged violation of standards or of unsafe or unhealthful working conditions. (Also included in this category are serious referrals of unsafe or unhealthful working conditions from other sources, such as local or state agencies or departments.) Next in priority are **programmed, or planned, inspections aimed at specific high-hazard** industries, occupations or health substances. Industries are selected for inspection on the basis of factors such as the death, injury and illness incidence rates, and employee exposure to toxic substances. Special emphasis may be regional or national in scope, depending on the distribution of the workplaces involved. States with their own occupational safety and health programs may use somewhat different systems to identify high-hazard industries for inspection. Finally, in list of priority, is a **follow-up inspection** to determine whether previously cited violations have been corrected.<br><br>Source: https://www.osha.gov/Publications/osha2098.pdf |
| 14. |  | The Occupational Safety and Health (OSH) Act gives each employee the right to request an OSHA inspection when the employee feels he or she is in imminent danger from a hazard or when he or she feels that there is a violation of an OSHA standard that threatens physical harm. OSHA will maintain confidentiality if requested, will inform the employee of any action it takes regarding the complaint and, if requested, will hold an informal review of any decision not to inspect. Just as in situations of imminent danger, the employee's name will be withheld from the employer, if the employee so requests. |
| 15. |  | OSHA evaluates each complaint to determine how it can be handled best-an off-site investigation or an on-site inspection. Workers who would like an on-site inspection must submit a written request. Workers who complain have the right to have their names withheld from their employers, and OSHA will not reveal this information. At least one of the following eight criteria must be met for OSHA to conduct an on-site inspection: |

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| | | •A written, signed complaint by a current employee or employee representative with enough detail to enable OSHA to determine that a violation or danger likely exists that threatens physical harm or that an imminent danger exists;<br>•An allegation that physical harm has occurred as a result of the hazard and that it still exists;<br>•A report of an imminent danger;<br>•A complaint about a company in an industry covered by one of OSHA's local or national emphasis programs or a hazard targeted by one of these programs;<br>•Inadequate response from an employer who has received information on the hazard through a phone/fax investigation;<br>•A complaint against an employer with a past history of egregious, willful or failure-to-abate OSHA citations within the past three years;<br>•Referral from a whistle blower investigator; or<br>•Complaint at a facility scheduled for or already undergoing an OSHA inspection. |
| 16. |  | An OSHA compliance inspector conducts an OSHA inspection. Most often the inspector is an industrial hygienist or a safety specialist. An OSHA compliance officer carries U.S. Department of Labor credentials bearing his or her photograph and a serial number than can be verified by phoning the nearest OSHA office. |

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| 17. |  | The OSHA inspection works this way. The inspector or team of inspectors (there may be more than one), come in and they show their credentials (as mentioned in previous slide). Then they hold an **opening conference**. In the opening conference, the compliance officer (CSHO) explains why the establishment was selected, the purpose of the visit, the scope of the inspection, and the standards that apply. The employer will be given a copy of any employee complaint that may be involved. If the employee has so requested, his or her name will not be revealed. The employer is asked to select an employer representative to accompany the compliance officer during the inspection. An authorized employee representative also is given the opportunity to attend the opening conference and to accompany the compliance officer during the inspection. The Act does not require that there be an employee representative for each inspection. Where there is no authorized employee representative, however, the compliance officer must consult with a reasonable number of employees concerning safety and health matters in the workplace; such consultations may be held privately. The next step is the **inspection tour**, when the compliance officer and accompanying representatives proceed through the establishment, inspecting work areas for compliance with OSHA standards. Employees are consulted during the inspection tour. The compliance officer may stop and question workers in private about safety and health conditions and practices in their workplaces. *You may realize here that this is why it is important for all employees to be familiar with the policies and procedures of their institutions.* During the inspection tour, posting and recordkeeping are checked. The compliance officer will inspect records of deaths, injuries and illnesses which the employer is required to keep. During the course of the inspection, the CSHO will point out to the employer any unsafe or unhealthful working conditions observed. At the same time, the CSHO will discuss possible corrective action if the employer so desires. An inspection tour may cover part or all of an establishment, even if the inspection resulted from a specific complaint, fatality or catastrophe. The last step in the inspection procedure is the **closing conference**, held between the compliance officer and the employer or the employer representative. It is a time for free discussion of problems and needs as well as a time for frank questions and answers. The compliance officer discusses with the employer all unsafe or unhealthful conditions observed on the inspection and indicates all apparent violations for which a citation may be issued or recommended. The employer is told of appeal rights. The compliance officer does not indicate any proposed penalties. Only the OSHA area director has that authority, and only after having received a full report.<br><br>Helpful source: https://www.osha.gov/dte/grant_materials/fy10/sh-20853-10/osha_inspections.pdf |

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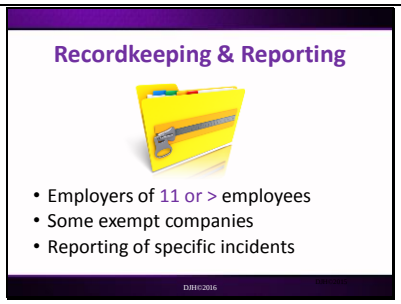
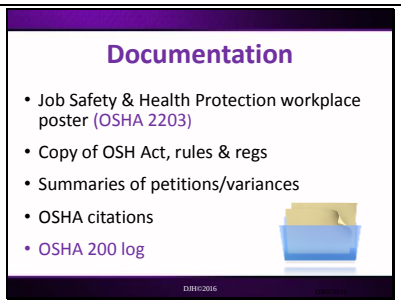
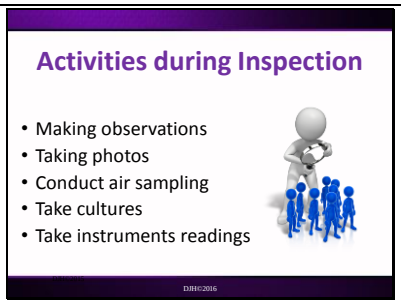
| 18. |  | Employers of 11 or more employees must maintain records of occupational injuries and illnesses as they occur. The purposes of keeping records are to permit survey material to be compiled, to help define high hazard industries, and to inform employees of the status of their employer's record. Employers in state plan states are required to keep the same records as employers in other states. OSHA recordkeeping is not required for certain retail trades and some service industries. Exempt employers, like nonexempt employers, must comply with OSHA standards, display the OSHA poster, and report to OSHA within 8 hours any accident that results in one or more fatalities or the hospitalization of three or more employees. If an on-the-job accident occurs that results in the death of an employee or in the hospitalization of three or more employees, all employers, regardless of the number of employees, must report the accident, in detail, to the nearest OSHA office within 8 hours. |
| 19. |  | Federal OSHA and states with their own occupational safety and health programs require that each employer post certain materials at a prominent location in the workplace. These include: 1) Job Safety and Health Protection workplace poster (OSHA 2203 or state equivalent) informing employees of their rights and responsibilities under the Act, 2) Besides displaying the workplace poster, the employer must make available to employees, upon request, copies of the Act and copies of relevant OSHA rules and regulations. 3) Summaries of petitions for variances from standards or recordkeeping procedures, 4) Copies of all OSHA citations for violations of standards. These must remain posted at or near the location of alleged violations for three days, or until the violations are corrected, whichever is longer. 5) Log and Summary of Occupational Injuries and Illnesses (OSHA No. 200). The summary page of the log must be posted no later than February 1, and must remain in place until March 1. All employees have the right to examine any records kept by their employers regarding their exposure to hazardous materials, or the results of medical surveillance. |
| 20. |  | While the OSHA inspection team conducts the inspection, they may participate in additional activities besides interviewing employees and making observations. The inspector might also take photos, conduct air samples, take cultures, or do instrument readings to see if there is contamination, such as with radiation. A possible example would be that there's a complaint from people who work in the sterilization area that the ethylene oxide isn't being aerated sufficiently, so they might want to do an instrument reading of the ethylene oxide levels to determine if they exceed permissible levels. |

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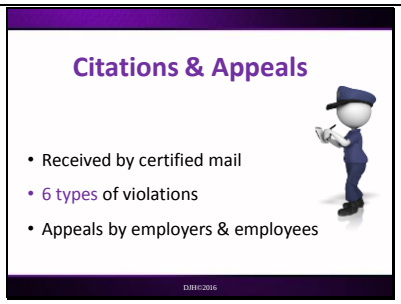
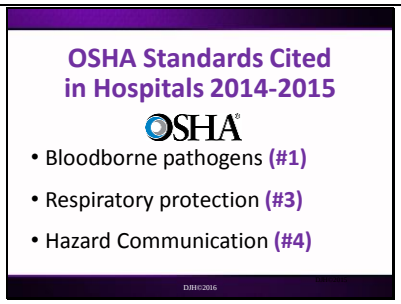
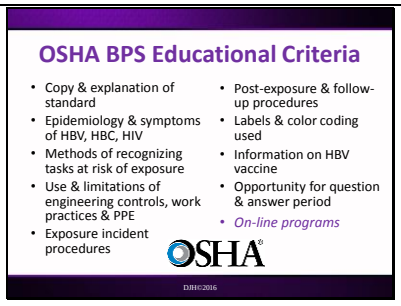
| 21. |  | After the compliance officer reports findings, the area director determines what citations, if any, will be issued, and what penalties, if any, will be proposed. Citations inform the employer and employees of the regulations and standards alleged to have been violated and of the proposed length of time set for their abatement. The employer will receive citations and notices of proposed penalties by certified mail. There are 6 types of violations that may be cited: 1) Other Than Serious Violation 2) Serious Violation 3) Willful Violation 4) Repeated Violation 5) Failure to Abate Prior Violation and 6) De Minimis Violation. (If you are interested, the definitions and penalties imposed differ are presented in more detail in the Supplemental reading for this week.) When issued a citation or notice of a proposed penalty, an employer may request an informal meeting with OSHA's area director to discuss the case. Employee representatives may be invited to attend the meeting. The area director is authorized to enter into settlement agreements that revise citations and penalties to avoid prolonged legal disputes. If an inspection was initiated due to an employee complaint, the employee or authorized employee representative may request an informal review of any decision not to issue a citation. Employees may not contest citations, amendments to citations, penalties or lack of penalties. They may contest the time in the citation for abatement of a hazardous condition. |
| 22. |  | The standards *related to infection prevention and control* and cited most frequently by Federal OSHA in Hospitals during the time period from October 2014 through September 2015 by frequency were: 1) Bloodborne Pathogens #1 *(39 citations in 17 inspections),* 2) Hazard Communication #3 *(14 citations in 9 inspections)* and 3*)* Respiratory Protection ranked #4 (*13 citations in 5 inspections)* The link for this information is located on the slide and in the transcript.<br><br>(*Source: https://www.osha.gov/pls/imis/citedstandard.naics?p_naics=622&p_esize=&p_state=FEFederal)* |
| 23. |  | OSHA requires that every year healthcare workers who have contact with blood and body fluids on a routine basis, receive education. All of the items listed on this slide must be covered every year, as well as the opportunity for questions and answers provided. To cover the same material the same way, year after year, is not an effective teaching method for adult learners. (*You will learn more about this in unit 9*.) One of the things that we tried to do at our facility was to mix it up every year. We used a role-playing vignette one year; developed a game called “Valley Feud” another year, then used a Jeopardy game. We used a pre and post-test and self-learning computer modules. There are OSHA-approved on-line and other interactive programs for this purpose.<br><br>Helpful source: OSHA BPS factsheet https://www.osha.gov/OshDoc/data_BloodborneFacts/bbfact01.pdf |

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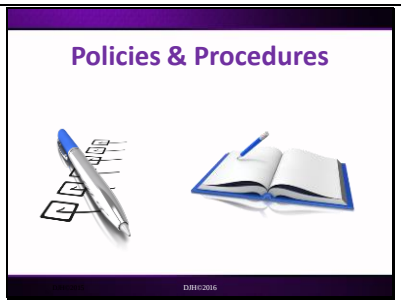
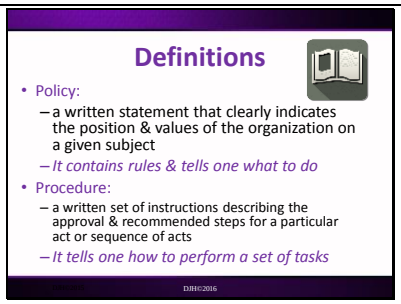
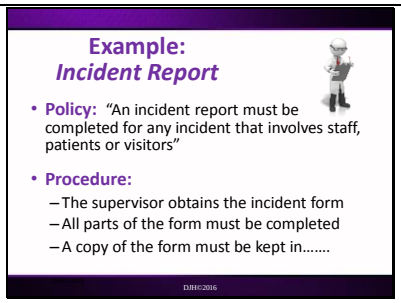
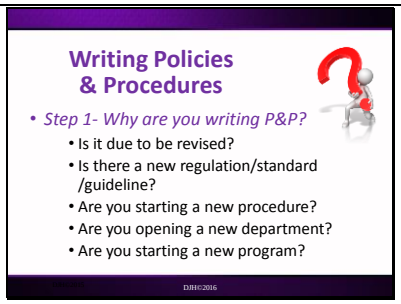
| 24. |  | We will now discuss policies and procedures. |
| 25. |  | There is a difference between a policy and a procedure. Often they're interchanged. Often they're combined. First, let's look at what the difference is. A policy is a written statement that clearly delineates the position and values of the organization on a given subject. It contains rules; and, it tells one what to do. I am going to give you examples in a minute. A procedure, on the other hand, is a written set of instructions describing the approval and recommended steps for a particular act or sequence of acts. It tells one how to perform a set of tasks. If you think about it, there are some things for which there is really only a procedure. There are some things for which there really can only be a policy. For many topics, a combination is required. |
| 26. |  | Let's use an incident report as an example to illustrate how this issue requires policy and procedure components. For the policy statement, an incident report must be completed for any incident that involves staff, patients, or visitors. For the procedure component, the incident report must be filled out by a particular person/persons, all parts of the form have to be completed, when completed, a copy is kept in the "x" location, and the original is submitted to "y" department. There are detailed guidelines for policies, procedures, mission and vision statements, and objectives in the Required Reading #3 this week. Please be sure to review these. |
| 27. |  | Let's talk about the steps of writing a policy and a procedure. For **Step 1**, you need to ask "why are you doing it in the first place?" Is it due to be revised? Is there a new regulation that's come out? For example, let's take mandatory reporting of healthcare acquired infections. There has to be a policy and a procedure for that. Pandemic influenza preparedness might need a new policy. Are you starting a new procedure in your facility? Are you opening a new department? If you have a new department, there have to be policies and procedures for that department. Are you starting a new open heart program? If so, you will need policies and procedures for that department. |

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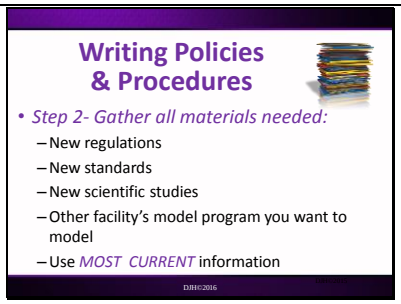
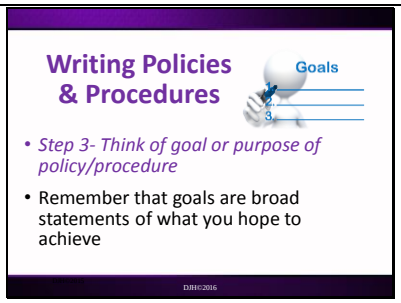
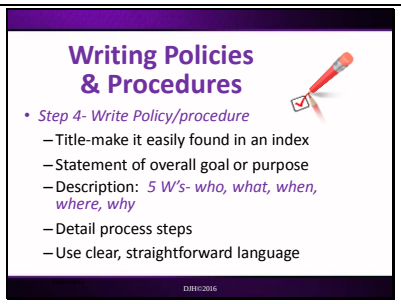
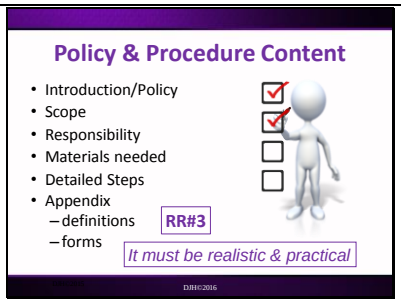
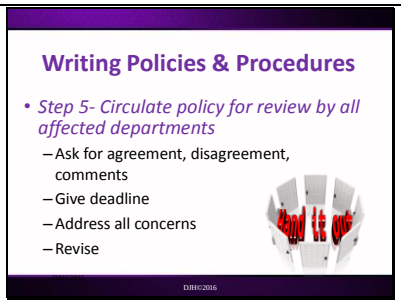
| 28. |  | **Step 2** is to make sure you have all the materials you need. This includes any new regulation, standard, or guideline. It is a really good idea to look at any scientific studies that have been done to support what you're going to do. Checking with colleagues at other facilities that have a policy about this particular subject can also be helpful. It is essential to have most current information. Your administrator and hospital are relying on you. |
| 29. |  | **Step 3** is to determine the goal or purpose of the policy/procedure. A goal is a broad statement of what you hope to achieve. An example would be a policy on handwashing by healthcare workers with the goal of "reducing transmission of infection between healthcare workers, patients, and visitors". |
| 30. |  | **Step 4** is to write the policy/procedure. Make it a title that is easily found in an index. If it's some obscure title that doesn't even relate to what you're trying to say, employees are going to have a hard time finding it. State the goal or purpose. Include the 5Ws: who does what, when, where, and why. Then write all the process steps that you need and use clear, straightforward language so that it's easy to follow. |
| 31. |  | Usually a policy and procedure, (which is a combined document), has an introduction or a policy statement. Then, it says who this applies to, either the program or the departments or the personnel, who is responsible for carrying it out, and for the procedure, what materials are needed with detailed steps. It is sometimes helpful either in the beginning or the end, to have definitions so that someone following a procedure with some new terms, will know what they are. Any forms that you might want to use to demonstrate that policy, if there is a checklist being used, if it's an incident report form, a needle stick injury report form, etc., can be included in an Appendix. The guidelines that I posted as Required Reading Set #3 outline these contents. |
| 32. |  | The **fifth step** is very, very important, "*Circulate policy for review by all affected departments".* Just as you would not want to use a product you had no input in selecting, persons in general do not like to hear about a new policy without having had some input or at least the chance to add suggestions before it becomes formalized. So, there should always be a component where the policy is in a draft form (and very clearly it has to be written "draft: on the procedure or document). You should then ask for disagreement, agreement, or comments and give a deadline from those to whom the policy/procedure is applicable to, to get back to you. Address as many concerns about those returned |

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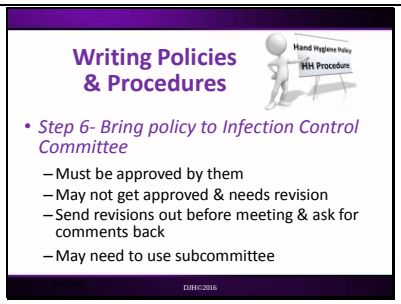
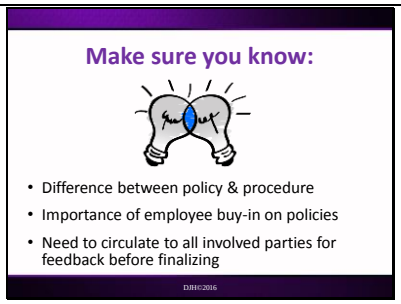
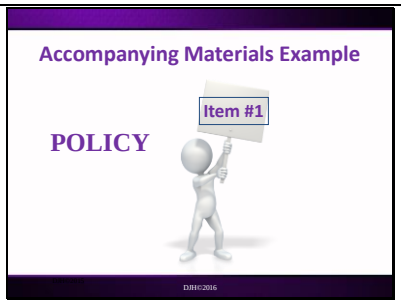
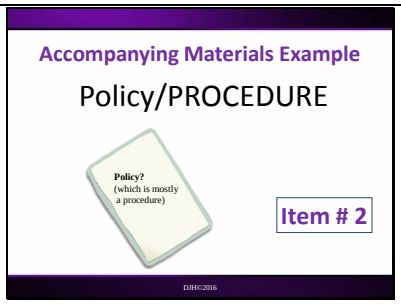
| | | comments as you can, revise it, and then you'll have to send it out again. You want to make sure that you've got buy-in because if impose a policy/procedure that no one agrees with or has had NO input on, compliance will become an issue. |
| 33. |  | **Step 6** is to bring the policy to the infection control committee, if you have an Infection Control Committee or any committee whose purview this contains, for approval. They might not get approval the first time and it may need revisions. Then, you have to send the revisions out again. Sometimes, it's very helpful to use a subcommittee of a larger committee to formulate or revise a particular policy. The example that comes to mind for me was when "Universal Precautions" first came out, and that affected numerous departments. We formed a subcommittee of front-line healthcare workers in affected departments to come up with a policy on "Universal Precautions". This way, all departments involved had input. Another advantage of using a subcommittee was that it did not take time away from the main infection control committee. |
| 34. |  | For this segment, make sure you know the difference between a policy and a procedure, the importance of employee's having a buy-in or having some input, and making sure everyone affected by the policy/procedure does see it before you finalize it. You should also be able to differentiate between policy, procedure, vision, mission and goal statements. |
| 35. |  | For this part, refer to the Accompanying Item #1 entitled "Influenza (Flu) Vaccination Policy for Employees" from the Louisiana State University Health Sciences Center. There are 6 policy statements that describe the Health Center's stance on either employees getting the influenza vaccine or wearing a mask while at work if they decline the vaccine. The policy also includes a purpose and a definition. |
| 36. |  | Now refer to Item #2 in the Accompanying Materials, entitled "Influenza Vaccination Policy for Healthcare Personnel" from "Immunize.org". In this document, even though it is labeled as a "policy"-it contains only 1 policy statement. Many healthcare facilities use these combined documents which include one or more policy statements and then the procedure steps for achieving the purpose of the policy. This document example also contains a purpose statement, a definition, and related documents/references. The majority of the rest of this document consists of procedure steps. The procedure steps are divided into sections, which include when and where to get the vaccine, prioritization, communication and education, to list a few. |

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| | | In summary, we have discussed a Joint Commission inspection, OSHA inspection issues, the reasons and steps for writing a policy and procedure. In addition, we have provided examples of policies and procedures.<br><br>**This concludes Unit 3, Part II.** |