TAHOE FOREST
HOSPITAL DISTRICT

2026-09-24 REGULAR Meeting of the Board of Directors (OPEN SESSION)

THURSDAY, SEPTEMBER 24, 2026, AT 4:00 PM

Everline Resort & Spa Lake Tahoe - Granite Chief Event Room,

400 Resort Road, Olympic Valley, CA 96146

Meeting Book - 2026-09-24 REGULAR Meeting of the Board of Directors (OPEN SESSION)

Agenda Packet Contents

AGENDA

2026-09-24 Regular Meeting of the Board of Directors_FINAL Agenda 3

ITEMS 1 - 10 See Agenda

11. MEDICAL STAFF EXECUTIVE COMMITTEE

11.1 MEC Consent Agenda 09.24.2026 6

11.2. Outpatient Procedure Consent 8

11.3-11.17 Policy Summaries 11

11.3.a. Admission of Emergency Department Patient- DED-2-(changes) 16

11.4.a. Fall Prevention, DED-11 (changes) 19

11.5.a. Family Presence During Invasive Procedures, DED-12 (changes) 21

11.6.a. Laboratory Results Culture Screening- DED-13-Changes 26

11.7.a. Multi-Casualty Incidents- DED-19-Changes 29

11.8.a. Standardized Procedure - Ordering and Performing Guideline for EKG in Emergency Department- DED-1801-Changes 32

11.9.a. Standardized Procedure for Administration of Acetaminophen - Ibuprofen for Fever in Pediatric Patients DED 1806-Changes 36

11.10.a. Transmission Based -Isolation- Precautions- AIPC-1501-Changes 41

11.11.a. Rodent Management- AIPC-109-Changes 54

11.12.a._Pest Control- AIPC-95-Changes 57

11.13.a. Infection Control Risk Assessment -ICRA- for Construction-AIPC-59-Changes 59

11.17.a. VOTE TO RETIRE - Rabies Series Vaccinations, DED-25 62

ITEMS 12 - 16: See Agenda

27. ADJOURN

TAHOE FOREST
HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
AGENDA

TO BE HELD ON

THURSDAY, SEPTEMBER 24, 2026, AT 4:00 PM

Everline Resort & Spa Lake Tahoe - Granite Chief Event Room,
400 Resort Road, Olympic Valley, CA 96146

If you would like to view the live meeting or speak on an agenda item, you can access the meeting remotely:
Please use this zoom link: https://tfhd.zoom.us/j/81070388983

Or join by phone:
If you prefer to use your phone, you may call in using the numbers listed:
(669) 900 6833 or (669) 444 9171
Meeting ID: 810 7038 8983

Public comment will also be accepted by email to sarah.jackson@tfhd.com or online at https://www.tfhd.com/board-of-directors/board-meetings/#comment. Please list the item number you wish to comment on and submit your written comments 24 hours prior to the start of the meeting.

Oral public comments will be subject to the **three-minute** time limitation (approximately 350 words). Written comments will be distributed to the board prior to the meeting but not read at the meeting.

1. **CALL TO ORDER**
2. **ROLL CALL**
3. **DELETIONS/CORRECTIONS TO THE POSTED AGENDA**
4. **INPUT – AUDIENCE**
   This is an opportunity for members of the public to comment on any closed session item appearing before the Board on this agenda.
5. **CLOSED SESSION**
   5.1. **Hearing (Health & Safety Code § 32155)**◈
   Subject Matter: Medical Staff Credentials
6. **OPEN SESSION – CALL TO ORDER (IMMEDIATELY FOLLOWING CLOSED SESSION)**
7. **REPORT OF ACTIONS TAKEN IN CLOSED SESSION**
8. **DELETIONS/CORRECTIONS TO THE POSTED AGENDA**

◈ Denotes Action Item

9. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Clerk of the Board 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot act on any item not on the agenda. The Board Chair may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

10. INPUT FROM EMPLOYEE ASSOCIATIONS

This is an opportunity for members of the Employee Associations to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes.

11. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

11.1. Medical Executive Committee (MEC) Meeting Consent Agenda ◈ ..... ATTACHMENT

MEC recommends the following for approval by the Board of Directors:

New Form

11.2. Outpatient Procedure Consent

Policies with Changes – Summary attached

11.3. DED-2 – Admission of Emergency Department Patients
11.4. DED-11 – Fall Prevention
11.5. DED-12 – Family Presence During Invasive Procedures
11.6. DED-13 – Laboratory Results Culture Screening, DED-13
11.7. DED-19 – Multi-Casualty Incidents
11.8. DED-1801 – Standardized Procedure – Ordering and Performing Guideline for EKG in Emergency Department
11.9. DED-1806 – Standardized Procedure for Administration of Acetaminophen/Ibuprofen for Fever in Pediatric Patients
11.10. AIPC-1501 – Transmission Based-Isolation-Precautions
11.11. AIPC-109 – Rodent Management
11.12. AIPC-95 – Pest Control
11.13. AIPC-59 – Infection Control Risk Assessment

Policies with No Changes

11.14. DED-30 – Sexual Assault Victim
11.15. DED-229 - Nitrous Oxide Use
11.16. DED-34 Students: EMT, AEMT, Paramedic Guidelines

Policies to Retire

11.17. DED-25 – Rabies Series Vaccination – VOTE TO RETIRE

12. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

13. BOARD MEMBERS' REPORTS / CLOSING REMARKS

14. CLOSED SESSION CONTINUED, IF NECESSARY

15. OPEN SESSION

16. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY

17. ADJOURN

◈ Denotes Action Item

AMR:smj

*Denotes material (or a portion thereof) will be distributed at a later date.

Tahoe Forest Hospital District has enabled live captioning and live Spanish translation in Zoom. To turn on live captions (subtitles) follow these steps:
1. In your Zoom meeting, look at the bottom toolbar.
You will see one of the following buttons:
- Captions
- Show Captions
- CC / Live Transcript

2. Click the button and select:
- Show Captions

3. To turn On Spanish Translation (live interpreted captions)
- Click the small arrow (^) next to the Captions button.
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- Select: Caption Language
- Choose: Spanish

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is October 22, 2026, 4:00 p.m. at Tahoe Forest Hospital – Eskridge Conference Room, 10121 Pine Avenue, Truckee, CA 96161. *A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting. Materials related to an item on this Agenda submitted to the Board of Directors, or a majority of the Board, after distribution of the agenda are available for public inspection in the Administration Office, 10800 Donner Pass Rd, suite 200, Truckee, CA 96161, during normal business hours.*

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions. Equal Opportunity Employer. The telephonic meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed or a reasonable modification of the teleconference procedures are necessary (i.e., disability-related aids or other services), please contact the Clerk of the Board at (530) 582-3583 at least 24 hours in advance of the meeting.

◈ Denotes Action Item

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: September 24, 2026	**ITEM:** Medical Executive Committee (MEC) Consent Agenda
DEPARTMENT: Medical Staff	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Johanna Koch, MD, Chief of Staff	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Consent and Policies**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Respective Departments have reviewed Department Consent and Policies, recommended approval to MEC. The MEC as reviewed the Consent and Policies during the September 17, 2026 Medical Executive Committee meeting, the MEC reviewed and made the following open session consent agenda item recommendations to the Board of Directors for the September 24, 2026 Regular Meeting of the Board of Directors.

SUMMARY/OBJECTIVES:

New Consent

Outpatient Procedure Consent

Policies with Changes – Summary attached

Policy Summary
DED-2 – Admission of Emergency Department Patients
DED-11 – Fall Prevention
DED-12 – Family Presence During Invasive Procedures
DED-13 – Laboratory Results Culture Screening, DED-13
DED-19 – Multi-Casualty Incidents
DED-1801 – Standardized Procedure – Ordering and Performing Guideline for EKG in Emergency Department
DED-1806 – Standardized Procedure for Administration of Acetaminophen/Ibuprofen for Fever in Pediatric Patients
AIPC-1501 – Transmission Based-Isolation-Precautions
AIPC-109 – Rodent Management
AIPC-95 – Pest Control
AIPC-59 – Infection Control Risk Assessment

Policies with No Changes

DED-30 – Sexual Assault Victim
DED-229 - Nitrous Oxide Use
DED-34 Students: EMT, AEMT, Paramedic Guidelines

Policies to Retire

DED-25 – Rabies Series Vaccination – VOTE TO RETIRE

SUGGESTED DISCUSSION POINTS:

Medical Executive Committee has reviewed the Department recommendations on the consent and policies. The committee makes the following open session recommendation for consent agenda to the Board of Directors.

- §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1).
- Procedures shall be approved by the Administration and Medical Staff where such is appropriate.
- Medical Staff approval is required when direct patient care/clinical practice is addressed, including contract services for patients, prior to forwarding to the Medical Executive Committee and the Governing Board.

For complete policy refer to: Policy & Procedure Structure and Approval, AGOV-9

SUGGESTED MOTION/ALTERNATIVES:

Move to approve the MEC consent agenda as presented.

Alternative: If a specific Policy, Procedure or Form is pulled from the MEC consent agenda, provide discussion under Item 16 on the Board Agenda. After discussion, request a motion to approve the pulled MEC item as presented.

LIST OF ATTACHMENTS:

11.1. Medical Executive Committee (MEC) Meeting Consent Agenda ATTACHMENT

11.2. Outpatient Procedure Consent ATTACHMENT

Policies with Changes – Summary attached

Policy Summary ATTACHMENT

11.3. DED-2 – Admission of Emergency Department Patients ATTACHMENT

11.4. DED-11 – Fall Prevention ATTACHMENT

11.5. DED-12 – Family Presence During Invasive Procedures ATTACHMENT

11.6. DED-13 – Laboratory Results Culture Screening, DED-13 ATTACHMENT

11.7. DED-19 – Multi-Casualty Incidents ATTACHMENT

11.8. DED-1801 – Standardized Procedure – Ordering and Performing Guideline for EKG in Emergency Department ATTACHMENT

11.9. DED-1806 – Standardized Procedure for Administration of Acetaminophen/Ibuprofen for Fever in Pediatric Patients ATTACHMENT

11.10. AIPC-1501 – Transmission Based-Isolation-Precautions ATTACHMENT

11.11. AIPC-109 – Rodent Management ATTACHMENT

11.12. AIPC-95 – Pest Control ATTACHMENT

11.13. AIPC-59 – Infection Control Risk Assessment ATTACHMENT

Policies with No Changes (not attached)

11.14. DED-30 – Sexual Assault Victim

11.15. DED-229 - Nitrous Oxide Use

11.16. DED-34 Students: EMT, AEMT, Paramedic Guidelines

Policies to Retire

11.17. DED-25 – Rabies Series Vaccination – VOTE TO RETIRE ATTACHMENT

Outpatient Procedure Consent

Patient Name: _____ **Date of Birth:** _____

Procedure Date: _____ **Medical Record #:** _____

Procedure Information

My healthcare provider has explained the outpatient procedure recommended for me, including the reason for the procedure, how it will be performed, and what to expect before, during, and after treatment.

Procedure Name:

Provider Performing Procedure:

Sedation or Anesthesia (if applicable)

☐ None
☐ Local Anesthesia
☐ Other: _____

Acknowledgment and Understanding

I acknowledge and understand that:

- I have had the opportunity to ask questions about the procedure and have received answers that I understand.
- The expected benefits, common risks, possible complications, and recovery process have been explained to me.
- Alternatives to the procedure, including choosing no treatment, have been discussed.
- No guarantees or assurances have been made regarding the outcome of the procedure.
- I may refuse or withdraw my consent at any time before the procedure begins, except when emergency treatment is necessary to protect my health or safety.

Consent for Treatment

I voluntarily consent to the outpatient procedure described above, including any medically necessary services or treatments directly related to the procedure.

Patient Signature: _____ **Date/Time:** _____

Representative Signature (if applicable): _____**Relationship to Patient:** _____

Witness / Staff Signature: _____ **Date/Time:** _____

Physician/Provider Certification

I, the undersigned physician/provider, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

• The risks and benefits of the procedure: ☐ Documented in Medical Record

_____

_____

_____

• Any adverse reactions that may reasonably be expected to occur: ☐ Documented in Medical Record

_____

• Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and

• The potential problems that may occur during recuperation; and

• Any research or economic interest I may have regarding this treatment.

I understand that I am responsible for filling in the risks, benefits and alternatives. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Physician/Provider Signature_____

Date: _____Time: _____

If an interpreter was utilized to obtain consent:	If consent was obtained via phone:
_____ INTERPRETER NAME _____ ID NUMBER Language: ☐ Spanish ☐ Other _____	_____ WITNESS SIGNATURE _____ WITNESS NAME _____ TITLE

Title	Department	Last Approved	Next Review	Summary of Changes
DED-2 – Admission of Emergency Department Patient	Emergency Department (DED)	N/A – Draft	N/A	Updates the admission workflow, including physician/hospitalist notification, charge nurse and case manager/House Supervisor notification, bed request and placement responsibilities, transport requirements based on patient acuity, handoff to receiving units, and surgery admission procedures.
DED-11 – Fall Prevention	Emergency Department (DED)	N/A – Draft	N/A	Clarifies the ED Fall Risk Assessment and expands/defines fall-risk criteria, including recent syncope/dizziness, confusion/generalized weakness, and inability to ambulate independently. Requires RN assessment on arrival and reassessment with condition changes. Adds/clarifies universal and high-risk interventions, including low bed positioning, fall-risk identification, call-light education, bathroom assistance, environmental safety, and reminders to request assistance.
DED-12 – Family Presence During Invasive Procedures	Emergency Department (DED)	N/A – Draft	N/A	Establishes a more detailed process for offering family presence when clinically appropriate and consistent with patient wishes. Adds assessment of family coping/safety, identifies a Family Facilitator role, generally limits presence to two support persons, and adds expectations for PPE, positioning, conduct, removal from the room, education, comfort measures, discontinuation of presence, debriefing, follow-up, and documentation.

Title	Department	Last Approved	Next Review	Summary of Changes
DED-13 – Laboratory Results Culture Screening	Emergency Department (DED)	N/A – Draft	N/A	Clarifies responsibility and timing for culture-result review. Results are routed through the EMR; the Charge RN/designated RN reviews results each shift and as new results arrive. Positive/clinically significant results are reviewed with the ED physician, follow-up and antibiotic changes are documented, patients are contacted as directed, and certified letters may be sent after unsuccessful contact attempts. Adds notification requirements for admitted/transferred patients and reportable organisms.
DED-19 – Multi-Casualty Incidents	Emergency Department (DED)	N/A – Pending	2 years after approval	Clarifies the coordinated ED response to MCIs. Updates notification responsibilities for House Supervisor, ED Manager, ED Medical Director, Trauma Program Manager, on-call Trauma Surgeon, and ancillary departments. Adds continual assessment of staffing/resources, assigns an RN to manage EMS communications, and establishes notification/debriefing when the incident concludes.
DED-30 – Sexual Assault Victim	Emergency Department (DED)	Jun-26	Jun-28	Updates/clarifies immediate rooming, bedside registration as a “Victim of Crime,” SART-sensitive triage and preservation of forensic evidence. Clarifies advocate recruitment through Sierra Community House, law-enforcement notification based on facility location, limits on questioning for medically unstable patients, MSE requirements, and discharge to a forensic-capable facility when indicated.

Title	Department	Last Approved	Next Review	Summary of Changes
DED-229 – Nitrous Oxide Use	Emergency Department (DED)	Jun-26	Jun-28	Clarifies separate requirements for anxiolysis versus moderate sedation. Defines RN competency requirements, nitrous oxide/oxygen concentrations, physician ordering and bedside supervision, verbal versus written consent, contraindications, monitoring, required equipment, post-procedure observation, complication management, and documentation.
DED-1801 – Standardized Procedure – Ordering and Performing Guideline for EKG in Emergency Department	Emergency Department (DED)	N/A – Pending	2 years after approval	Updates the standardized procedure for RN-initiated EKGs, including qualified personnel/competency requirements, annual evaluation, RN/ED Tech roles, clinical indications such as chest pain, palpitations, shortness of breath and possible ACS, immediate physician review, EKG recordkeeping, physician co-signature, and monthly chest-pain performance-improvement review.
DED-1806 – Standardized Procedure for Administration of Acetaminophen/Ibuprofen for Fever in Pediatric Patients	Emergency Department (DED)	N/A – Pending	2 years after approval	Clarifies RN authority and qualifications for treating febrile pediatric patients under 60 kg. Defines age/weight/temperature criteria, medication timing when acetaminophen or ibuprofen was previously administered, contraindications, dosing, physician notification for emergent/critical symptoms, annual competency, EMR documentation, physician review/co-signature, and annual policy review.
AIPC-1501 – Transmission Based (Isolation) Precautions	Infection Prevention & Control (AIPC)	Jul-26	Jan-27	Updates transmission-based isolation guidance and incorporates current CDC recommendations, including initiation of precautions when infection is suspected rather than waiting for test results. Clarifies isolation signage, EMR orders, PPE, contact/droplet/airborne precautions, patient transport, hallway ambulation, perioperative requirements, and discontinuation criteria. Updates CDC references through 2025.

Title	Department	Last Approved	Next Review	Summary of Changes
AIPC-109 – Rodent Management	Infection Prevention & Control (AIPC)	Jul-26	Jan-27	Updates rodent reporting, cleanup and disposal procedures using CDC recommendations. Clarifies reporting to supervisors, Occupational Health and Engineering; quarterly review by Facilities/IP&C; safe cleanup and disinfection; pest-control escalation; employee symptom monitoring for hantavirus; vehicle inspection/food-storage precautions; and monthly hospital vehicle inspections.
AIPC-95 – Pest Control	Infection Prevention & Control (AIPC)	Jul-26	Jan-27	Clarifies facility measures to prevent pest entry, including self-closing exterior doors, screened/closed windows and controlled exhaust air. Clarifies safe pest-control practices, seasonal contractor spraying, case-by-case response to identified pest issues, and summer West Nile prevention measures. References AIPC-109 for rodent management.
AIPC-59 – Infection Control Risk Assessment (ICRA) for Construction	Infection Prevention & Control (AIPC)	Jul-26	Jan-27	Updates construction/renovation infection-control responsibilities between IP&C and A&E/Facilities. Clarifies use of the ASHE ICRA 2.0 Matrix and Permit, assignment of patient risk group and construction type, permit review/sign-off, posting and monitoring requirements, contractor occupational-health clearance, and procedures for modifying and communicating updated ICRA permits.
DED-34 – Students: EMT, AEMT, Paramedic Guidelines	Emergency Department (DED)	N/A – Draft	N/A	**No changes.** Policy continues to define student responsibilities, supervision, scope of practice, patient assessment/documentation, reporting of abnormal findings, assistance with patient care, HIPAA compliance, and procedures students may perform under direct RN supervision and physician order.

Title	Department	Last Approved	Next Review	Summary of Changes
DED-25 – Rabies Series Vaccination	Emergency Department (DED)	N/A	N/A	**Retire – Vote to Retire.** The policy currently addresses registration, documentation and ordering of the rabies vaccine series and directs subsequent doses to appropriate follow-up locations rather than routine ED administration. The submitted document is identified for retirement rather than revision.

Status Active PolicyStat ID 21255416

Origination Date	01/1982
Last Approved	08/2026
Effective	08/2026
Last Revised	08/2026
Next Review	08/2028
Department	Emergency Department - DED
Applicabilities	Tahoe Forest Hospital

Admission of Emergency Department Patient, DED-2

~~**RISK: Failure of staff to work collaboratively to ensure admission of ED patients to an in-patient Nursing or Surgical Department may lead to a break in continuity of patient care resulting in delay of patient care.**~~

RISK:

Failure of staff to work collaboratively to ensure admission of ED patients to an in-patient Nursing or Surgical Department may lead to a break in continuity of patient care resulting in delay of patient care.

POLICY:

The ED will work collaboratively with other departments to facilitate patient placement in a timely manner.

PROCEDURE:

A. Emergency department physician discusses admission with hospitalist, alerts ED charge nurse ~~and~~, orders admission and places bed request in ~~EMR~~electronic health record.

B. ED nurse notifies case manager (when on duty) or House Supervisor after hours of impending admit. Information to include:

1. Name of patient
2. Diagnosis
3. Age
4. Gender
5. Bed Status: Level of care required i.e. ICU, , Step-Down (ICU), In-Patient or

Observation status (Medical-Surgical, Obstetrics, Pediatrics, and Telemetry), In-patient Surgery, or OAS (Out-patient Ambulatory Surgery).

C. In-patient department room and RN assignment for admission is decided by ED Case manager/House Supervisor/Team Leader. ED staff is notified of room number and the assigned admitting RN.

D. Transport of all cardiac patients to ICU or telemetry bed with portable O2 (if ordered), portable monitor and IV or saline lock in place. An RN or paramedic will accompany all patients on telemetry~~, or in unstable condition~~ or going to the ICU.

E. Non critical and non telemetry patients may be transported by EMT or transporter.

F. ~~Receiving department staff will have room prepared (bed up, linen down, furniture moved) and required equipment at bedside prior to patient's arrival.~~

G. ~~ED nurse will review Admission Orders placed in EMR by admitting physician to ensure all now orders are completed prior to transport.~~

H. A patient report will be given to the receiving department nurse by the ED staff before or at time of patient arrival.

1. The ED staff will facilitate patient admission to the receiving department according to agreed upon guidelines and timing.
2. Receiving units will assist with transfer and expediting of patient admission when ED patient load or emergency conditions dictate.
3. Postponing admissions during lunch or breaks or other usual routines is not acceptable.

I. ~~Upon arrival of the patient to the receiving department, the receiving nurse will be expected to assist the ED nurse in transferring the patient to bed.~~

J. Surgery Admissions:

1. Complete ED Chart and Surgical Checklist. If patient to be admitted after surgery, Case Manager or House Supervisor must be notified.
2. ~~ED nurse to witness consent with MD and verify patient signature.~~
3. Carry out Pre-op orders that are placed in Emergency section of ~~EMR~~EHR as "now" orders.
4. Patient to empty bladder just prior to transport to OR if able.
5. OR staff will come to ED to transport patient to surgery.
6. If a STAT emergency case, it is only necessary to send the signed consent and surgical checklist. Other forms may follow once completed.

K. If assistance is needed to transport, call Transporter on duty, House Supervisor and/or Surgery.

L. ~~ED RN will use SBAR to give bedside report (or telephone report if OR RN cannot come to ED) to OR RN prior to OR staff transferring patient to OR.~~

M. ~~If a STAT emergency case, it is only necessary to send the signed consent and surgical checklist. Other forms may follow once completed.~~

Related Policies/Forms:

Admissions, ANS-2

References:

Memorandum "Accepting Admissions in a Timely Manner" 4-20-09;CNO

All Revision Dates

08/2026, 01/2026, 03/2025, 07/2022, 04/2021, 01/2020, 03/2019, 04/2018, 07/2015, 01/2014, 03/2013, 07/2012, 04/2011, 06/2010

Approval Signatures

Step Description	Approver	Date
	Trent Foust: Director of Nursing	08/2026
	Katie Lamb: ED Manager	08/2026

Status **Active** PolicyStat ID **21255230**

Origination Date	03/2006
Last Approved	08/2026
Effective	08/2026
Last Revised	08/2026
Next Review	08/2028
Department	Emergency Department - DED
Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital

Fall Prevention, DED-11

RISK:

Failure to identify and ~~define Fall Risk~~implement appropriate interventions for patients at risk for falls may ~~lead to an increase~~result in patient falls ~~and~~, injury, or other adverse outcomes.

POLICY:

~~A. Patients who have a score of more than one of the following criteria will be classified as a Fall Risk Patient~~

~~1. Has a recent history of syncope or dizziness.~~

~~2. Is confused or has significant generalized weakness.~~

~~3. Inability to walk unassisted. Uses a device for ambulation i.e. cane, walker, crutches.~~

A. Patients meeting one or more of the following criteria in the ED Fall Risk Assessment will be considered at high risk for falls and appropriate fall prevention interventions will be implemented:

1. Age greater than 70 years.
2. History of falls due to intrinsic factors in the last 30 days (e.g., visual impairment, weakness, poor coordination).
3. Altered mental status (e.g. intoxicated, confused, or unable to understand fall precautions).
4. Impaired mobility (e.g. use of an assistive device, unsteady gait, or inability to ambulate)
5. Nursing judgment identifies the patient as being at increased risk for falls.

PROCEDURE:

~~A. RN will complete Fall Risk questionaire in the EMR to identify patients at high risk for fall.~~

~~B. Appropriate interventions may include, but are not limited to:~~

~~1. Placing gurney in its lowest position with side rails up and brakes applied.~~

~~2. Placing a yellow band on the patient indicating Fall Risk.~~

~~3. Using restraints for patients as appropriate to condition with a doctor's order only after other measures have failed.~~

~~4. Instructing patients on the use of the call light system for assistance at bedside and in bathrooms. Have call light within reach of patient after instruction how to use it.~~

~~5. Attending patients in the bathroom or while on a bedside commode if they are considered to be a Fall Risk.~~

~~6. Wiping up spilled fluids, melted snow, ice etc. in the ED as soon as noticed.~~

~~7. Reminding patients at Fall Risk not to attempt to get up without assistance.~~

~~C. Encourage family member presence at the bedside.~~

A. The RN will complete the ED Fall Risk Assessment in the electronic medical record (EMR) upon arrival and reassess whenever the patient's condition changes.

B. All patients will receive Universal Fall Risk Interventions as documented in the EMR.

C. Patients identified as High Fall Risk will receive Universal Fall Risk Interventions plus additional High Fall Risk Interventions as clinically indicated and documented in the EMR.

Related Policies/Forms:

~~Nursing Services/Administration: Falls Program~~

Fall Program, ANS-246

All Revision Dates

08/2026, 12/2023, 04/2022, 03/2021, 03/2019, 07/2015, 01/2014, 03/2013, 05/2009

Approval Signatures

Step Description	Approver	Date
	Trent Foust: Director of Nursing	08/2026
	Katie Lamb: ED Manager	08/2026

Status **Active** PolicyStat ID **21255211**

Origination Date	01/2010	Department	Emergency Department - DED
Last Approved	08/2026	Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital
Effective	08/2026		
Last Revised	08/2026		
Next Review	08/2028		

Family Presence During Invasive Procedures, DED-12

RISK:

Failure to ~~provide opportunities~~outline the criteria and process for family ~~to be present~~presence during invasive procedures or resuscitative events ~~increases stress and emotional turmoil to both~~may lead to injury or harm to the patient ~~and~~, staff or family members.

~~Failure to outline specifics and criteria of family presence during invasive procedures or resuscitative events may lead to injury or harm to patient, staff or family member.~~

POLICY:

~~Family members will be permitted, when appropriate and if approved by patient and staff, in the patient care area either during invasive procedures or resuscitative situations.~~

Family presence during invasive procedures and resuscitative events will be offered whenever clinically appropriate, consistent with the patient's wishes, and when it can be safely accommodated without compromising care.

DEFINITIONS:

A. ~~Invasive procedure: any intervention that involves manipulation of the body or penetration of the body's natural barriers to the external environment.~~

Invasive Procedure: any intervention that involves manipulation of the body or penetration of the body's natural barriers to the external environment.

B. ~~Resuscitation: a sequence of events: including invasive procedures, which are initiated to sustain life or prevent further deterioration of the patient's condition.~~

Resuscitation: a sequence of events including invasive procedures initiated to sustain life or

prevent further deterioration of the patient's condition.

C. ~~Family: a relative of the patient or any person (significant other) with whom the patient shares an established relationship.~~

Family: Individuals identified by the patient as family, including relatives, significant others, partners, close friends, or other support persons.

D. ~~Family Facilitator: a staff member or other health care team member, assigned specifically to initiate interventions that assist the family and provide emotional, spiritual and psychosocial support.~~

Family Facilitator: a staff member or other health care team member, assigned specifically to initiate interventions that assist the family and provide emotional, spiritual and psychosocial support.

PROCEDURE:

~~A. The health care team will be responsible for assessing patient and family needs for visitation during invasive procedures or resuscitation efforts in selected situations and will adhere to patient requests when possible.~~

~~B. When family members are being given information about the patient's status, response to treatment, and identified needs, staff shall participate with the family facilitator in evaluation whether families are suitable candidates for bedside visitation. Before the Family Presence (FP) option is offered, families will be assessed for appropriate levels of coping and the absence of combative behavior, extreme emotional instability, and behaviors consistent with altered mental status.~~

~~C. If the direct care providers agree that family visitation is possible, the patient will be asked (if conscious) if he or she wishes to have a family member present. If the patient and direct care providers agree, then the family will be offered the option of family presence. If possible contact the House Supervisor or Nurse Case Management/Social Services to be in attendance with the family member.~~

~~D. When prioritizing family member's visitation and determining the next of kin, the consent for medical treatment guidelines will be used by the staff. Routinely two people (depending on assessment of individual needs) will be allowed in the room. Family members who do not wish to participate shall be supported in their decisions.~~

~~E. Before entering the patient care area, the family facilitator will:~~

1. ~~Notify ED Staff the family will be entering the room, observing patient care being given.~~
2. ~~Explain the patient's appearance, treatments, and equipment used in the care room.~~
3. ~~Prepare the family for entering the patient care area by communication that patient care is the priority.~~
4. ~~Explain how many family members may enter the room, where they may stand or sit, what not to touch to prevent contaminating the patient or supplies during a sterile procedure~~
5. ~~Explain situations in which they would be escorted out of the room (such as unexpected patient events or family becoming overwhelmed or disruptive).~~

6. ~~Explain possible time restrictions, when they may leave the room, and any other pertinent factors.~~
7. ~~Explain interventions~~
8. ~~Interpret medical or nursing jargon~~
9. ~~Provide information about expected outcomes or the patient's response to treatment~~
10. ~~Supply comfort measures, such as a chair at the patient's bedside or tissues~~
11. ~~Give an opportunity to ask questions~~
12. ~~Grant an opportunity to see, touch, and speak with the patient~~

F. ~~The family member(s) will enter the patient care area escorted by the family facilitator. If appropriate, the family member(s) will be provided with personal protective equipment and instructed on its use.~~

G. ~~If a family member becomes faint, hysterical or disruptive at the bedside, the family facilitator will immediately escort him or her from the area and arrange appropriate supportive care.~~

H. ~~After completing the patient visit, the facilitator will escort the family to a comfortable area, address their concerns, provide comfort measures, and address other psychosocial needs identified during the intervention.~~

I. ~~If staff requests, a debriefing should occur as soon as possible after the incident with all team members.~~

J. ~~The family facilitator will also communicate need for family follow-up to the care team.~~

A. The healthcare team will assess the patient’s condition, preferences, family needs, staff resources, and environmental safety to determine whether family presence is appropriate.

B. Family presence may be limited or declined by the healthcare team when patient safety, staff safety, or the delivery of care would be compromised.

C. The healthcare team, in collaboration with the Family Facilitator when available, will assess whether family members are appropriate candidates for bedside presence. Considerations include the family's ability to cope, follow directions, avoid interference with patient care, and maintain safe behavior.

D. When available, the House Supervisor, Case Management, Social Services, Chaplain, or other designated support person should assist as the Family Facilitator.

E. Generally, no more than two support persons will be present at one time unless otherwise approved by the healthcare team.

F. Before entering the patient care area, the Family Facilitator will:

1. Provide personal protective equipment as indicated and instruct on its use.
2. Notify the healthcare team that the family will be entering the patient care area.
3. Prepare the family by explaining that patient care remains the healthcare team's priority.

4. Explain how many family members may enter the room, where they may stand or sit, and instruct them not to touch the patient, equipment, or sterile supplies unless directed by staff.
5. Explain situations in which they would be escorted out of the room (such as unexpected patient events or family becoming overwhelmed or disruptive).
6. Explain any time limitations and other pertinent expectations.
7. Explain the patient's condition, appearance, equipment, ongoing interventions, anticipated events, and expected outcomes using language the family can understand.
8. Provide comfort measures, such as a chair at the patient's bedside or tissues.
9. Encourage questions and, when appropriate, provide opportunities for family members to see, speak to, or touch the patient.

G. Family presence may be discontinued at any time if it interferes with patient care, compromises safety, or becomes clinically inappropriate.

H. After completing the patient visit, the Family Facilitator will escort the family to a comfortable area, address their concerns, provide comfort measures, and address other psychosocial needs identified during the intervention.

I. A team debriefing should be considered following significant resuscitative events to identify opportunities for improvement and address staff support needs.

J. The Family Facilitator will communicate the need for family follow-up to the care team.

K. The RN should document whether family presence was offered, accepted, or declined, and any significant events related to the intervention.

Related Policies/Forms:

Visitors for Patient Care Units, ANS-118

References:

~~ENA Guidelines; www.ena.org/.../Family_Presence_-_ENA_PS.pdf~~

Bradford J, Camarda A, Gilmore L., et al. (2024). ENA Clinical Practice Guideline Synopsis: Family Presence During Resuscitation and Invasive Procedures. *Journal of Emergency Nursing, 50*(4), 463-468

All Revision Dates

08/2026, 12/2023, 04/2022, 03/2021, 01/2019, 01/2018, 07/2015, 12/2013, 12/2012, 08/2010

Approval Signatures

Step Description	Approver	Date
	Trent Foust: Director of Nursing	08/2026
	Katie Lamb: ED Manager	08/2026

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Origination Date	01/1982	Department	Emergency Department - DED
Last Approved	08/2026	Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital
Effective	08/2026		
Last Revised	08/2026		
Next Review	08/2028		

Laboratory Results Culture Screening, DED-13

RISK:

~~Failure to identify steps to be taken as part of routine follow through for cultures obtained in the Emergency Department increases the risk of harm to the patient.~~

Failure to ensure timely review and follow-up of Emergency Department culture results may lead to delayed treatment, inappropriate antimicrobial therapy, and patient harm.

POLICY:

~~Systematic documentation of all cultures obtained in the Emergency Department will be provided to facilitate timely and appropriate medical intervention and follow through.~~

All Emergency Department culture results will be reviewed promptly, documented appropriately, and acted upon to ensure timely patient follow-up and treatment when indicated.

PROCEDURE:

~~A. Cultures obtained at TFH ED will automatically result into ED culture results router folder when lab processes them.~~

~~B. ED Charge nurse will review all culture results at the beginning and throughout each shift.~~

~~C. ED MD will be notified of all positive culture results and will communicate with Charge RN any follow up action needed. Communication may be verbal but must also be documented in the culture results router folder in EMR to indicate exact follow up needed.~~

~~D. ED MD is responsible for documenting in culture results router folder in EMR any required follow up care to include any additions or changes in antibiotics.~~

~~E. Lab will verbally notify ED RN of any critical results as well as send in the culture results router.~~

~~F. ED Charge Nurse is responsible for contacting patients and facilitating in changing or adding~~

~~antibiotics per MD orders.~~

~~G. IVCH ED culture results will be in the results router folder and each morning the ED RN and the ED physician will discuss results.~~

~~H. ED RN on duty is responsible for contacting the patient and informing the patient of any change in treatment.~~

~~I. ED MD is responsible for documenting in culture results router folder in EMR any required follow up care to include any additions or changes in antibiotics.~~

~~J. Culture and slide reports will be screened by the Lab for reportable organisms and reported to the Health Department, if applicable.~~

~~1. Lab will notify the ED of these specific test results.~~

~~K. Culture & Sensitivity reports will be sent to the ED via culture results router folder in EMR.~~

~~L. If a patient is not able to be reached by phone within 3 days, a certified letter will be sent to the patient with culture results and MD recommendations for follow up care and/or additional treatment.~~

~~M. If a patient is admitted to the hospital or transferred to another facility, the ED staff will notify that unit of the culture results and document action taken as a note in patient EMR.~~

A. Culture results will be routed to the appropriate electronic medical record (EMR) results folder for provider and nursing review.

B. The ED Charge Nurse or designated RN will review culture results at least once each shift and throughout the day as new results become available.

C. Positive or clinically significant results will be reviewed with the ED physician to determine whether additional treatment or follow-up is needed.

D. The ED physician will document recommended follow-up, including any changes to antimicrobial therapy, in the EMR.

E. The designated ED RN will contact the patient regarding changes in treatment or additional follow-up as directed by the ED physician and document all communication attempts in the EMR.

F. If the patient cannot be contacted by telephone after reasonable attempts within three days, a certified letter will be sent when clinically indicated.

G. For patients admitted or transferred to another facility, the receiving care team will be notified of significant culture results, and the notification will be documented in the EMR.

H. Reportable organisms will be communicated to the appropriate public health agency by the laboratory in accordance with applicable reporting requirements.

I. All required follow-up actions will be completed as soon as reasonably possible after culture results become available.

All Revision Dates

08/2026, 04/2022, 03/2021, 04/2019, 06/2018, 02/2018, 07/2015, 01/2014, 03/2013, 08/2012, 07/2010, 07/1997

Approval Signatures

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	Trent Foust: Director of Nursing	08/2026
	Katie Lamb: ED Manager	08/2026

Status **Active** PolicyStat ID **21255165**

Origination Date	07/1991
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Last Revised	08/2026
Next Review	08/2028
Department	Emergency Department - DED
Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital

Multi-Casualty Incidents, DED-19

RISK:

~~When patient acuity and numbers increase in a very short period of time, failure to acknowledge and follow a set policy may result in harm to patients.~~

Failure to implement a coordinated response during a mass casualty incident (MCI) may result in delays in care, resource limitations, and patient harm.

POLICY:

~~To clarify steps to be taken when patient numbers increase dramatically in a short period of time.~~

The Emergency Department will implement a coordinated response during a mass casualty incident (MCI) to ensure timely patient care, effective communication, and appropriate resource utilization.

PROCEDURE:

~~A. Emergency Room Staff in Multi-casualty Incidents (MCI) situations requiring additional backup may:~~

~~1. Call additional staff including the back up physician as deemed necessary by ED Charge nurse.~~

~~2. Call ED Medical Director.~~

~~3. Call ED Director.~~

~~4. Call ED Manager.~~

~~5. Call Trauma Program Manager.~~

6. ~~Call House Supervisor.~~
7. ~~Notify the on-call Trauma Surgeon.~~
8. ~~Notify x-ray.~~
9. ~~Notify lab.~~
10. ~~Notify respiratory therapy.~~
11. ~~Only notify OR crew on call if they are needed to come in.~~

B. ~~Medical Director and ED Director or Manager, if present, will determine if additional staff should be utilized if not already done. Otherwise Charge Nurse and ED physician on duty will make this decision.~~

C. ~~Radio and/or MICN trained nurse will:~~

1. ~~Ask for identity of Medical Communication Officer (MED-COM) on scene if one has been assigned.~~
2. ~~Ask for a description of the incident.~~
3. ~~Ensure decontamination is initiated if needed~~
4. ~~Ask for number of patients~~
5. ~~Ask for severity levels of patients~~
6. ~~Ask for type of patient identification system to be used~~
7. ~~Ask if use of air ambulance is needed:~~
    a. ~~Medical Communication Officer or medic in charge will give a brief assessment of patients before ambulance leaves the scene and ETA (there will be no other radio traffic unless there is a major change in the patient's condition or to report: example:" 2 min ETA, no changes".)~~

A. Upon notification or recognition of an MCI, the Charge Nurse or designee will initiate the following actions, as appropriate:

1. Notify House Supervisor.
2. Notify ED Manager.
3. Notify ED Medical Director.
4. Notify Trauma Program Manager (TFH-only).
5. Notify on-call Trauma Surgeon (TFH-only).
6. Notify ancillary departments:
    a. Laboratory
    b. Radiology
    c. Respiratory Therapy (TFH-only)
    d. Operating Room (TFH-only; if operative intervention is anticipated)

B. The ED physician, Charge Nurse, and available ED leadership will continually assess staffing and resource needs and activate additional personnel as indicated.

C. The Charge Nurse or designee will assign an RN to manage EMS communications (e.g., Charge Nurse, MICN-trained nurse, or designee). The assigned RN will communicate with responding agencies in accordance with Local EMS (LEMS) policies.

D. Upon conclusion of the incident, the Charge Nurse or designee will notify hospital leadership that normal operations have resumed. A post-event debriefing should be conducted, as appropriate.

Related Policies/Forms:

Emergency Preparedness, DPH-16

All Revision Dates

08/2026, 12/2024, 12/2023, 07/2022, 04/2021, 01/2020, 03/2019, 01/2018, 07/2015, 01/2014, 07/2013, 09/2009, 05/2009, 03/2008

Approval Signatures

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	Trent Foust: Director of Nursing	08/2026
	Katie Lamb: ED Manager	08/2026

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Last Revised	04/2026
Next Review	2 years after approval
Department	Emergency Department - DED
Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital

Standardized Procedure - Ordering and Performing Guideline for EKG in Emergency Department, DED-1801

RISK:

A. Inability to provide expedited EKG evaluation to meet national guidelines for standard of care in all patients presenting to ED with complaint of pain from nose to naval can lead to delays in recognizing critical and sometimes fatal cardiac conditions.

~~SPECIFIC REQUIREMENTS:~~

~~A. The evaluation of the patient and the implementation of the order for the EKG will only be preformed by a qualified Emergency Department evaluator. A qualified evaluator is the attending ED MD or an RN employed in the Emergency Department with at least one year ED experience and the competencies defined in this standardized procedure.~~

~~EXPERIENCE, TRAINING AND EDUCATIONAL REQUIREMENTS:~~

~~A. To implement the order for EKG, the qualified evaluator must be a licensed RN with at least one year Emergency Department experience and successful completion of the following required competencies.~~

~~B. Completion of electrocardiogram performing 12-Lead competency and checklist through return demonstration.~~

~~C. To perform an EKG the end-user can be either a Registered Nurse or Emergency Department~~

~~Technician whom have completed the required competency and checklist.~~

~~INITIAL AND CONTINUED EVALUATION:~~

~~A. The qualified end-user will complete the initial department orientation and will be reevaluated annually on skills day.~~

~~B. The Registered Nurse will complete and maintain current certifications for BLS, ACLS and PALS.~~

~~C. The Emergency Department Technician will complete and maintain current certifications in BLS and EMT-B.~~

SETTING:

A. This standardized procedure applies to any patient presenting to the Tahoe Forest Emergency Department for evaluation.

~~STANDARDIZED PROCEDURE REQUIREMENTS:~~

~~A. The RN will evaluate every patient presenting to the Emergency Department.~~

~~B. The RN may initiate the standardized procedure for EKG order based on clinical judgment for the following patients:~~

~~1. Any Patient complaining of chest pain.~~

~~2. Any patient complaining of palpitations.~~

~~3. Any patient complaining of shortness of breath.~~

~~4. Any patient exhibiting potential acute coronary syndrome symptoms concerning to the nurses' clinical judgment.~~

~~C. The RN will ensure the EKG is immediately shown to the ED MD for evaluation. Two copies of every EKG will be printed. One copy of the EKG will be scanned and charged by the ED tech. The second copy will go to the MD, who will place sticker on back of EKG and place in folder at MD desk for over read. The oncoming ED physician will read and cosign. After over reads the EKG's are sent to medical records for scanning.~~

PERSONNEL:

A. To implement this standardized procedure, the qualified evaluator must be a licensed RN with at least one year Emergency Department experience or an Emergency Department Technician and successful completion of the following required competencies:

1. Completion of electrocardiogram performing 12-Lead competency and checklist through return demonstration.
2. TFH/IVCH Emergency Department orientation including submission of completed skills checklist.
3. The Emergency Department RN will complete annual competency requirements and maintain all required licensing as directed by Department Manager and hospital

policy.

4. The Registered Nurse will complete and maintain current certifications for BLS, ACLS and PALS.
5. The Emergency Department Technician will complete and maintain current certifications in BLS and EMT, AEMT or Paramedic.

SUPERVISION AND ~~SPECIAL~~SUPERVISING INSTRUCTIONS ~~/ DEFINITIONS~~:

A. The Emergency Department MD on duty will assume all responsibility for EKG orders placed by the RN under the guidelines of this standardized procedure.

B. Prior to initiating any orders, the RN will immediately inform MD of any patient presenting with emergent or critical symptoms requiring prompt medical intervention.

REQUIREMENTS TO INITIATE STANDARDIZED PROCEDURE:

A. The RN may initiate the standardized procedure for EKG order based on clinical judgment for the following patients:

1. Any Patient complaining of chest pain.
2. Any patient complaining of palpitations.
3. Any patient complaining of shortness of breath.
4. Any patient exhibiting potential acute coronary syndrome symptoms concerning to the nurses' clinical judgment.

PROCEDURE:

A. The RN will evaluate every patient presenting to the Emergency Department.

B. The RN may initiate the standardized procedure for EKG order based on clinical judgment.

C. The RN or ED tech will complete the EKG on identified patient.

D. The RN will ensure the EKG is immediately shown to the ED MD for evaluation. One copy of every EKG will be printed and

RECORD KEEPING:

A. The RN will complete all documentation in the EMR in the EKG are with time performed documented.

DEVELOPMENT AND APPROVAL:

A. This standardized procedure was developed through collaboration between Nursing Leadership, Lab, Education, Vituity Emergency Physicians group, and the IVCH Emergency Department.

PERIODIC REVIEW:

A. A review of the patient record by the responsible physician will be completed in a timely manner and the reviewing physician will co-sign the EKG order.

B. Chart review of patients meeting the criteria of chest pain will be reviewed monthly on a performance improvement measurement.

~~AUTHORIZATION TO PERFORM MEDICAL SCREENING BY RN:~~

~~A. All RN's and ED Techs who have trained to perform EKG's. Only RN's may place an order for EKG.~~

~~RECORD KEEPING:~~

~~A. The RN will complete all documentation in the EMR in the EKG are with time performed documented..~~

~~DEVELOPMENT AND APPROVAL:~~

~~A. This standardized procedure was developed through collaboration between Nursing Leadership, Lab, Education, Vituity Emergency Physicians group, and the IVCH Emergency Department.~~

All Revision Dates

04/2026, 06/2024, 12/2022, 04/2021, 02/2020, 03/2019, 04/2018

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	Trent Foust: Director of Nursing	Pending
	Katie Lamb: ED Manager	04/2026

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Department	Emergency Department - DED
Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital

Standardized Procedure for Administration of Acetaminophen / Ibuprofen for Fever in Pediatric Patients DED 1806

RISK:

Failure to provide specific policy for medicating febrile pediatric patients may lead to delay in care.

~~POLICY:~~

~~To provide expedited care of the pediatric patient < 60kg presenting to the Emergency Department (ED) with fever.~~

~~Specific Requirements:~~

~~The evaluation of a patient and the implementation of the standardized procedure for the pediatric patient, presenting with elevated temperature, will only be performed by a qualified Emergency Department evaluator. A qualified evaluator is the attending ED Physician or Registered Nurse (RN) employed in the Tahoe Forest Health District (TFHD) ED's with at least two year ED experience.~~

~~Experience, Training and Continued Educational Requirements:~~

~~To implement the standardized procedure, the qualified evaluator must be a licensed RN with at least one year ED experience and successful completion of TFH/IVCH ED orientation including departmental~~

~~checklist and annual competency requirements.~~

~~Initial and Continued Evaluation:~~

~~The qualified evaluator will complete the initial departmental orientation and validation of competency will occur annually during nursing skills day. The qualified evaluator will complete and maintain current certifications in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS).~~

~~Standardized Procedure Requirements:~~

~~The RN will evaluate every patient presenting to the Emergency Department. The RN may initiate the standardized procedure for elevated temperature or fever for any patient based on clinical judgment.~~

~~Setting:~~

SETTING:

The standardized procedure applies to any patient, <60kg presenting to the ED for evaluation.

~~Indications:~~

~~Any patient age > 8 weeks, weighing < 60kg, presenting to the ED with elevated temperature or fever of > 100.4 Degrees Farenheit without clinical concern for NPO status. If patient received Acetaminophen (Tylenol) in previous 4 hours, then the RN will provide Ibuprofen for children > 6 months only. Pediatric patients less than 6 months are not to receive ibuprofen. If patient received Ibuprofen (Motrin) in previous 6 hours, then the RN will provide Acetaminophen.~~

~~Contraindications:~~

~~A. Allergy to Ibuprofen (Motrin)~~

~~B. Allergy to Acetaminophen (Tylenol)~~

~~C. Avoid Acetaminophen in patients with liver disease~~

~~Nursing Intervention:~~

PERSONNEL:

A. To implement this standardized procedure, the qualified evaluator must be a licensed RN with at least one year Emergency Department experience and successful completion of the following required competencies:

1. TFH/IVCH Emergency Department orientation including submission of completed skills checklist and validation of competency will occur annually during nursing skills day.
2. The Emergency Department RN will complete annual competency requirements and

maintain all required licensing as directed by Department Manager and hospital policy.

3. The RN will complete and maintain current certifications in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS).

SUPERVISION & SUPERVISING INSTRUCTIONS:

Prior to initiating any orders, the RN will inform the MD of any patient presenting with Emergent or Critical symptoms requiring prompt or immediate medical intervention. The ED Physician on duty will assume all responsibility for the standardized procedure.

REQUIREMENTS TO INITIATE STANDARDIZED PROCEDURE:

A. The RN will evaluate every patient presenting to the Emergency Department.

B. The RN may initiate the standardized procedure for fever in pediatric patients based on clinical judgment for the following patients:

   1. Any pediatric patient presenting to the Emergency Department with complaint of:

      a. Any patient age > 8 weeks, weighing < 60kg, presenting to the ED with elevated temperature or fever of > 100.4 Degrees Fahrenheit without clinical concern for NPO status.

C. If patient received Acetaminophen (Tylenol) in previous 4 hours, then the RN will provide Ibuprofen for children > 6 months only. Pediatric patients less than 6 months are not to receive ibuprofen.

D. If patient received Ibuprofen (Motrin) in previous 6 hours, then the RN will provide Acetaminophen.

E. Contraindications:

   1. Allergy to Ibuprofen (Motrin)
   2. Allergy to Acetaminophen (Tylenol)
   3. Avoid Acetaminophen in patients with liver disease

PROCEDURE:

A. For any patient age > 8 weeks, weighing < 60kg, presenting to the ED with elevated temperature or fever of > 100.4 Degrees Fahrenheit without clinical concern for NPO status. The RN may order the following as needed per clinical judgment.

   1. Acetaminophen (Children's Tylenol) 15mg/kg PO x 1 dose (max 975 mg per dose and/or 4 grams per 24 hours)
   2. Acetaminophen (Tylenol) 20mg/kg PR (rectally) x 1 dose (max 975 mg per dose and/or 4 grams per 24 hours)
   3. Ibuprofen (Children's Motrin) 10mg/kg PO x 1 dose (max 40mg/kg/day)

~~Supervision and Special Instructions:~~

~~Prior to initiating any orders, the RN will inform the MD of any patient presenting with Emergent or Critical symptoms requiring prompt or immediate medical intervention. The ED Physician on duty will assume all responsibility for the standardized procedure.~~

~~Periodic Review:~~

RECORD KEEPING:

The RN providing care for the patient will complete all required documentation in the electronic medical record.

DEVELOPMENT AND APPROVAL:

The standardized procedure was developed through an interdisciplinary collaboration between Nursing Leadership, Pharmacy, Education, Vituity Emergency Physician's group and the TFH/IVCH Emergency Department.

PERIODIC REVIEW:

A. A review of the patient's electronic medical record will be performed by the responsible ED Physician in a timely manner and the reviewing Physician will co-sign the order set.

B. The Standardized Procedure for Administration of Acetaminophen and/or Ibuprofen for Fever Control in Pediatric Patients will be reviewed annually during the Emergency Departmental Meeting.

~~Record Keeping:~~

~~The RN providing care for the patient will complete all required documentation in the electronic medical record.~~

~~Development and Approval:~~

~~The standardized procedure was developed through an interdisciplinary collaboration between Nursing Leadership, Pharmacy, Education, Vituity Emergency Physician's group and the TFH/IVCH Emergency Department.~~

All Revision Dates

04/2026, 06/2024, 12/2022, 04/2021, 01/2020, 05/2018

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	Trent Foust: Director of Nursing	Pending
	Katie Lamb: ED Manager	04/2026

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Last Approved	07/2026	Applicabilities	System
Effective	07/2026		
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Next Review	01/2027		

Transmission Based (Isolation) Precautions, AIPC-1501

RISK:

Not having specific infection prevention and control processes in place when caring for patients with suspected or known infectious diseases may lead to increased transmission risk of microorganisms from patients to staff, and staff to patients.

POLICY:

A. Transmission-based precautions with clear and concise hand-off communication are used for patients with selected known or suspected infections and conditions in addition to the Standard Body Substance Precautions (AIPC-4) used for all patients regardless of diagnosis or infection or colonization status.

B. The physician, primary nurse, Infection ~~Preventionist~~Prevention and Control RN, or Clinical Resource Nurse initiates transmission-based precautions based on CDC recommendations for the diagnosed or suspected infection or condition. The clinician will enter an order into electronic medical record (EMR) for the type of isolation required, based on diagnosis.

C. Transmission-based precautions are discontinued based on the CDC's recommendations for Type and Duration of Precautions in the CDC 2007 Guideline for Isolation Precautions and Type and Duration of Precautions Recommended for Selected Infections and Conditions (Appendix A of the above mentioned CDC guide).

DEFINITIONS:

A. **Personal Protective Equipment (PPE):** Equipment used to prevent exposure from blood or other body fluids, including gloves, gowns, surgical masks, and face shields or goggles. Refer to Personal Protective Equipment PPE (AIPC-94) for information on donning and doffing.

B. **PAPR:** Power Air Purifying Respirator, DEH-27 worn by healthcare personnel when caring for a patient in "Airborne Precautions".

C. **Standard Precautions:** they combine the major features of Universal Precautions and Body Substance Isolation, and are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. They are basic infection control interventions used in the care of all patients to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. Standard Precautions include the use of hand hygiene, personal protective equipment (PPE), and respiratory hygiene and cough etiquette.

D. **Transmission:** Movement of microorganisms from one source to a new host by various routes.

E. **Transmission Routes:** the passing of a pathogen from an infected individual to other people.

    1. **Contact (direct):** transmission occurs when microorganisms are transferred from one infected person to another person without a contaminated intermediate object or person.
    2. **Contact (indirect):** transmission involves the transfer of an infectious agent through a contaminated intermediate object or person.
    3. **Droplet:** transmission occurs when respiratory droplets carrying infectious pathogens transmit infection when they travel directly from the respiratory tract of the infectious individual to susceptible mucosal surfaces of the recipient, generally over short distances (about 3 feet).
    4. **Airborne:** transmission occurs by dissemination of either airborne droplet nuclei (small droplets a micron or smaller in size which remain suspended in the air for long periods of time) or dust particles containing the infectious agent. Such microorganisms can be widely dispersed by air currents and may become inhaled by a susceptible host within the same room or over longer distance, depending on environmental factors.

F. **Transmission-Based Precautions:** these precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. There are three types of transmission-based precautions based on the mode of transmission of a specific disease. Each category may be employed alone or combined for certain diseases which have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

    1. ***Contact Precautions:*** In addition to Standard Precautions, the contact precautions are used for patients known or suspected to have infections that are easily transmitted by direct patient contact or by indirect contact with items in the patient's environment.

        a. **Most commonly include:** Clostridium difficile (C. diff); Shigella; Hepatitis A; Rotavirus; Norovirus; Respiratory Syncytial Virus (RSV); Multidrug Resistant Organisms (MDROs) such as Methicillin-Resistand Staph Aureus (MRSA), Extended-Spectrum Beta-lactamase (ESBL); Vancomycin-Resistant Enterococci (VRE); Carbapenem-Resistant Enterobacteriaceae (CRE); Clostridioids *difficile* Infection (CDI); lice; scabies; viral hemorrhagic fevers: Ebola, Lassa, Marburg; Escherichia coli 0157:H7; contagious skin

and/or soft tissue infections. For complete list of infections or conditions that require Contact Precautions, refer to Type and Duration of Precautions Recommended for Selected Infections and Conditions (Appendix A of the above mentioned CDC guide).

2. ***Droplet Precautions:*** Used for patients not in control of their respiratory secretions and not reliable for source control (consists of reliable cough hygiene or ability to wear a surgical mask), as well as for patients known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the patient coughing, sneezing, talking, or during the performance of an aerosol-generating procedure.
    a. **Most Commonly Include:** respiratory viruses (e.g., influenza, parainfluenza virus, adenovirus, respiratory syncytial virus (RSV), human metapneumovirus), Bordetella pertussis, and meningitis, MRSA (+) sputum. For complete list of infections or conditions that require Droplet Precautions, refer to Type and Duration of Precautions Recommended for Selected Infections and Conditions (Appendix A of the above mentioned CDC guide).

3. ***Airborne Precautions:*** Used for patients known or suspected to be infected by an infectious angent transmitted by an airborne droplet nuclei that remain suspended in the air and can be widely dispersed.This includes the use of negative pressure room or portable hepa, plus appropriate respiratory protection for the caregiver.
    a. **Most commonly include:** Tuberculosis (TB), Rubeola (measles), varicella (chickenpox or disseminated herpes zoster/shingles). For complete list of infections or conditions that require Airborne Precautions, refer to Type and Duration of Precautions Recommended for Selected Infections and Conditions (Appendix A of the above mentioned CDC guide).

G. **Aerosol Transmissible Diseases (ATD):** diseases that are transmitted through dissemination of airborne droplet nuclei, such as small particle aerosols or dust particles containing the disease agent. Airborne Precautions or Droplet Precautions or both are required for Aerosol Transmissible Diseases. There are a wide variety of diseases that are considered ATD including, Influenza, Tuberculosis (TB), Pertussis (Whooping Cough), Meningitis, and Pneumonia. The California Occupational Safety and Health Administration (Cal/OSHA) issued the Aerosol Transmissible Diseases Standard, Title 8 Section 5199 in August, 2008, to mitigate occupational exposures to pathogens transmitted via aerosols and droplets.

PROCEDURE:

A. Initiating Transmission-Based Isolation Precautions:
    1. Nursing will:
        a. Activate appropriate transmission-based precautions as soon as an infectious illness is suspected, will not wait for tests to result (e.g. if respiratory infection is suspected, at a minimum activate droplet precautions, if patient presents with diarrhea, activate enteric contact precautions):
            i. Place appropriate transmission-based precaution sign outside

the patient room.

ii. Place an isolation cart outside of patient's room.

iii. Utilize appropriate PPE, based on precautions type.

iv. To facilitate communication between caregivers/units, place an order in patient's Electronic Medical Record (EMR) for appropriate transmission-based isolation precautions.

v. Evaluate the need for continued or ~~additonal~~additional precautions The need for precautions should be evaluated once applicable tests have resulted.

2. In the event of patient being transported to another unit (e.g. for tests or procedures, or for changed level of care), the bed side nurse will communicate specific transmission-based isolation precautions as it pertains to that patient.
3. In the event of patient being transfered out to an outside facility, the nurse will communicate specific transmission-based isolation precautions as it pertains to that patient.
4. Color of Labels and Signs:
    a. Contact Precautions - Green
        i. Enteric Contact Precautions - Lavender (for Clostridium difficile, Norovirus, or infectious diarrhea/vomitting)
    b. Droplet Precautions - Orange
    c. Airborne Precautions - Pink
5. Visitors: Nursing will instruct visitors on appropriate infection prevention and control measures, and contact Infection Preventionist, individual department leadership, or Nurse Supervisor for assistance as needed.

B. PPE Donning and Disposal:
    1. Perform hand hygiene before donning PPE
    2. Don PPE prior to entering patient room
    3. Remove PPE immediately before exiting patient room, except for respirators (N95 and PAPR) which are removed in the ante room after exiting patient room
    4. Dispose of used PPE prior to exiting patient room or immediately outside of the room
    5. Perform hand hygiene immediately after PPE disposal
    6. Use designated isolation cart outside patient's room to store PPE and other necessary supplies

C. Transmission-based isolation precautions, used **in addition** to Standard Precautions:
    1. Contact Precautions:
        a. Patient placement: A private room is preferred, but if not possible, cohort with same organism patient but no other infection

b. PPE for healthcare workers and visitors:
    i. Gloves
    ii. Fluid resistant isolation gown
    iii. Surgical mask and face shield or goggles, if splash is anticipated
c. Door to room may be left open
d. For suspected or diagnosed Clostridioids *difficile* infection, Norovirus, diarrhea and/or vomiting of unknown cause, or if directed by public health department or Infection Prevention:
    i. Clean environmental high touch surfaces and patient care items with sporocidal disinfectant such as bleach.
    ii. Clean hands with soap and water rather than alcohol-based hand sanitizer.
e. For suspected or confirmed Clostridioides *difficile* infection (CDI), place patient on Enteric Contact Precautions, which included hand washing rather than hand sanitizer and using of hospital approved sporocidal cleaning/desinfecting agent (e.g. bleach).
f. Whenever possible, have dedicated non-critical patient care equipment; if not possible, clean and disinfect items immediately after use and before use on another patient.

2. Droplet Precautions:
    a. Patient placement: A private room is preferred, but if not possible, cohort with same organism patient but no other infection
    b. PPE for healthcare workers and visitors:
        i. Surgical mask
        ii. Gloves and fluid resistant isolation gown, if respiratory droplets not contained
        iii. Face shield or goggles if splash is anticipated or respiratory source control not reliable
    c. Door to room may be left open.
    d. Whenever possible, have dedicated non-critical patient care equipment; if not possible, clean and disinfect items immediately after use and before use on another patient.

3. Airborne Precautions:
    a. Patient placement: A private negative pressure room
        i. Negative pressure ventilation rooms:
            a. Tahoe Forest Hospital: Medical Surgical Unit: room 215; ICU room 6

b. Incline Village Community Hospital: ED bed 4 and Medical Surgical room 206

ii. Inform engineering to initiate daily monitoring and documenting of the negative room pressure by a "tissue test"

iii. Use portable Hepa filtration units in areas of the hospital where negative pressure ventilation room is not available per policy Hepa-Care Portable Filtration Units (AIPC-49) (e.g. TFH ED and surgical services).

iv. Remove respirators (N95 or PAPR) after exiting patient room in the ante room (if patient is in negative pressure room), or after exiting patient room

b. PPE for healthcare workers:

i. PAPR or fit-tested and fit-checked N95 respirator donned and removed in anteroom before entering patient room and and after exiting patient room.

a. Persons with documented immunity to measles or varicella need not wear respiratory protection with cases of rubeola (measles) or varicella (chickenpox or disseminated herpes zoster/shingles) unless directed by infection control based on public health guidance during an outbreak.

ii. PAPR can be re-used several times and routinely cleaned and disinfected

c. Door to room and anteroom must remain closed

d. Whenever possible, have dedicated non-critical patient care equipment; if not possible, clean and disinfect items immediately after use and before use on another patient.

e. Non-immune/susceptible persons should not enter the room of patients known or suspected to have rubeola (measles) or varicella (chickenpox or disseminated herpes zoster/shingles). Assign immune healthcare workers.

i. If susceptible persons must enter the room of a patient with known or suspected rubeola (measles) or varicella (chickenpox or disseminated herpes zoster/shingles), patient to wear a surgical mask if possible and healthcare workers to wear respiratory protection (PAPR or fit-tested/checked N95 mask)

f. Cleaning and disinfection of Airborne isolation negative pressure room after patient is discharged: wait 30 minutes before entering without respiratory protection. During the 30 minute wait period, the door should remain closed and respiratory protection is required to enter the room.

g. In a clinic or other non-acute care setting where a portable hepa is not used, leave exam room unoccupied for one hour to allow any potential TB

or other airborne aerosols to be cleared before rooming another patient.

4. Enhanced Barrier (Enhanced Standard) Precautions:
    a. Utilized at the Skilled Nursing Facility(SNF)/Extended Care Center (ECC) per California Deparment Public Health (CDPH) and Centers for Medicare & Medicaid Services (CMS) requiements. Refer to policy titled ECC Enhanced Barrier (Enhanced Standard) Precautions, DECC-1502 for details.

D. Assume that MDRO carriers are colonized permanently and manage them appropriately; however, if basic infection control measures are being effective, contact precautions are not required for colonized patients. For infomation on precautions for specific MDRO's, refer to "Isolation Guidance on MDROs" attachment.

E. Patient Transport
    1. Limit the movement and transport of the patient from the room only for essential purposes.
    2. If transport or movement between units, rooms, or care areas is necessary:
        a. Alert receiving department regarding the type of isolation precautions required, so the appropriate supplies will be available when patient arrives there.
        b. Perform hand hygiene and don indicated PPE prior to entering patient room.
        c. Place a surgical mask on patient who is on Droplet or Airborne Precautions.
        d. Healthcare personnel transporting patient who is on Droplet Precautions do not need to wear a mask during transport if the patient is wearing a mask
        e. Healthcare personnel transporting patient who is on Airborne Precautions do not need to wear a mask or respirator during transport if the patient is wearing a mask and infectious skin lesions are covered (e.g. varicella or smallpox or draining skin lesions caused by tuberculosis)
        f. Contain drainage or body fluids of patients on Contact or Airborne Precautions prior to transport.
        g. Instruct patient to perform hand hygiene (assist as needed) prior to moving patient onto the transport vehicle.
        h. Remove PPE before leaving patient's room and perform hand hygiene, then move patient into hall.
        i. Healthcare worker transporting patient will wear clean PPE based on transmission-based precaution identified.
        j. It is strongly encouraged, when transporting patients on Contact Precautions, to utilize two individuals for transport (one wearing PPE and a "clean" individual pushing elevator buttons, opening doors, etc.)
        k. All receiving staff will clean hands and don appropriate PPE based on the

transmission-based precaution identified, while caring for that patient

l. Do not place patient chart on bed when alternative is possible. If chart must be placed on patient bed, place patient chart a fluid impermeable barrier before placing on patient's bed.

F. Ambulating patients in hallway

1. General principals:

a. Therapeutic ambulation in the hallway for physical therapy qualifies as medically necessary when it cannot be adequately performed within the patient's room.

b. Plan on having two staff. The second staff will watch the patient during the PPE change out and follow with a container of disinfectant wipes to wipe anything touched by the patient or the PT with PPE on, such as hand rails, during the ambulation session.

c. Patient must meet all three following criteria before they are allowed to ambulate with therapy in the hallway. If unable to meet all three criteria listed, patient cannot ambulate in the hallway:

i. Patient must be CLEAN: bathed/showered beforehand that morning/day and performed hand hygiene prior to leaving the room.

ii. Patient's secretions, drainage, or excretions must be CONTAINED: surgical mask for coughing, clean/dry/intact dressing for draining wounds, disposable brief for fecal/urine incontinence.

iii. Patient must be COOPERATIVE with hand hygiene requests, able to follow commands, and has sufficient understanding of ways they can assist in preventing transmission of infection.

d. Notify unit staff of the planned ambulation route and timing so the hallway can be cleared of unnecessary traffic/equipment.

e. As much as possible, coordinate timing to minimize exposure to other patients and visitors (e.g., avoid meal delivery, shift change, or high-traffic periods).

f. Ensure all equipment the patient will contact (e.g., gait belt, walker, handrails) is cleaned and disinfected immediately after use.

g. Patient on transmission based precautions are not allowed to visit other patients, ambulate into kitchen/pantry on the unit, into the cafeteria, gift shop, or waiting rooms.

2. Contact precautions (e.g., MRSA, VRE, C. difficile, scabies):

a. Staff PPE:

i. Hand hygiene before donning and after doffing of PPE

ii. Donn PPE before entry into patient's room to prepare patient for ambulation in the hallway

iii. Change into clean PPE upon exiting the patient's room.

iv. Ensure extra gloves are readily available in case of contamination during session.

b. Patient requirements:

i. Ensure infected or colonized areas are covered/contained:

a. Wounds are dressed with clean, intact dressings;

b. Diarrhea is contained (clean depends) or patient is continent of stool;

c. Drains/drainage bags are emptied and secured.

ii. Ensure patient is bathed with CHG wipes and wearing a clean gown prior to ambulating in hallway.

iii. Ensure patient thoroughly washes their hands before leaving the room.

c. During ambulation:

i. The second staff member follows with a container of disinfecting wipes (Bleach wipes if C diff, PDI Sani-Cloth if another organism) and wipes anything touched by patient or PT in PPE during the ambulating session in the hallway.

d. Post-ambulation:

i. After patient is back in their room, staff to remove and dispose of PPE and perform hand hygiene.

ii. Ensure all touched surfaces, including equipment, are disinfected. Use Bleach wipes if C diff, PDI Sani-Cloth if another organism.

3. Droplet precautions (e.g., influenza, RSV, pertussis):

a. Staff PPE:

i. Surgical/procedure mask donned before close contact with the patient.

ii. Gown and gloves per Standard Precautions if contact with secretions is anticipated.

iii. Eye protection is not routinely required, but should be considered if the patient is actively coughing or sneezing.

b. Patient requirements:

i. Surgical mask worn throughout hallway ambulation.

ii. Instruct the patient in respiratory hygiene/cough etiquette (cover coughs, avoid touching the mask).

iii. Ensure patient thoroughly washer their hands before leaving the room.

iv. Have patient to wear a second clean patient gown (opening in the front) to serve as additional barrier/more complete coverage.

c. Post-ambulation:

i. Doff PPE, and perform hand hygiene.

ii. Disinfect any shared equipment and all touched surfaces.

4. Airborne Precautions (e.g., tuberculosis, measles, chicken pox, disseminated shingles):

a. Hallway ambulation is discouraged for patients on Airborne Precautions. In-room exercise and mobility should be maximized. If hallway ambulation is deemed medically essential, it will need to be approved by infection prevention and safe plan for hallway ambulation must be created to reduce risk of exposure to other patients, staff, and visitors.

b. Staff PPE:

i. Fit-tested, fit-checked N95 respirator or higher, such as PAPR

ii. Gown, gloves, and eye protection per standard precautions

c. Patient requirement:

i. Surgical mask placed on the patient before leaving the airborne infection isolation room (AIIR); the mask must remain on for the entire duration outside the AIIR.

ii. Ensure patient thoroughly washer their hands before leaving the room.

iii. The patient should not remove the mask to cough or sneeze; provide tissues to place over the mask if needed.

d. Route planning:

i. Use the most direct, least-trafficked route possible.

ii. Avoid passing through waiting or common areas.

iii. The AIIR door should remain closed when not in active use for entry/exit.

e. Post-ambulation:

i. Patient returns to AIIR; patient's mask may be removed once inside.

ii. Staff doff PPE outside the room and perform hand hygiene.

iii. Hallway areas do not require the same air-clearance time as enclosed rooms, but minimize other patient/visitor traffic in the corridor during and briefly after ambulation.

5. Airborne + Contact Precautions (e.g., SARS-CoV-2, disseminated varicella with skin lesions):

a. This represents the highest level of PPE burden and hallway ambulation should be reserved for cases where in-room therapy is truly insufficient. Refer to both precautions above for staff and patient requirements.

6. Applies to all isolation precautions:
    a. Have patient wear a second clean patient gown (opening in the front) to serve as additional barrier/more complete coverage.
    b. Ensure patient thoroughly washes their hands before leaving the room.
    c. Near the door, use a chair covered with a clean sheet for patient to use while staff remove and reapply PPE upon exiting patient's room.
    d. Place gate belt on patient.
    e. If patient uses a walker, wipe it down with disinfecting wipes prior to it being brought out of the patient's room.
    f. One clinical staff watches the patient while the other doffs their PPE and performs hand hygiene
    g. The assistant will follow with a container of disinfectant wipes to wipe anything touched by the patient such as hand rails during the ambulation session. The process will be reversed to return the patient back to their room.

G. Perioperative Services
    1. Make efforts to schedule procedures for patient on transmission-based isolation precautions as last case of day or as late in the day as possible.
    2. Use dedicated isolation cart in the Operating Room (OR), Ambulatory Surgery Unit (ASU), and Post Anesthesia Care Unit (PACU).
    3. The isolation cart will follow patient from unit to unit within the Perioperative Services (OR to PACU, ASU to OR to PACU, etc.)
    4. Appropriate signage will be posted outside the patient room and/or surgical suite entrances and PACU entrances to alert personnel.
    5. All unnecessary equipment and supplies will be removed from the patient room, surgical suite/procedure room and the PACU prior to the patient's arrival.
    6. All Periopereative Services personnel (scrub technicians, scrub nurses, circulating nurses, anesthesiologists, surgeons, assistants, PACU nurses, PCTs, ASU nurses, special procedure room staff, etc.) will wear appropriate PPE, based on transmission-based isolation precautions identified. Example: for patient on Contact Precautions, everyone who positions the patient on the operating room table will wear isolation gown and gloves.
    7. Perioperative personnel will notify receiving team members when the patient is being moved from one area of the department to another i.e. from ASU to OR, and will communicate/indicate what transmission-based isolation precautions should be taken to prevent disease transmission.
    8. The OR/procedure room, PACU, and/or ASU areas, where patient on transmission based isolation precautions was treated/held, will be terminally cleaned after the

patient's discharge from these areas.

H. Discontinuation of contact precautions:

1. For MDROs: MRSA, VRE, and ESBL:
    a. Active infection/current infection: Keep patients on contact precautions for the duration of admission.
    b. History of infection/presumed colonization: No contact precautions are required if patient is in single occupancy room. Educate patient and maintain good hand hygiene practices.
2. For all other MDROs (CRO, CRE, C. auris, etc.):
    a. Active or history of infection/presumed colonized: Keep ~~pateint~~patient on contact precautions for each admission for duration of stay.
3. For Clostridioids *difficile* infection (CDI), continue contact precautions until diarrhea is absent for at least 48 hours. Clostridium *difficile* infected patients continue to shed organisms for a number of days, weeks or even months following cessation of diarrhea. Contact infection prevention and control to discuss discontinuing enteric contact precautions.

Related Policies/Forms:

Body Substance Standard Precautions, AIPC-6

Cleaning and Disinfecting Patient Room Equipment, AIPC-19

Disposing Contaminated Equipment, AIPC-31

Hand Hygiene and Glove Use, AIPC-46

Hepa-Care Portable Filtration Units, AIPC-49

Linen Management, AIPC-75

Personal Protective Equipment PPE, AIPC-94

Power Air Purifying Respirator, DEH-27

Standard Body Substance Precautions, AIPC-4

TB Detection, Prevention and Control, AIPC-126

ECC Enhanced Barrier (Enhanced Standard) Precautions, DECC-1502

References:

CDC 2007 Guideline for Isolation Precautions, September 2024

CDC Type and Duration of Precautions Recommended for Selected Infections and Conditions, Appendix A, February 2025

AORN Guidelines for Perioperative Practice

All Revision Dates

07/2026, 02/2026, 02/2025, 01/2023, 03/2022, 01/2020, 07/2018, 06/2017, 02/2017, 01/2017, 01/2016, 09/2015

Attachments

Attachment 1: Isolation Guidance on MDROs.pdf

Attachment 2: Ambulation iso patient outside of patient room.pdf

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	07/2026
	Svetlana Schopp: Infection Preventionist	07/2026

Status **Active** PolicyStat ID **21027417**

Origination Date	03/2006
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Last Revised	07/2026
Next Review	01/2027
Department	Infection Prevention and Control - AIPC
Applicabilities	System

Rodent Management, AIPC-109

RISK:

By not following proper handling, disposal and control of rodents it could lead to increase spread of diseases carried by rodents.

POLICY:

A. Proper precautions are taken by all system healthcare workers whose activities may put them in contact with rodent droppings or secretions.

B. These precautions reduce the likelihood of infection with hantavirus (the sin nombre virus), a virus transmitted to humans by direct contact with infected deer mice, their droppings or nests, or through inhalation of aerosolized virus particles from mouse urine and feces.

C. Precautions and prevention measures begin with education.

PROCEDURE:

A. Report any citing of mice, their droppings or nests to your supervisor immediately ~~and complete employee event form to notify Occupational Health~~.

B. Report any evidence of rodents to Engineering by putting in an electronic Facilities Work Request.

C. Facilities and Infection Prevention and Control will review reports quarterly to identify patterns and address as needed.

D. ~~Report any evidence of rodents in the acute care hospital to Engineering who~~Facilities will ~~follow the CDC recommendations for safe~~manage disposal and clean up of the dead rodents, nests and/or rodent droppings.

E. ~~Dead rodents in all out buildings will be handled per CDC recommendations by out building staff. Safety supplies will be available i.e. gloves, disinfectants, masks, bags.~~

F. Follow CDC recommendations for safe disposal and clean up:
    1. Do not sweep or vacuum droppings or nests as these activities may put virus-laden dust into the air.
    2. Use gloves.
    3. Thoroughly wet the dead rodent, trap, droppings and/or nest with the EPA-approved general *disinfectant currently used at the hospital.
    4. Let area soak for 30 minutes.
    5. Using gloves, single bag the disinfectant-soaked rodent droppings and/or nest and clean-up material (gloves, newspaper, paper towels etc.) securely in a regular bag and seal by tying into a knot or using a twisty and place in regular trash.
    6. Wash hands thoroughly with soap and water.

G. Engineering will determine if additional action is needed e.g. inspection/extermination by a contracted outside pest control service.
    1. Pest control methods are safe for use around patients and staff~~.~~; if used, traps are placed so as not to present a hazard to patients or staff.

H. If you have performed clean up and disposal of rodents, their droppings or nests, watch for the following symptoms of hantavirus pulmonary syndrome (HPS) 2 – 6 weeks afterwards:
    1. Fever of 101° - 104°F which does not respond to medication
    2. Severe muscle aches in large muscle groups e.g. thighs, hips, back and shoulders
    3. Lower abdominal pain
    4. Headache, coughing, vomiting
    5. Report any of the above symptoms to ~~OH~~Occupational Health or your private ~~physician~~care provider immediately.

I. ~~Employees who use hospital vehicles should also be aware that mice might nest on the vehicle's engine; a check of the engine' surface prior to operating the vehicle is recommended.~~
    ~~1. Mice are attracted to food and nesting materials. Do not leave food in vehicle and inspect the interior of the vehicle.~~

J. ~~Departments who use storage areas on site or in off site buildings should report evidence of more than one stray rodent to Engineering.~~

K. Facilities performs monthly inspection of all hospital vehicles, including for evidence of mice or nesting.

L. Contact Occupational Health (ext. 3277) with questions or concerns.

M. ~~Videos on Hantavirus are available in staff development.~~

N. MSDS information is available on line through Tahoe Forest Health System Intranet page at SDS on-line web link.

References/Related Policies:

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

Settings

SDS Online

Pest Control, AIPC-95

All Revision Dates

07/2026, 02/2026, 08/2021, 06/2019, 01/2016, 01/2015, 01/2014, 04/2007, 03/2006

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	07/2026
	Svetlana Schopp: Infection Preventionist	07/2026

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Effective	07/2026		
Last Revised	07/2026		
Next Review	01/2027		

Pest Control, AIPC-95

RISK:

If pests are not controlled, we could have an outbreak of infections from pests and their feces.

POLICY:

Measures are taken to reduce the access for insects and others pests to into the facility.

PROCEDURE:

A. All openings to the outside of the physical facility are protected to reduce the potential of the entrance of pests. These protective measures include but are not limited to:
    1. Outside doors have self-closing devices
    2. Windows are permanently closed or have sufficient screening.
    3. Exhaust air ducts have controlled air current per Engineering Preventive Maintenance checks.

B. Pest control is done in a manner that is safe for patients, staff and visitors. ~~Seasonal Spring spraying for insects is done by a pest control contractor.~~

C. Seasonal Spring spraying for insects is done by a pest control contractor.

D. As pest control issues are identified, they get addressed on case by case basis.

E. West Nile Virus control issues are addressed by inspecting for areas of standing water and dead ~~bird reporting~~in the summer months.

F. ~~See AIPC-109 for Rodent Management.~~

References/Related Policies:

Rodent Management, AIPC-109

All Revision Dates

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	Janet VanGelder: Director	07/2026
	Svetlana Schopp: Infection Preventionist	07/2026

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Department	Infection Prevention and Control - AIPC
Applicabilities	System

Infection Control Risk Assessment (ICRA) for Construction, AIPC-59

RISK

If proper containment and procedures are not followed construction can lead to contamination and spread throughout the hospital potentially causing a variety of infectious processes.

POLICY:

For all construction, renovation and repair projects, Infection Prevention & Control and the architect & engineering (A&E) team will collaborate on the assignment of general and specific responsibilities related to infection control concerns. Security and Interim Life Safety (fire) issues are covered in separate policies. Vaccination and other occupational health requirements to reduce the risk of transmitting communicable disease apply. Use of an Infection Control Risk Assessment (ICRA) as required by American Institute of Architects (AIA) guidelines will be an internal component of the contract bidding process and be included in the Contractors Specification Book. Additionally all design documents will include assignment of Infection Control Patient Risk Group and the Construction Project Type as per the ICRA.

PROCEDURE:

A. Construction superintendent/project manager/engineering will send written documentation to Infection Prevention and Control (IP&C) prior to implementation detailing the planned procedures to be followed at each stage of construction, renovation or repair.

B. IP&C and A&E team will identify and assign the Infection Control Patient Risk Group (group Low Risk, Medium Risk, High Risk, or Highest Risk) and the Construction Project Type (Type A,

B, C, or D) for all construction, renovation and repair projects. The team will utilize attached PDFs of the "ASHE's Infection Control Risk Assessment 2.0 Matrix of Precautions for Construction and Operations" and "ICRA 2.0 Infection Control RIsk Assessment and Permit" to conduct the assessment, and develop and publish the ICRA Permit.

C. Infection Prevention and Control RN Coordinator and Facilities Manager will review and sign off on each ICRA Permit.

D. ICRA Permit will be published in contract bidding documents and contractor's specification book.

E. The ICRA Permit will be posted at entrance to project.

F. A&E team and Infection Control will collaborate in the monitoring and enforcing of infection control-related items; e.g. effective ventilation/filtration, dust barrier placement, circulation & traffic control patterns, debris removal & control, risk reduction of employee injury/illness.

G. ~~Infection Control will sign off on ICRA Permit.~~

H. ~~The ICRA Permit will be posted at entrance to project.~~

I. The project will be evaluated regularly for compliance.

J. Occupational Health clearance is required prior to commencement of work by contracted worker.

K. An individual ICRA Permit may be modified throughout the project. Revisions must be communicated to the Project Manager with input from Infection Prevention and Control and Facilities Manager regarding concerns and risks. An updated ICRA Permit will be posted and used to guide project monitoring.

References/Related Policies/Forms:

ASHE & AHA Infection Control Risk Assessment 2.0 (ICRA 2.0) (ASHE 2022)

FGI Guideline for Design and Construction of Hospitals (2018)

Infection Prevention Manual for Construction and Renovation (APIC, 2015)

Carpenters International Training Fund: Infection Control Risk Assessment (ICRA): Construction Trades Best Practice Awareness Training (December 2018)

All Revision Dates

07/2026, 08/2022, 08/2021, 06/2019, 05/2018, 01/2016, 06/2015, 01/2015, 01/2014, 11/2012, 04/2007

Attachments

- 2022 05 ASHE ICRA-2.0-Assessment and Permit.pdf
- 2022 05 ASHE ICRA-2.0-Matrix FORM.pdf

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	07/2026
	Svetlana Schopp: Infection Preventionist	07/2026

RISK:

Failure to provide continuity of care for providing rabies series vaccinations could lead to patients missing required medications.

POLICY:

Patients initially seen and treated by the ED MD who require rabies series vaccinations and will have ongoing series given by TFH or IVCH series patient will use the following steps listed under Procedure.

PROCEDURE:

A. Patient Registration will register the patient as an ED patient on their first visit.
B. RN and MD will document Initial visit in Electronic Medical Record.
C. On initial visit, ED MD will order all rabies medications to be administered in ED during initial visit.
D. ED MD will order subsequent rabies injections for days 3/7/14
    1. In disposition click on DISCHARGE ORDERS, NEW ORDER
    2. Type in INF2 and choose Hospital Performed
    3. In department field: add TFH IV THERAPY or IVCH IV Therapy
    4. Remove defaulted comments so that comments field is empty
    5. ADD: **.rabiesreferral** in comment field
    6. Choose date of tomorrow and check the "approximate" box
    7. In expired field, leave 1 year (which is the default)
    8. This order will route to the cancer center for future visits for this patient. For IVCH staff will set up future visits
E. Tahoe forest patients are directed to the cancer center for subsequent visits during business hours. During after hours, patients are directed to med/surg for subsequent visits. IVCH patients will return to IVCH ED.
F. Patients do not return to ED for subsequent rabies injections. except at IVCH.
G. RN will give patient an immunization record card recording Day 0 injections. Write in the dates the patient is to receive the next 3 injections.
H. Instruct patient to follow up on Days 3, 7, and 14 to complete the series. Initial visit is considered Day 0. The effectiveness is not guaranteed unless medication is given on exact schedule.

Related Policies/Forms:

What You Should Know About Rabies

References:

CDC Rabies