



AHMC ANAHEIM REGIONAL  
MEDICAL CENTER

## **REGISTRY, STUDENTS, Intern Orientation Guidelines & Annual update 2017**

Welcome to AHMC Anaheim Regional Medical Center, also known as ARMC. We are glad to help you in meeting your needs and hope to provide many learning opportunities. We are committed to providing excellent health services and medical care to our patients and our community. We believe that working as a team is far more effective to provide optimal health services to our patients.

To optimize your time here at ARMC, we want to provide you with some vital information. This orientation packet contains information to help you during your clinical rotation/ shift and also contains important information in which you will be expected to abide by. Training elements in this self-instructional module include mandatory performance expectations, service excellence, teamwork expectations, communication and patient/family education guidelines, patient safety, error reduction, reporting, policy & procedures and general safety guidelines which are to be implemented at ARMC at all times.

Each of the areas contains instructional information to provide you with the facts you need to know and a post-test to evaluate the knowledge you gained from this module. The module is to be completed before the first worked shift for registry and students, and annually thereafter for registry.

### Directions:

1. *Read the self-learning module*
2. *Complete the POST TEST*
3. *Make sure to PRINT your name on "Answer Sheet"*

The "Answer Sheet" can be completed in pen or pencil.

Thank you.

The Department of Human Resources  
Education Department

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## ADMINISTRATIVE

### Mission Statement:

To provide compassionate, high-quality healthcare to a culturally diverse community.

### Vision Statements:

To be recognized by patients, physicians and staff as the *BEST* place to receive health care, the *BEST* place for physicians to practice and the *BEST* place to work.

### Values:

*Advocacy*

*Responsiveness*

*Mutual Respect*

*Caring*

### Mission, Vision, Values

*Corporate Credo/Motto:*

*Compassion FIRST*

*Family*

*Innovation*

*Respect*

*Safety*

*Teamwork*

### Patient Experience & Service Excellence

Customer satisfaction is essential for any business, but in healthcare, it is critical because patient safety and outcomes are interwoven into the patient experience. As healthcare workers (this is everyone who works in the hospital), we must acknowledge that the patients that we serve are not the same type of customers as those encountered in a restaurant, retail store or at Starbucks. We are not simply providing a product, but instead we are providing a complex system of care and services. This care is delivered by our staff who must be able to first, connect with the patient/family in a compassionate manner, establish a trust relationship, listen to their fears and concerns, provide teaching about complex disease process and procedures and work together with the healthcare team to coordinate the needed care. This is a complex task, but our team does this every day.

So, how do we know if we are doing a good job? We survey our patients to get their perception of the care that we provide, then we compare our results to ourselves (we want to see that we are improving), to our community (we need to do better than our competitors), and to the national results. The federal government is also interested in the patient experience... WHY, you might ask. The reasons are many, but essentially it gets down to quality, safety and outcomes. For example, we measure responsiveness. One of the reasons it is important to respond quickly to our patients is because delays are associated with patient injury and poor outcomes. Think of the elderly patient who needs to use the restroom. They push the call light and wait (keep in mind, when they call they need to go now). If no one comes immediately to assist, they try to get up themselves and they fall, fracturing their hip (bad outcome, extended hospital stay). This is called a "hospital acquired condition" and the hospital will not get paid for anything related to this injury. You can see how important that this is!

The patient experience begins when the patient/family enters the driveway to the hospital. Every employee that encounters a patient or family must follow our Service Excellence standards, from the valet, to admitting



representatives, transporters, lab, radiology, dietary, engineering, housekeeping, to the clinical care providers (physicians, nursing, respiratory, cardiology, etc). Patients are our priority, and without them we have no business, therefore, in order to be successful, it starts with us... we must hold each other accountable to the standards.

So for us to be successful, we must have a TEAM approach with every employee supporting one another at all times. We need to use our training and tools provided to help improve our communication. One of the tools that all employees are expected to utilize is a communication style called "AIDET" which is an acronym that stands for Acknowledge, Introduce, Duration, Explanation and Thank You. Listed below are the discription of each element and actions to complete them:

"Acknowledge" a patient/family/physician or coworker, it means that you stop what you are doing, smile and greet them promptly using their name (if you know it). This makes the patient/family/physician and coworker feel important and that their issue will be addressed promptly. It is also important to Acknowledge visitors in the hallways and assist them to their destination.

"Introduction" is an important element so that our patients/families/physicians know who is interacting with them and what their role or function in the hospital is. This is especially important because most departments wear scrubs and personnel all look the same to our patients/families.

"Duration" is the next element, and is important so that our patients/families can anticipate how long a wait or procedure will be. It is important to keep the patient/family informed if a delay is encountered and update as to how long a procedure may take so that we can allay any fear or anxiety that our patients/families may be experiencing. Remember to add a few extra minutes when setting a time expectation.

"Explanation" is the next element of AIDET and is used to communicate information to the patient/family regarding the diagnosis, treatment plan, what to expect upon discharge and signs and symptoms to be alert for which may indicate a change in condition. This element is crucial, as this is where we answer questions and reassure our patients about their condition, the routine in the hospital, or other complex processes. It is important that we use common terminology that the patient/family can understand and incorporate safety instructions into our explanations. If English is a second language for our patient/family, then make sure you get an appropriate translator or dial operator for translation services. ALWAYS remember to ask the patient/family if you have answered all their questions, and use the script "Is there anything else I can do for you" before leaving the room.

The last element of AIDET is

"Thank You". We need to demonstrate appreciation to our patients/families and thank them for the privilege of caring for them. Our patients do have a choice in selecting hospitals and we want them to select our facility because of the exceptional care and service provided by our staff. Yes, YOU are the most important reason that our patients/families keep coming back! When you complete the "Thank You" step, you will acknowledge the patient, provide them the opportunity to ask/answer questions and provide closure for the patient/family.

Onstage/Backstage are concepts that we have incorporated into our hospital expectations. Our employees are "ONSTAGE" when interacting with our customers (patients, families, physicians, vendors, coworkers etc) which means that you are in performance mode and everything that you do needs to be done as if you were performing on a stage in public view for everyone to see. Most of our departments and care areas are "Onstage Areas" and interactions need to be professional and in performance mode at all times.

"BACKSTAGE", like in a theater, are those areas that the public does not see and this is where all the preparation, set up, discussion about issues, and other items that you don't want the public to see occur. Backstage areas may include break rooms, storage areas, rest areas, closed offices, or other area where conversations or preparations can be done confidentially. We expect all employees to utilize the ONSTAGE and BACKSTAGE principals in the workplace.





### **Complaint and/or Grievance Process**

Complaints and Grievances are topics that all employees need to understand and participate in so that we can respond and resolve issues as they are brought to our attention. The Centers for Medicaid and Medicare Services (CMS) conditions of participation require that all hospitals have a process that addresses patient complaints and grievances.

A *COMPLAINT* is a verbal communication from a current patient or family member, about an issue that caused them to be dissatisfied (i.e. wait times, food issues, cleanliness, etc.). A *COMPLAINT* should be immediately resolved by staff in the department. Issues and actions taken should be shared with the supervisor of the department so that follow up can occur with the patient/family to assure that the issue has been adequately resolved. If a complaint is not adequately resolved, it becomes a grievance.

A *GRIEVANCE* is a complaint that has not been resolved to the patient/family satisfaction; or it is any written notice of dissatisfaction with care or service; or any allegation of abuse or neglect. All grievances need to be communicated to the supervisor of the department, and to the Patient Experience Coordinator and CNO for follow-up action. Grievances require the hospital to respond to the patient/family in writing indicating the actions taken to resolve the issue. Grievances that cannot be resolved within 7 days require an acknowledgement letter with final resolution within 30 days. A grievance is considered resolved when the patient/family states satisfaction, or no further communications are received after a response is sent.

Here are some frequently asked questions about complaints/grievances:

1. Whose job is it to address a complaint? Every staff member should do everything in their scope to resolve a patient complaint. Complaints should be resolved at the lowest level possible, but make sure to communicate your actions to your supervisor!
2. If I need assistance with a complaint, who do I call? First you should call your supervisor and/or director and let them know about the complaint. If you need further assistance, you can communicate the issue to the Patient Experience Advocates (pager #44081) or House Supervisor (pager #46765) who will round on the patient to assist with resolution. For issues that cannot be resolved, make sure to notify your director AND the Chief Nursing Officer.
3. What if there is a lost belonging? Complete an IMP. You need to start the investigation on your unit. Document all your efforts to locate the item in the IMP. Check the Belonging record and track back to other units. DO NOT tell the patient that the hospital will reimburse them, as the Conditions of Service puts the responsibility for belongings on the patient.

If we all work together as a team to attend to the patient's needs, then we will not have any complaints which will make all of our work easier! Thank you for working to improve our patients experience!

### **Team Building**

Effective team building contributes to the organization's success. Effective teams are successful because they work more efficiently than they could have if each individual had been doing the same task separately. By working in teams each person makes a bigger impact and is able to achieve more. The medical, nursing, ancillary and professional staff of ARMC functions collaboratively as part of a multi-disciplinary team united in a purpose to achieve positive patient outcomes. When teams are effectively used, there is a supportive and encouraging environment which fosters patient safety and improved patient outcomes. Open communication is important to foster team building and to establish trust among working groups. Employees are encouraged to communicate with each other and management any issues or concerns which may be perceived as hindering professional conduct and customer service

*Essential factors for team building include setting clear goals and expectations, team member commitment, competence, collaboration and coordination. Each member must be culturally sensitive and able to utilize effective communication, active listening, and constructive criticism strategies.*



AHMC Anaheim Regional Medical Center expects its employees to function as a team toward a common goal of quality patient care and satisfaction.

**Staff Rights (Policy #: HR 502 & HR 503)**

- Employees may request to their immediate manager not to participate in an aspect of patient care that is in direct conflict with their cultural, ethical, or religious values or beliefs. Policies: Employee's Rights Re: Conflict in Aspect of Patient Care and Employee's Right Re: Care of Patients Having Abortions are provide at the beginning of employment.
- Policies are also posted on hospital bulletin boards, and on the intranet in accordance with Health Code requirements.
- AHMC Anaheim Regional Medical Center ("ARMC") will make every effort to accommodate the request, provided that there is no compromise in patient care or safety.

**Dress Code ( Policy #: HR 204)**

- Must be clean, neat and well groomed at all times.
- Attire must be appropriate to occupation and profession.
- Picture ID must be worn at all times facing out and at a level that others can readily see.
- Attire must be appropriate for stooping and bending.
- Hair on head and face shall be clean and trimmed.
- Clinical staff; longer hair should be pulled above the shoulder.
- Hair color and style should remain conservative.
- Shoes should be clean and in good repair.
- Clothing must cover the back, shoulders, thighs, midriff, and must not be excessively short or revealing.
- Jewelry should be minimal and should not compromise safety.
- Conservative earrings and conservative piercings will be acceptable.
- Tattoos, which may be offensive to others, are not to be visible at any time.
- Perfume and cologne should be minimal
- Nail polish should not be chipped or peeling and the color should be subtle.
- The natural nails of healthcare workers are to be kept short, i.e. not extending more than ¼ inch beyond the tips of the fingers. Artificial nails, nail tips and gel nail polish are prohibited for all health care workers and providers who provide direct, "hands-on" patient care, across the continuum of care, including but not limited to: inpatient, ambulatory and home care, invasive or diagnostic procedures or therapies, perioperative services, critical care, newborn, perinatal services (labor and delivery, post partum, nursery), etc.
- Casual business attire does not include blue jeans and recreational-type sandals known as "flip-flops".

**Meal and Rest Periods**

Non-exempt employees working in excess of five hours are required to take a 30 minute duty free unpaid meal period; however, employees working a shift of less than six hours can elect to waive their 30-minutes duty free unpaid meal period. Non-exempt employees working in excess of six hours must take a 30 minute duty free unpaid meal period. Non-exempt employees working in excess of 10 hours a day will be required to take a second thirty-minute duty free unpaid meal period, unless waived by mutual agreement. Non-exempt employees working in excess of 12 hours who are approved for overtime, may decline their 2<sup>nd</sup> meal period (provided they have a signed second meal break waiver on file). Any such waivers must be in writing and approved in advance by the Facility's Human Resources Representative.

Non-exempt employees are also required and permitted to take a paid "net" ten (10) minute rest period during each consecutive four (4) hour period of work or major fraction thereof, and to the extent possible such rest periods should be scheduled to take place approximately midway through each four hour period of the work day. Rest periods may not be combined with the meal period.



### **CULTURAL COMPETENCY**

Cultural competence is: a set of congruent behaviors, knowledge, attitudes and policies that come together in an organization that enables professionals to work effectively in cross-cultural situations. In health care settings, cultural awareness, sensitivity, and competence behaviors are necessary because even such concepts as health, illness, suffering and care mean different things to different people.

Dr. Josepha Campinha-Bacote developed a Culturally Competent Model of Care. She referred to cultural competence as a process, meaning that the health care provider should continually strive to effectively work within the cultural context of each client. The model consists of 5 constructs which are: 1) **Cultural Awareness**: A self-reflection of one's own biases. 2) **Cultural Knowledge**: Obtaining information about different cultures. 3) **Cultural Skill**: Conducting an assessment of cultural data of the patient. 4) **Cultural Encounters**: Personal experiences with patients of different backgrounds. 5) **Cultural Desire**: The process of wanting to be culturally competent

Why is cultural competency important at ARMC?? Because, according to the Institute of Medicine's report on "Unequal Treatment Confronting Racial and Ethnic Disparities in Healthcare" – a consistent body of research indicates a lack of culturally competent care directly contributes to poor patient outcomes, reduced patient compliance, and increased health disparities, regardless of the quality of services and systems available.

Cultural competence begins with an honest desire not to allow biases to keep us from treating every individual with respect. As healthcare providers, ARMC employees need to acknowledge one's own values, beliefs, and communication styles. Whether it is with employers, patients, colleagues or others; acknowledging them will help us to understand how they contribute in communicating with others. The first step of becoming culturally competent requires each one of us to honestly assess our positive and negative assumptions about others. Knowledge of cultural customs enables healthcare providers to provide better care, and help avoid misunderstandings among staff, patients and families.

### **CULTURAL SENSITIVITY**

Cultural Sensitivity goes hand in hand with Cultural Competency. Here at ARMC, we view all patients and co-workers as unique individuals regardless of cultural background. Some characteristics of being culturally aware include:

- Awareness of age, gender, income, community, ethnicity, religion, values, beliefs, communication (language), race, functional abilities, sexual orientation, nutrition and personal experiences (including acculturation).
- Recognition of your own prejudices and stereotypes, and that a patient/co-worker may hold different views.
- Knowledge of the culture of the United States healthcare system. For example, treatment usually emphasizes technology and physical procedures. Also facilities may have specific rules in regards to visitors and visiting hours.
- Ask patients to describe their health practices, symptoms, and illnesses in their own terms. Explain that you would like the patient to teach you about their culture.
- Use "cultural ambassadors", such as family members, priests or pastors, or other community "elders" who can assist the medical professional in discussions with patients and families.
- Different values that people place on their health and the health services received. For example not all patients want to know their prognosis, not everyone believes in preventative care.
- Language barriers need to be identified and actions put in place to eliminate or reduce these barriers. Interpreters, telephone interpreter service, sign language interpreters and patient communication boards are available.

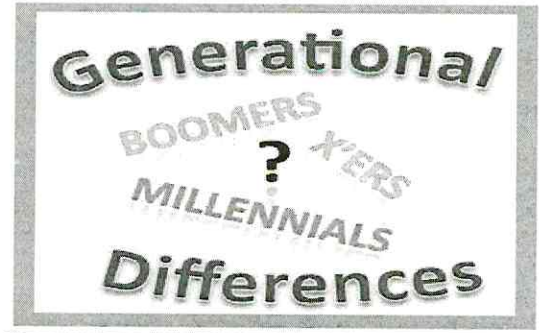
- Verify that you are being understood by asking open-ended questions or having the patient repeat things back to you as they understand them.
- Confirm that you understand what is being communicated by clarifying or repeating back.
- Non verbal cues may include looking for patriarchal permission to speak.

A MASTER level interpreter must be used when obtaining consent from ALL non-English speaking patients.

ARMC is striving to create a culture of inclusion and in doing so request that we respect our peer employees by speaking English only so that no one feels isolated or excluded.

### GENERATIONS in WORKPLACE

- Traditionalists/Silents- 1900-1945
- Baby Boomers- 1946-1964
- Generation X-1965-1980
- Millennials – 1977-2000



The key is to be able to effectively address and take advantage of the differences in values and expectations of each generation. But experts say one must be careful not to follow blanket stereotypes.

#### Let's take a look at each generation individually:

**Traditionalists/Silents:** Silents are considered among the most loyal workers. Traditionalists/Silents possess a strong commitment to teamwork and collaboration and have high regard for developing interpersonal communications skills. They are considered dedicated, hardworking, respect authority and have pay your dues mentality.

**Baby Boomers:** Boomers are the first generation to actively declare a higher priority for work over personal life. They generally distrust authority and large systems. They are more optimistic and open to change than the prior generation, but they are also responsible for the “Me Generation,” with its pursuit of personal gratification, which often shows up as a sense of entitlement in today’s work force. They value personal growth, teamwork, youthfulness and expect respect from younger workers.

**Generation Xers.** Generation Xers are often considered the “slacker” generation. They naturally question authority figures and are responsible for creating the work/life balance concept. Born in a time of declining population growth, this generation of workers possesses strong technical skills and is more independent than the prior generations.

Because Gen Xers place a lower priority on work, many company leaders from the Baby Boomer generation assume these workers are not as dedicated; however, Gen Xers are willing to develop their skill sets and take on challenges and are perceived as very adaptive to job instability in the post-downsizing environment. They work smarter and with greater output, not work longer hours, eliminate tasks, self-reliant, wants structure and direction.

**Millennials or Generation Ys.** This group is the first global-centric generation, having come of age during the rapid growth of the Internet and an increase in global terrorism. They are among the most resilient in navigating change while deepening their appreciation for diversity and inclusion.



The Millennials are also the most educated generation of workers today. Additionally, they represent the most team-centric generation since the Traditionalists/Silents, as they have grown up at a time where parents programmed much of their lives with sports, music, and recreational activities to keep them occupied while their Boomer parents focused on work.

They are ambitious, multitasking, looks for meaningful work and innovation, looks for career and stability, obsessed with career developments, thrive in a collaborative work environment, training is important to them, understand the importance of great mentors and want to enhance their work skills by continuing their education.

#### **Strategies to lead Four Generations at Work;**

1. Facilitate mentoring between different aged employees to encourage more cross-generational interaction. The more structure you can lend to your mentoring program to create knowledge transfer the better. First determine younger employees' goals and developmental needs, and then pair them with older, more experienced employees to create cross-organizational dialogue among generations.
2. Open up the office. Millennials generally don't work well under rigid management structure. They prefer open collaborations that allow employees to share information and for everybody to contribute to decision-making. Assign work to teams of employees and have them present finished product to the entire department. The idea is to take advantage of the Millennials' preference for teamwork and to encourage more solidarity throughout the workplace.
3. Create recognition programs. Even simple gestures like a pat on the back or positive email congratulations can help boost productivity with Gen Xers. Boomers may seek status so may respond best to an office-wide memo that announces that they are meeting or exceeding their goals. Millennials may seek validation and approval so will appreciate increased responsibility and additional training opportunities. To this end, Millennials may also prefer more frequent employee reviews.
4. Create a respectful, open and inclusive environment where workers of all ages and cultural backgrounds can share who they are without fear of being judged, "fixed," or changed. Regardless of age and tenure, give all employees a forum in which to present ideas, concerns and complaints. Department heads should facilitate open communication throughout the office and set aside time to provide honest feedback. They must avoid projecting their own expectations about work and remain open to different perspectives based on generational attitudes.
5. Don't apply a blanket communication-method policy. Boomers may prefer to communicate by phone or in person. Millennials grew up being in constant communication with peers and coworkers so are accustomed to emailing, texting or sending instant messages.
6. Don't confuse character issues like immaturity, laziness or intractability with generational traits. Whereas Boomers may see a 60-hour work week as a prerequisite to achieving success, many hard-working Millennials may prefer a more balanced life that includes reasonable working hours—with occasional bouts of overtime—and weekends off. The latter may also voluntarily choose to make up the time in unstructured settings like working at a Starbucks on weekends.

## CODE of CONDUCT

### Ethics and Compliance

- AHMC Anaheim Regional Medical Center (“ARMC”) is committed to operating in a manner that is compliant with all laws, rules, regulations, and guidelines, as well as in a manner that meets appropriate ethical standards.
- ARMC addresses conflicts of interest in an ethical manner. A conflict may exist if an employee is in a position to influence a decision that may result in personal gain for that employee or a family member or friend as a result of ARMC’s business dealings. Employees should identify and report any suspected conflicts.
- The purpose for existence of ARMC is to provide high quality and safe care to our patients. The integrity of decisions is based on identified care, treatment, and service needs of the patient. Any employee and/or patient concerned about the safety or quality of care provided in the facility may report these concerns to the Joint Commission.
- ARMC employees will apply appropriate standards of conduct to everyday work decisions and behavior. Every employee, contracted service worker, and physician is expected to adhere to the Hospital’s Code of Conduct and Ethics Policy.
- ARMC employees and contracted service workers will refrain from using ARMC assets for their personal business.
- ARMC employees and contracted service workers (“ARMC staff”) must be vigilant in avoiding any conduct that could violate or appear to violate federal and state laws concerning fraud, waste and abuse (F/W/A), false claims, and self-referral. Such Laws include the Federal False Claims Act, Anti-kickback statute, Stark Statute (Physician Self-Referral Law), California False Claims, HIPAA/HITECH, etc.
- ARMC/AHMC has many checks and balances in order to prevent fraud, waste and abuse. ARMC/AHMC has internal and external audits and subscribes to many publications to keep updated and informed of changes in order to detect and prevent claims problems. ARMC staff receives compliance training at New Employee Orientation and annual reorientation.
- ARMC staff shall not solicit, offer or accept any consideration, i.e. gifts, donations, meals, transportation, entertainment that might be construed as conflicting with ARMC business interests. ARMC prohibits any payment or receipt of payment that has or could be interpreted as having the appearance of a bribe or kickback, particularly related to contracting with the government (i.e. Medicare, MediCal, etc.).
- ARMC staff should feel free to ask ethical or compliance questions, request compliance clarification or to report suspected or detected noncompliance without fear of retaliation. ARMC has an obligation to protect these individuals from any retaliation resulting from an individual’s good faith in reporting potential or actual violations of the Code of Conduct or the law.
- ARMC staff will diligently create and maintain patient and company records accurately and completely and adhere to ARMC policies and procedures with regard to confidentiality and their preservation.





- ARMC staff is prohibited from processing any claim for payment or reimbursement that they know, or have reason to know, is false, fraudulent or known to be otherwise inaccurate. Under the False Claim Act, the term “knows or has reason to know” is defined as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. Examples of prohibited behavior/activities include: billing for services not rendered; billing for undocumented services; double billing for items or services; making false statements; participating in kickbacks; including improper entries on cost report; billing for medically unnecessary services; and assigning incorrect codes to secure higher reimbursement.
- ARMC staff that engage in prohibited behavior/activities may be required to attend compliance retraining and may be subject to disciplinary action up to and including termination. ARMC staff that fail to report a known or suspected violation may also be subject to retraining and disciplinary action.
- Any ARMC staff that observes or has knowledge of actual or suspected noncompliance or potential insurance (i.e. Medicare/Medical) fraud/waste/abuse has the duty to report this activity. ARMC staff may report noncompliance to any of the following without fear of retaliation:
  - Immediate Supervisor
  - Department Manager
  - Executive Leadership
  - Human Resources (ARMC or Corporate)
  - Ethics Helpline (877)246-2367 (1-877-AHMC-for-U)
  - www.ahmcforu.com
- ARMC/AHMC is committed to act on this information immediately to correct violations and is required to report noncompliance to the health plan sponsor/ payer. ARMC staff may also report infractions directly to the sponsor or to governmental agencies.

### Impaired Staff

If you suspect that a physician or coworker is impaired, report it to your supervisor immediately.

Some of the indications for impairment are listed below and should be evaluated in terms of the total picture and not just one of the listed behaviors:

- **Physical symptoms:** Disorientation, confusion, red or glassy eyes, slurred speech, deterioration of personal grooming habits, always wears long sleeves, on-the-job accidents or injuries, odor of alcohol or marijuana.
  - **Behavioral symptoms:** Extreme and rapid mood swings, aggressiveness, irritability, inattentiveness, hyperactivity, withdrawn, lunch alone, difficulty with short term memory, attendance, or availability problems.
  - **Suspicious behavior concerning narcotics:** Signs out more controlled drugs than anyone else, waits to be alone to open the narcotics cabinet, frequent spills or breakage.
- Intoxicated behavior:** stumbling, unsteady gait or balance.

## EMPLOYEE CONDUCT IN THE WORKPLACE

### **Policy Against Discrimination, Harassment and Retaliation**

AHMC Anaheim Regional Medical Center is committed to maintaining a work environment that is free of prohibited discrimination, harassment, and retaliation based on race, color, creed, sex (which includes pregnancy, childbirth, breastfeeding, or related medical conditions), gender (which includes gender identity and expression), age, sexual orientation, national origin (which includes language use and possession of a driver's license issued to persons unable to prove their presence in the United States is authorized under federal law), ancestry, religion (which includes all aspects of religious belief, observance, and practice including religious dress and grooming practices), marital or registered domestic partner status, military and veteran status, physical or mental disability, genetic information, medical condition (which includes genetic characteristics, cancer or a record or history of cancer), or any other legally protected class (collectively referred to as "protected classifications" or "protected class"). The Facility also prohibits discrimination and harassment based on the perception that someone is a member of a protected class or is associated with a member of a protected class. Consistent with state and federal law, reasonable accommodation will be provided to qualified applicants, employees, and unpaid interns with disabilities (including pregnancy, childbirth and related medical conditions), and/or to accommodate religious practices of applicants, employees, and unpaid interns unless doing so would result in an undue hardship.

- Harassment: Harassment includes unwelcome verbal, written, physical, visual or other conduct that creates an intimidating, offensive, or hostile working environment, or that interferes with an employee's work performance. In the case of sexual harassment, such conduct constitutes harassment when (1) submission to the conduct is made either an explicit or implicit condition of employment; (2) submission or rejection of the conduct is used as the basis for an employment decision; or (3) the harassment interferes with an employee's work performance or creates an intimidating, hostile, or offensive work environment.
- Harassing conduct can take many forms and may include, but is not limited to, the following when based upon an employee's protected status: slurs, jokes, statements, gestures, assault, impeding or blocking another's movement or otherwise physically interfering with normal work, pictures, drawings, or cartoons, violating someone's "personal space," foul or obscene language, leering, stalking, staring, unwanted or offensive letters, poems, offensive email or voicemail messages. Conduct that is verbal or nonverbal directed at a specific person that causes substantial emotional distress to that person and serves no legitimate purpose.
- Sexual harassment: Unwanted sexual advances, requests for sexual favors, graphic, verbal or physical conduct of a sexual nature. Sexual harassment may occur between members of the same or opposite sex. Further, harassment based on a person's sex is not limited to instances involving sexual desire or behavior. That is, harassment on the basis of sex may occur without sexual advances or sexual overtones when conduct is directed at individuals because of their sex. This is often referred to as sex or gender harassment, and violates this Policy. The following conduct: unwanted sexual advances or propositions; Offering employment benefits in exchange for sexual favors; Making or threatening reprisals after a negative response to sexual advances; Visual conduct such as leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters; Email and other communications of a sexual nature; Verbal conduct such as making or using derogatory comments, epithets, slurs, and jokes; Verbal abuse of a sexual nature such as graphic verbal commentaries about an individual's body, sexually degrading words to describe an individual, suggestive or obscene letters, notes, or invitations; Physical conduct such as touching, assault, or impeding or blocking movements; or any action, whether or not sexual, that is discriminatory on the basis of the victim's gender.



- Additional unacceptable behavior is any behavior that is unwelcome, based on the "protected classifications" noted above, interferes with his or her job, or is offensive or felt to be hostile or threatening.
- Conduct between co-workers in a non-workplace and purely social setting is not subject to the Non-Harassment Policy. Such conduct is only significant if it carries over to the workplace in the form of harassing conduct. As long as non-employment conduct does not interfere with the individual job performance it is not subject to the Non-Harassment Policy.
- The Non-Harassment Policy applies to any person, whether or not they are an employee, on any business premises or workplace. Any harassment by vendors, clients, contractors, customers, or any other person doing business with AHMC Anaheim Regional Medical Center must be reported.
- You can report personal or witnessed sexual harassment to your supervisor, Human Resources, or another member of the management team. If the harasser is your supervisor, you can report it to an appropriate member of the management team.
- The complaint can be verbal, in person, through telephone, letter, email, fax, or other method of communication. All complaints and investigations will be kept confidential to the extent possible under the circumstances. If an investigation confirms that a violation of this policy has occurred, AHMC Anaheim Regional Medical Center will take appropriate, corrective action, including discipline up to and including immediate termination of employment.
- At no time, and under no circumstances, will there be any retaliation or reprisals against those who make complaints or who assist or cooperate in the investigation of the complaint.
- Any member of the management team who learns of any conduct violating the Non-Harassment Policy through any means must take appropriate action including filing a written report and seeing that the information is promptly processed and investigated. It is the responsibility of the management team to deal with harassing conduct, whether or not the victim complains.



#### **Workplace Violence Prevention/Employee Conduct**

- AHMC Anaheim Regional Medical Center supports a violence-free workplace. Acts or threats of physical violence including intimidation, harassment, or coercion which occur on any part of the hospital property will not be tolerated. Violations are considered misconduct and can lead to disciplinary and/or legal action as appropriate.
- All incidents of aggressive behavior must be reported whether they involve an injury or not. Call the Operator at 3737 and state "Code Gray" if you need immediate assistance.
- The presence of a weapon is a code silver and should be called to the operator as soon as possible.

- Signs of violent behavior are loud, angry speech, pacing, and hitting the wall.
- Stand back from the potentially violent person and give them calm, clear, and quiet directions. Don't provoke the individual and attempt to de-escalate their emotions.
- Allow the person to verbalize their concerns. Listen carefully, and have another employee call security.
- All employees are responsible in maintaining a workplace free of violence. Employees must not engage in threats or physical actions that create a security hazard for others in the workplace and must immediately report concerns or observed incidents of violence to his/her supervisor or, in the absence of such supervisor, to Human Resources, Security or any manager, and when applicable, to the Police Department or other appropriate law enforcement agency.
- Manager must take immediate action to prevent violence by reporting any potential violence or reports of potential or actual threats or acts of violence to Security, Human Resources, or Risk Management, and when applicable to Police Department.

### De-escalation Techniques

There is a need to effectively defuse the anger of a patient, family, or visitor in a calm and professional manner. When a potentially violent situation threatens to erupt on the spot and no weapon is present, verbal de-escalation techniques are an appropriate strategy.

- Appear calm; centered and self-assured even though you don't feel it.
- Do not be defensive-even if the comments or insults are directed at you, they are not about you.
- Give the person undivided attention; be nonjudgmental; focus on the person's feelings, not just the facts; allow silence; and use restatement to clarify messages.
- Never turn your back for any reason, always be at the same eye level.
- Allow extra physical space between you – about four times your usual distance
- Do not point or shake your finger; Do not touch – even if some touching is generally culturally appropriate and usual in the setting.
- Do not get loud or try to yell over a screaming person.
- Do not argue or try to convince.
- Be aware of any resources available for back up. Know that you can always leave, or seek additional support as needed, should de-escalation not be effective.
- Dial 3737 & call Code Gray when needed.
- Be sure to debrief with coworkers, team members, or a supervisor after a major incident. Talking about it can relieve some of the stress and is also a good time to start planning for next time: what was done correctly, what could have been handled better, how could the response be improved the next time a similar situation occurs.



### **CONFLICT in TEAMS**

Conflict can occur in teams and it is important to know how to handle such situations when they occur. The two types of conflict we will address are informational and interpersonal.

- Informational conflict involves differing views, ideas, and opinions related to information. This is task-related and could involve disagreement about the best method to proceed with the plan of care.
- Interpersonal conflict stems from interpersonal compatibility and is not usually task related. This type of conflict tends to revolve around the team members themselves, not the actions or information. Tension, annoyance, and animosity are common and interactions can become very argumentative.



Attempts should be made to resolve both types of conflict before they interfere with work and undermine quality and patient safety. Informational conflicts left unresolved may evolve into interpersonal conflicts in the long run and severely weaken teamwork.

Disruptive behavior among staff is actively discouraged. ARMC maintains a strict policy (HR 207) prohibiting violent or assaultive behavior or threats of such behavior directed toward any person on ARMC property. Types of disruptive behavior include condescending language or voice intonation, impatience with questions, reluctance or refusal to answer questions or telephone calls, strong verbal abuse or threatening body language, and physical abuse.

All employees are responsible for following all directives, policies and procedures and for assisting in maintaining a safe and secure work environment. Employees must not engage in threats or physical actions that create a security hazard for others in the workplace and must immediately report concerns or observed incidents of violence to his/her supervisor or, in the absence of such supervisor, to Human Resources.

[**TeamSTEPPS** (Team Strategies and Tools to Enhance Performance and Patient Safety) was developed by AHRQ ( Agency for Healthcare Research and Quality) & DoD ( Department of Defence) as a team system to improve collaboration and communication within the system. It also helps with improving inter-departmental relationship/team work & communication thus improving the Patient Safety].

Two TeamSTEPPS tools can be used to address conflict in teams: the Two-Challenge Rule and DESC script.

- Two-Challenge Rule
  - The Two-Challenge Rule can serve as a method to advocate and assert for patient safety; but it can also be used as a conflict resolution strategy. When team members have different information, the Two-Challenge Rule can be used to bring up the differing information so it can be addressed.
- DESC script:
  - The DESC script can be used for both informational and interpersonal conflict but is most effective when conflict is of a personal nature.

#### **Conflict Resolution:** DESC Script

The DESC script can be used to communicate effectively during all types of conflict and is most effective in resolving interpersonal conflict. The DESC script can be used in situations involving greater conflict, such as when hostile or harassing behaviors are ongoing and safe patient care is suffering.

DESC is a mnemonic for:

D = Describe the specific situation.

E = Express your concerns about the action.

S = Suggest other alternatives.

C = Consequences should be stated.

Ultimately, consensus should be reached... DESC It!

There are some crucial things to consider when using the DESC script:

- Time of discussion.
- Work on win-win—Despite your interpersonal conflict with the other party, team unity and quality care depend on coming to a solution that all parties can live with.
- Frame problems in terms of personal experience and lessons learned.

- Choose the location—A private location that is not in front of the patient or other team members will allow both parties to focus on resolving the conflict rather than on saving face.
- Use “I” statements rather than blaming statements.
- Critique is not criticism.
- Focus on what is right, not who is right.

### A DESC Scenario

Let’s examine scenarios with conflict.

1. A nurse feels that a patient has abdominal distension and pain secondary to a distended bladder and needs an Intermittent Catheterization. The nurse follows the protocol and performs an intermittent catheterization. When the attending later realizes that the procedure was done without his order, he raises his voice to the nurse in front of other staff and the patient.

- How could the DESC script be used here?

Example Answer:

#### DESC:

- D** “I (nurse) am sensing that you (attending) are upset with me for doing an Intermittent Catheterization for your patient.”
- E** “When you question my judgment in front of others, it embarrasses me and makes me very uncomfortable. It also undermines my credibility with the patient.”
- S** “If you are concerned or have a question regarding hospital protocol, I would appreciate it if you would speak to me in private or to my Supervisor.”
- C** “A private conversation would be more beneficial to me because I would feel less embarrassed and would be able to ask questions and supply information. Can we agree to follow such a procedure if this were to occur again?”
2. Employee A, who works as per-diem, four weekend shifts a month. Employee B on the unit refused to answer a question about patient care. When asked about patient precautions, Employee B replied, “I don’t know what it means. If it’s there, I put it in my documentation”.

- How could the DESC script be used here?

Example Answer:

- D** “I (Employee A) am sensing that you (Employee B) are upset with me for asking about the patient precaution.”
- E** “Your answer makes me very uncomfortable and I feel I won’t be able to ask questions to you in future”.
- S** “If you are concerned or did not understand my question, I would appreciate if you would discuss that with me.”
- C** “I would appreciate from you a willingness to be open to questions and discussion in the future.



**Fatigue Management Plan (Policy Number: HR 215)**

**Impact of Fatigue** – inadequate amount of sleep or insufficient quality of sleep over an extended period of time:

1. Lapses in attention, memory and inability to stay focused
2. Compromised problem-solving
3. Slowed or faulty information processing and judgment
4. Diminished reaction time

**Contributing Factors to Fatigue and Risks to Patients and staff safety:**

1. Length of shift and extended work shift (more than 12 hours)
2. Work Schedules, e.g. working more than 3 consecutive 12-hour shifts without a day off
3. Quantity and quality of sleep

Except in the case of an emergency as declared by local, state, or federal authorities, or based on unit managers discretion if additional staff is needed to meet unit and patient safety needs, direct and indirect patient care employees will not be scheduled to work more than ten (10) eight-hour shifts, seven (7) twelve-hour shifts or 84 hours without at least 24 hours off to rest between shifts. Research has demonstrated that provider fatigue is associated with an increase in the risk of clinical errors and caregiver injuries.

**Strategies/Guidelines to prevent fatigue**

Suggested Strategies for Staff in Preventing Fatigue:

1. Get enough sleep (7- 8 hours of sleep each 24-hour period before you go to work).
2. Practice good sleep habits, such as relaxing pre-sleep routine, like yoga or reading.
3. Consider healthy life style choices, such as healthy diet, exercise, etc.
4. Prior to sleep time avoid food, alcohol or stimulants (such as caffeine) that can impact sleep.
5. Take your rest and meal breaks timely.
6. Do not work more than three consecutive 12-hour shifts without a day off.

Nurturing the Culture of Safety pertaining to Fatigue

1. All staff is encouraged to express concerns about fatigue to co-worker and immediate supervisors.
2. If staff do not feel that their concerns regarding fatigue are being heard and/or addressed; they should accelerate their concerns to their manager, director, Administrative House Supervisor, etc. (Chain of Command).
3. Leaders will support staff when appropriate concerns about fatigue are raised and take action to address those concerns, including but not limited to :
  - a. For staff that work extended shifts to support ARMC and for the safety of our staff; the organization will provide safe transportation home and return to facility.
  - b. Adjusting break time.
  - c. Reassess patient assignment.
4. Teamwork is strongly encouraged as a strategy to support staff who work extended work shifts/hours to protect patients from potential harm.

**Fatigue Management Steps:**

1. **F** - Focus on hand-off communication and high risk, complex procedures. Take extra steps to ensure patient safety!
2. **A** - Accept work assignments that give you ample sleep and/or nap time between scheduled work shifts.
3. **T** - Take your breaks on time.
4. **I** - Inform your immediate supervisor when you are struggling with fatigue, so that they can monitor critical tasks and complex patients with you to protect patients.

5. **G** - Get enough sleep (quantity and quality of sleep). Practice good sleep habits. Avoid food, alcohol, or stimulants that can impact sleep.
6. **U** - Utilize strategies for fighting fatigue, including but not limited to: engaging in conversations with others (not just listening or nodding); do something that involves physical action (even if it is just stretching); strategic caffeine consumption; follow double checks (two signature) on critical processes; other strategies that you have found to be effective for you to fight fatigue in the workplace.
7. **E** - Educate yourself about sleep hygiene and practice good sleep management to protect yourself and patients.

#### **Conflicts Of Interest & Disclosure (Policy Number: ORG 594)**

All individuals shall conduct business transactions with Third Parties in a manner that avoids conflicts of interest and the potential for personal gain. Managers and those who work regularly with Third Parties on the hospital's behalf shall annually report any actual or potential conflicts of interest by completing the Conflict of Interest (COI) Disclosure Form. In addition, any time a potential conflict arises; individuals shall complete a COI Disclosure form and seek guidance from the Corporate Compliance Officer before proceeding.

1. If any individual has any business, financial, or other relationship with any Third Party whereby the existence of that relationship creates a conflict of interest, the individual must disclose this relationship by completing the COI Disclosure form. The designated senior manager supervising the individual will review the COI Disclosure form and provide comments and/or recommendations regarding the disclosure. The Corporate Compliance Officer will be consulted to determine if an actual conflict of interest exists.
2. Leaders, as well as employees authorized to conduct business transactions with Third parties on behalf of ARMC must disclose annually any business, financial, or other relationships outside of ARMC with Third Parties which currently or in the future may conduct business. The annual disclosure will be submitted using the COI Disclosure form.
  - a. Employees subject to this policy must complete a disclosure within thirty (30) days of employment.

#### **Plan for the Provision of Patient Care (Policy: PCS: P-009)**

AHMC Anaheim Regional Medical Center leadership is defined as the Board of Directors, Executives, administrative staff and physicians in designated leadership positions. The leadership takes responsibility for delivering and ensuring that there is support for planning, directing, coordinating, and providing healthcare services. These services are based on an assessment of community needs and are developed with the objective to improve patient outcomes.

Effective leadership is inclusive and encourages staff participation in shaping the hospital's vision and values. The executive leadership team at AHMC Anaheim Regional Medical Center continuously develops leaders at every level who help to fulfill the hospital's values, mission, and vision, accurately assessing the needs of patients, and developing an organizational culture that focuses on continuously improving performance to meet these needs. To realize the hospital's vision and values, leadership plays a role in teaching and coaching staff.

Education and development of staff is consistent with standards of practice and competency requirements and is the joint responsibility of the individual employee and the hospital.



**Integration of patient care and support services:**

The importance of a collaborative multidisciplinary team approach, which takes into account unique knowledge, judgment and skills of a variety of disciplines in achieving desired outcomes, serves as a foundation for the plan for provision of patient care services. As such, patient care services are planned, coordinated, provided, delegated and supervised by professional care providers who recognize the unique age-specific, physical, emotional, and spiritual needs of each person. Patient care encompasses the recognition and treatment of disease, the promotion of wellness patient teaching, patient advocacy, spirituality, and research. Under the auspices of the hospital, medical staff, registered nurses and allied healthcare professionals and support staff functions collaboratively as part of a multidisciplinary team to achieve positive patient outcomes.

Anaheim Regional Medical Center has the capability to safely care for patients of all ages and diagnosis within the hospital scope of service and licensure. Anaheim Regional Medical Center **DOES NOT** have the capability to provide care beyond emergency medical stabilization for the following patient populations:

1. Pediatric Intensive Care
2. Pediatric patients 13 years and younger for outpatient surgery (excluding pregnancy and gynecological related conditions).
3. Pediatric patients 13 years and younger for admission (excluding pregnancy and gynecological related conditions).
4. Hyperbaric Treatment
5. Psychiatric patients
6. Burn Victims
7. Organ transplantation
8. Outpatient Dialysis

**Staffing for patient care:**

Staffing plans for patient care service departments are developed based on the level and scope of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately and competently provide the type of care needed.

The plan for staffing at AHMC Anaheim Regional Medical Center includes a patient classification system designed to establish the care needs of individual patients that reflect the assessment made by a registered nurse. This acuity tool provides for shift-by-shift staffing (for inpatients) based on the patient care requirements identified during the assessment. Also provided is a mechanism for ongoing assessment/monitoring to ensure the patient/family receives appropriate and timely interventions. (*Also see AHMC Anaheim Regional Medical Center policy "Patient Classification System (Acuity)"*).

**Chain of Command (Policy Number: ORG 573)**

The chain of command is a course of action involving administrative and clinical lines of authority that is in place to facilitate conflict resolution in patient care situations. It is used only in times when there are no other resources. Before initiating the chain of command, the employee must be familiar with the hospital's policies, procedures, and rules and regulations (Smalls, 2009).

1. All efforts are made to resolve concerns in a timely and direct manner with a positive outcome.
2. Peers may be consulted for guidance or information. Clinical Shift Managers/Leads in the patient care areas are consulted if peers are unable to resolve an issue related to patient care or organizational practice in any area of the hospital.
3. Organizational, Patient Care Services, and department policy manuals are utilized as references to clarify policies and practice.
4. Department Director/Manager/House-Supervisor or designee is consulted prior for initiating the chain of command. The Director/Manager/House-Supervisor or designee initiates the Chain of Command.

5. Concerns or unresolved issues are addressed through one or both of the following chains of command (administrative or medical):
  - a. Administrative Chain of Command:
    - House Supervisor/Department Director/Manager
    - Chief Nursing Officer
    - Chief Executive Officer
 (If Chain of Command is executed and requires contact with the next level of Administration, during non-business hours, contact is initiated by the House Supervisor.)
  - b. Medical Staff Chain of Command:
    - Attending Physician
    - Department Chair (or Sub-Section Chair when applicable)
    - Chief of Staff
6. The nature of some medical situations may dictate immediate action by the employee, such as contacting an available physician with appropriate expertise to question and act quickly on physician orders. In certain cases, the medical staff consultation policy may be required to be activated.
7. The Risk Manager and Patient Safety is consulted if the problem raises patient safety, risk, legal, or liability issues. In serious patient safety situations, this contact is made only after the patient's safety is assured.
8. Patient treatment and related physician orders provided through the Medical Staff Chain of Command are documented in the medical record.

#### **The Role of health care professional in Patient Advocacy**

Advocacy is a means of safeguarding good patient care. Patients may need extra support to express and secure their own choices for treatment, especially where the patient's choice may seem bizarre or not preferred by the clinical staff. Also, where patients are not medically trained an advocate could help clarify matters and keep them informed. It also presumes that the advocate is willing to represent the patient's needs as the patient perceives them fairly and without distortion.

Through the years the registered nurse often has been the first to recognize situations which are not in the best interest of the patient and to report these situations to persons who could effect change -- for example, to report a questionable drug or procedure order to the physician who wrote the order or to report an incompetent health care provider to a nursing supervisor. Some RNs have not recognized these as instances of patient advocacy and have wondered how it would be possible to be both patient advocate and valued employee. Reporting patient abuse is another example of patient advocacy. Some problems would be handled entirely within the nursing chain of command; others requiring medical staff or chain of command, such as whether an ordered treatment regimen is appropriate for the patient, would be referred for medical decision. Usually a staff would report a situation to an immediate supervisor, who would then have the responsibility to handle the problem appropriately.

If the reporting staff, after reporting abuse or any other situation, is not satisfied that the patient's interests are being safeguarded, the staff must pursue chain of command and if still not satisfied, may report it to the Joint Commission. The healthcare professionals have the duty to promote what is best for the patients, ensure patient's needs are met, and to protect patient's right.



## LIFE SAFETY

### Emergency Response Codes

- *In the event of any emergency, remain calm.*
- *Dial “3737” from any telephone. **DONOT** dial “0” for operator.*
- *State “CODE.....” (Blue, Red, etc.) and room number or location.*

<b>CODE RED</b>	FIRE
<b>CODE BLUE</b>	ADULT MEDICAL EMERGENCY
<b>CODE GREEN</b>	ED EXPECTING EMERGENCY
<b>CODE WHITE</b>	PEDIATRIC MEDICAL EMERGENCY
<b>CODE PINK</b>	INFANT ABDUCTION
<b>CODE PURPLE</b>	CHILD ABDUCTION
<b>CODE YELLOW</b>	BOMB THREAT
<b>CODE GRAY</b>	COMBATIVE PERSON
<b>CODE SILVER</b>	PERSON WITH WEAPON OR HOSTAGE SITUATION
<b>CODE ORANGE</b>	HAZARDOUS MATERIAL SPILL

<b>CODE TRIAGE EXTERNAL:</b>	EXTERNAL DISASTER
<b>CODE TRIAGE INTERNAL:</b>	INTERNAL DISASTER
<b>CODE Z:</b>	INJURY ON PREMISES
<b>CODE S:</b>	STROKE TEAM
<b>CODE ID:</b>	INFECTIOUS DISEASE Example: Ebola, Anthrax
<b>CODE RBC</b>	OBSTETRIC Hemorrhage
<b>CODE STEMI</b>	INHOUSE CODE STEMI
<b>ED PRE SAT NOTIFICATION</b>	ED impacted with patients and admits. <b>ALL departments RESPOND!!!</b>
<b>RAPID RESPONSE TEAM</b>	Patient deviates from baseline “ <b>SOMETHING NOT QUITE RIGHT</b> ”

### Occupational Employee Health Services: (EHS)

1. Personal Protective Equipment (PPE) is designed to provide hospital personnel with appropriate barriers as additional protection against occupational exposure to blood borne pathogens. PPE includes gloves, fluid resistant gowns, masks, protective eyewear, and ventilation devices that prevent direct physical contact with patient body fluids when worn. Other safety equipment such as safety needles and safety scalpels provide protection against injuries when the safety device is activated after use.
2. Hepatitis B vaccination - The hospital provides, at no cost, the Hepatitis B vaccination to all employees determined to be at risk of occupational exposure to blood or body fluids in the performance of their job duties.

3. Post-Exposure Evaluation and Follow-Up - Hospital personnel having a specific eye, mouth or other mucous membrane, non-intact skin, or needle stick exposure to blood or body fluids inform their immediate supervisor and fill out an Employee Accident Form.
4. Tuberculosis Control Program - To prevent the transmission of infectious tuberculosis within the hospital through the early identification, isolation, and treatment of patients with Mycobacterium Tuberculosis. The hospital has a tuberculosis control program which addresses screening, identification, and proper isolation.
5. Annual Influenza Vaccine - Influenza vaccine will be offered annually to employees and others according to current national recommendations to reduce the transmission of influenza in the work place. **All direct care givers will be required to wear a mask from November 1<sup>st</sup> to March 31<sup>st</sup> if a flu vaccine is declined.** Influenza vaccination of employees will be indicated by a sticker on their work badge.

### AHMC ANAHEIM REGIONAL MEDICAL CENTER SAFETY PROGRAMS

#### Training of Employees

Training will be provided as follows:

1. For all new employees upon hire.
2. Whenever an employee is given a new job assignment for which training has not previously been provided.
3. Whenever new substances, processes, procedures, or equipment that represent a safety or health hazard are introduced into the workplace.
4. Whenever the hospital is made aware of a new or previously unrecognized hazard.
5. Whenever the hospital or the Program Administrator believes that additional training is necessary.

#### ASSESSMENT OF UNSAFE CONDITIONS AND PRACTICES

##### Periodic Scheduled Inspections

The Environment of Care Committee makes general safety and hazardous material inspections of the entire hospital on a continuing basis. The inspections are scheduled so as to completely cover the hospital twice per year, as required.

All discrepancies are recorded and sent to the department head and also to the department responsible for making corrections. The Environment of Care Committee Manager maintains all inspection documents. Results are discussed at the Environment of Care Committee meetings.

##### Sharps Injury Prevention Program

In accordance with AB 1208, CAL OSHA Amendment to the Blood-Borne Pathogen Standard (Effective August 1, 1999) AHMC Anaheim Regional Medical Center utilizes *Administrative Controls*, *Engineering Controls*, and *Work Practice Controls* to reduce/prevent sharps injuries to our employees. This includes but is not limited to:

- Proper use of specific devices used for:
  - IV catheter insertion
  - Injection Devices
  - IV delivery systems

In order to minimize injury from sharps it is expected that all healthcare providers will activate the safety device and dispose of used sharps in the sharps container provided by AHMC Anaheim Regional Medical Center.



**Sharps Injury Log**

AHMC Anaheim Regional Medical Center has established and maintains a Sharps Injury Log, which is a record of each exposure incident involving a sharp. The exposure incident shall be recorded on the log within 14 working days of the date the incident is reported to the employer.

**New Devices**

New devices will continue to be evaluated and selected in an ongoing effort to further reduce sharps related injuries. Education related to new devices will continue to be mandatory for all healthcare providers at AHMC Anaheim Regional Medical Center.

**Injury & Illness Prevention Program**

AHMC Anaheim Regional Medical Center is firmly committed to maintaining a safe and healthy working environment. To achieve this goal, AHMC Anaheim Regional Medical Center has developed and implemented a comprehensive Illness & Injury Prevention Program. This program is designed to prevent workplace accidents, injuries, and illnesses. A complete copy of the program is maintained in the Safety/Disaster Manual. A copy of the relevant portions is provided to employees at the time of orientation and to current employees at the time of implementation of the program.

**In the event of a work-related injury:** Report the injury to your **supervisor** immediately, then to Employee Health, and complete the Injury Report Form. Contact House Supervisor during non-business hours. Appropriate investigation and treatment will be provided as needed.

## BACK INJURY PREVENTION

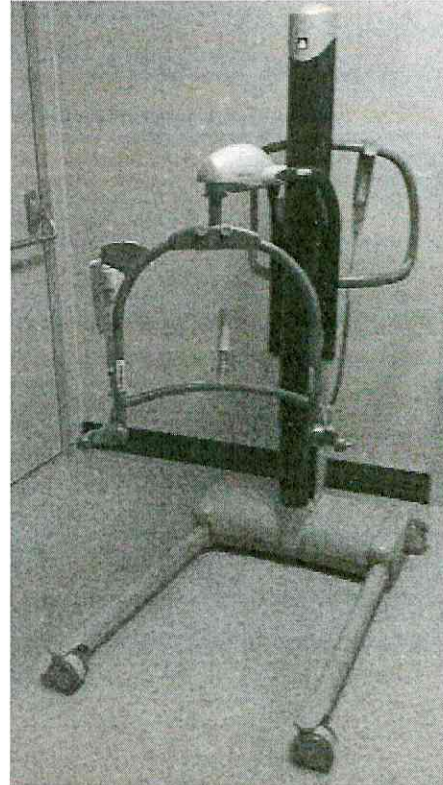
### Prevention of back injuries

Back injuries continue to have one of the highest rates of preventable injuries amongst healthcare workers. **In order to minimize the occurrence of back injuries at ARMC a mobility coach program** has been initiated which incorporates the use of lift equipment to safely move patients. The equipment includes a **SARA STEDY** mobility device and a **MAXI-MOVE** lift device.



**ARJO SARA STEDY**

**ARJO MAXI-MOVE**



All patients that are admitted into hospital are to be assessed for their ability to mobilize and if required, which equipment would be best suited for them during their hospital stay.

The SARA STEDY is an unpowered device that provides mobility for patients that may be unsteady on their feet but retain enough upper body strength to be able to support themselves when moved around in the device. **The maximum weight the SARA STEDY can hold is 400 pounds.**

The MAXI-MOVE lift is a battery powered total lift device for patients that have limited or no mobility. The lift uses a disposable FLITE (sling) that can be obtained from central supply and can be used for the duration of the patient's hospital stay. The MAXI-MOVE can lift a patient from the ground to bed height as well as being able to either recline the patient or sit them up. **The maximum weight the MAXI-MOVE device can hold is 500 pounds.**

All patient care staff are required to obtain competencies on use of all devices and responsible to use the devices when required for their own safety and that of the patient. Any person that is competent with the use of all devices can educate someone who has not obtained competency if no one available; contact your manager to arrange for an in-service and to obtain competencies with these devices.



## Good Body Mechanics for Health Care Workers

At work, you perform many tasks every day that could cause back injury. These include repetitive lifting, prolonged standing, bending, reaching, pushing, and pulling. Protect your back by using good body mechanics to maintain the 3 natural curves of your spine.

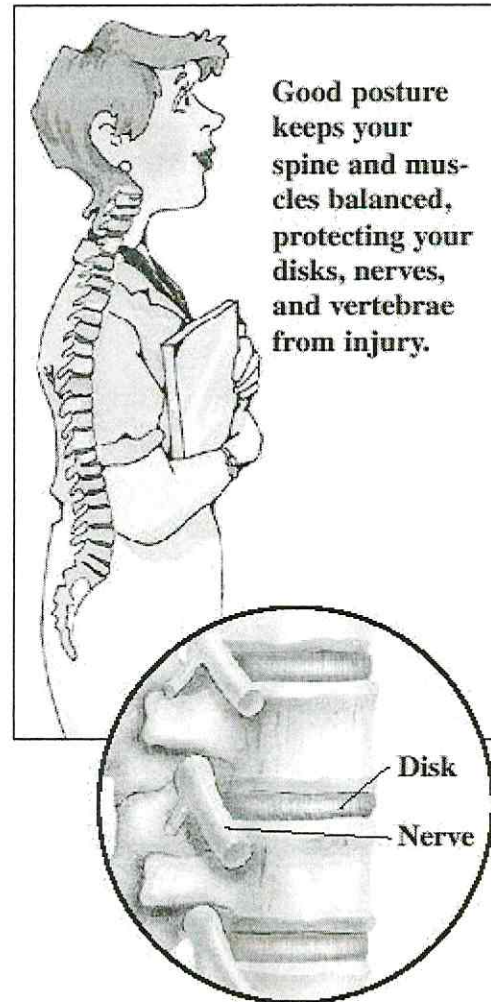
### A Balanced Spine

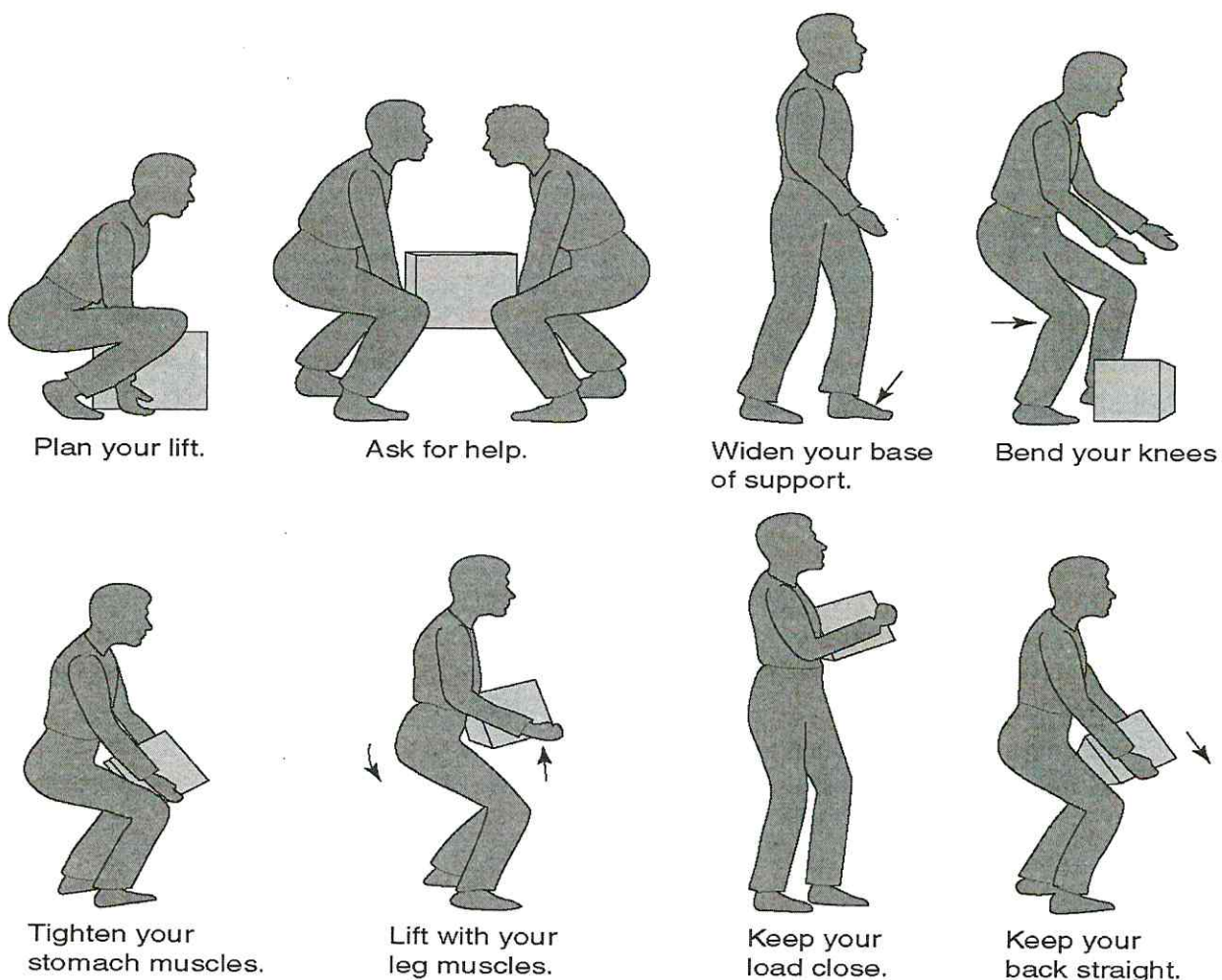
- A balanced spine is made of bones (**vertebrae**) and pads of cartilage (**disks**) arranged in 3 natural curves.
- Your neck (**cervical curve**) supports your head. And your middle back (**thoracic curve**) is supported by your rib cage.
- Your lower back (**lumbar curve**) carries more than its fair share, balancing your entire upper body. This extra load and the mobility of the lumbar curve make it the most susceptible to injury.

### Using Good Body Mechanics

Moving your body correctly is a skill that requires your constant attention. How well you perfect the skill can mean the difference between a fatigued or injured back and a healthy back. Below are a few tips to help you use good body mechanics:

- Hold loads close to your body to minimize the effect of their weight.
- To prevent twisting injuries, move your torso — from your shoulders to your hips — as 1 solid unit.
- Keep your knees bent to make your legs work harder, reducing the stress on your back.
- Avoid quick, jerky movements.
- Tighten abdominal muscles to help support your movements





#### Pushing or pulling:

- Use the weight of your body to help push the object.
- Tighten your abdominal muscles to protect your back.
- Your feet should be apart as in the standing position.
- Keep your back straight.
- Lower your body to get close to the object. Bend from your hips and knees. **DO NOT** bend at the waist.
- If the object or person you are pushing is too heavy, ask someone to help you.
- Always try to push heavy loads, not pull.



#### Computer Workstation-Good Working Positions

To understand the best way to set up a computer workstation, it is helpful to understand the concept of neutral body positioning. This is a comfortable working posture in which your joints are naturally aligned. Working with the body in a neutral position reduces stress and strain on the muscles, tendons, and skeletal system and reduces your risk of developing a musculoskeletal disorder (MSD). The following are important considerations when attempting to maintain neutral body postures while working at the computer workstation:

- *Hands, wrists, and forearms* are straight, in-line and roughly parallel to the floor.



- *Head* is level, or bent slightly forward, forward facing, and balanced. Generally it is in-line with the *torso*.
- *Shoulders* are relaxed and *upper arms* hang normally at the side of the body.
- *Elbows* stay in close to the body and are bent between 90 and 120 degrees.
- *Feet* are fully supported by the floor or a footrest may be used if the desk height is not adjustable.
- *Back* is fully supported with appropriate lumbar support when sitting vertical or leaning back slightly.
- *Thighs* and *hips* are supported by a well-padded seat and generally parallel to the floor.
- *Knees* are about the same height as the hips with the *feet* slightly forward.

Regardless of how good your working posture is, working in the same posture or sitting still for prolonged periods is not healthy. You should change your working position frequently throughout the day in the following ways:

- Make small adjustments to your chair or backrest.
- Stretch your fingers, hands, arms, and torso.
- Stand up and walk around for a few minutes periodically.

#### ▪ Upright Sitting

*Upright sitting posture.* The user's torso and neck are approximately vertical and in-line, the thighs are approximately horizontal, and the lower legs are vertical.

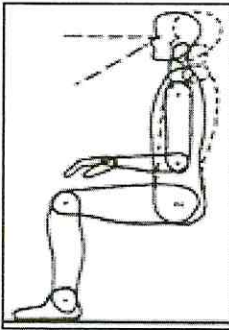


Figure 1. Upright sitting posture



Figure 2. The user's torso and neck are approximately vertical and in-line, the thighs are approximately horizontal, and the lower legs are vertical.

## ■ Standing

*Standing posture.* The user's legs, torso, neck, and head are approximately in-line and vertical. The user may also elevate one foot on a rest while in this posture.

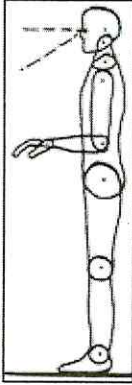


Figure 3. Standing posture



Figure 4. The user's legs, torso, neck, and head are approximately in-line and vertical.

### Hazardous Drugs

Medications are used within the hospital that may represent different risks to all hospital personnel. These medications may exhibit any one of the following characteristics:

1. Carcinogenicity – causes cancer
2. Teratogenicity or developmental toxicity – will affect a developing baby
3. Reproductive toxicity – will affect an individual's ability to father or conceive a baby
4. Organ toxicity at low doses – will affect a specific organ
5. Genotoxicity – damages the DNA of a cell which may cause heritable mutations
6. Structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria

In order to safely deal with these medications they have been divided into risk categories and are labeled if they represent one of the following:

1. High Risk
2. Low Risk
3. Reproductive Risk

**High risk medications** are medications that may be considered carcinogenic or cause organ damage.

**Low risk medications** still have some risk associated, but the risk is significantly lower than high risk medications.

**Reproductive risk medications** affect individuals who are trying to conceive, are pregnant or are breast feeding.

A Reproductive-category employee may request modifications in assignments or transfer to an area where there is no exposure to hazardous drugs.

### **Precautions**

The following precautions apply to hazardous medications:

- Safety needles are used whenever possible
- Personal Protective Equipment (PPE) comprising of face protection, gown and nitrile gloves is used whenever possible and disposed of after use. Hand washing is performed before and after administration of drugs as well as when gloves are changed. PPE is used when handling body wastes and fluid of patients receiving hazardous drugs for 48 hrs after administration.



- Low –risk hazardous drugs: For regular employees, no specific precautions are required if the drug is maintained in its original manufacturer-supplied container.
- Use of nitrile gloves for reproductive category employees is recommended for routine administration of drugs regardless of their hazardous classification
- Warning sign is posted inside patient room for a minimum of 48 hrs after administration for patients receiving high-risk hazardous drugs. Signage reads “CHEMO 48 HOURS”.
- Hazardous waste is disposed of in yellow hazardous waste bins labeled “CHEMOTHERAPY WASTE”.

## FIRE SAFETY

### Code Red/Fire Safety

A Code Red is paged over the intercom system to indicate a fire within the hospital.

You are part of a team sharing responsibility for the safety of patients, visitors, and hospital staff. Your individual actions as part of the team effort could make the difference between life safety and disaster. In order to handle the tasks that will be required of you in a fire emergency, you must recognize and accept your responsibility for yourself and others with regard to fire safety.

In case of fire, it is very important to prevent panic. Never shout "FIRE!". Be calm and reassuring and remain in control. You can accomplish this by knowing your unit specific fire emergency plan, your assignment, cooperating fully in fire drills, and by participating in the fire drills.

### Priorities in any Emergency

1. Save lives
2. Prevent injury
3. Treat injury
4. Save property

### Fire in a Patient Area

In case of fire, all employees must:

- Remove the patients from the fire area.
- Close patient 's doors
- Sound the alarm
- Call 3737 to alert of a fire. PBX will call 911 when applicable.
- Extinguish the fire, if safe to do so



### Important Locations You Need to Know

- Fire extinguisher in your department
- Closest fire-alarm pull station
- Evacuation routes
- Fire doors and walls
- Next safe fire zone (smoke compartment)

### Important Facility Conditions to Maintain

- Keep emergency exits, fire-fighting equipment, and fire-alarm pull stations clear at all times.
- **Never** put door wedges under doors that prevent doors from closing.
- Keep doors closed unless they are controlled by an electromagnetic system.
- Keep all corridors and exits clear of all unnecessary traffic and/or obstruction.
- Keep telephone lines clear for fire control.

Your role at a fire's point of origin and away from a fire's point of origin:

- At fire's point of origin, remove patients from the fire area and close all patient room doors.
  - Away from the point of origin: close all doors, free hallways from clutter, calm patients, and await specific instructions.
1. **Safety of life:** If fire or smoke is discovered, remove any threatened person and close the door. Turn off any oxygen equipment at wall outlet (if time permits).



2. **Notification:** Dial 3737, report the fire and location, and pull the closest fire alarm. The order depends on which is the quickest; **do that first**. When calling the operator, state "this is (GIVE YOUR NAME) reporting a **CODE RED** in (STATE THE EXACT LOCATION). Repeat twice.
3. **Extinguish the fire:** Use a fire extinguisher if the fire is small and can be extinguished safely.
4. **Relocate/evacuate,** as necessary, to an area past at least one set of fire doors.

### Preplanning for a Fire Emergency

1. Take fire drills seriously. Repetition reinforces the correct response to a fire.
2. Sound the alarm at the first hint of smoke or fire - no guesswork!
3. Learn fire alarm pull station locations. Know how to find them in the dark.
4. Learn to operate extinguishing equipment. Know how and when to help patients to safety.
5. Know your assignment in a fire emergency.
6. Observe and promote smoking regulations.
7. Challenge the presence of unauthorized persons in restricted areas.
8. Look for and report electrical hazards or equipment that is not functioning properly.
9. Keep your area clean and neat.
10. Wash any oil or grease off your hands before touching oxygen equipment or controls.
11. When using portable units, fasten cylinders securely in an upright position in a rack or on a cart.

### Fight the Fire

Follow the **5-Second Rule:** Fight the fire, if you can *safely* put the fire out within five seconds without leaving the room. Methods you can use are:

- Smother flames with a mattress pad, blanket, or coat.
- Smother a pan or trash fire with a cover.
- Use water from a pan, bucket, pitcher, etc.
- Unplug electrical equipment.
- A fire extinguisher (that you brought to the fire in response to the Code Red).



### Extinguishers

#### CLASS TYPE OF FIRE

- |   |  |
|---|--|
| A | Ordinary combustibles (wood, paper, cloth, plastic, rubber = water extinguisher            |
| B | Flammable liquids (gasoline, acetone, alcohol, fuel, oil, grease) = Carbon dioxide (B & C) |
| C | Electrical (fires that involve energized electrical equipment)                             |

Avoid using water where live electrical wires or equipment are involved. Unplug the equipment. By law, any evidence of a fire must be reported. Notify your supervisor or the nursing supervisor immediately if there is smoke or flames.

### Smoke Compartments

Your department's evacuation plan, posted **next to every fire pull station**, outlines the floor plan of your department, including the location of your department's automatic fire doors in the corridors, which define smoke compartments. These are important to locate, since patients will need to be moved beyond them if you are instructed to move them due to a fire. Remember, smoke compartments prevent smoke or fire from spreading for up to two hours.

**Fire Prevention**

The main danger is smoking. Everyone, including patients, visitors and employees, must cooperate with smoking regulations.

**Flammable Liquids**

Know the liquid you are using, read label warnings, and follow instructions. Most liquid vapors are flammable. Vapors are usually heavier than air. They can travel unexpected distances with air currents or by flowing across the floor. Ventilate the area; do not smoke; avoid sparks, heat, and flames. Use these liquids in small amounts in the work area. Containers should be clearly labeled.

Store or dispose of containers per strict regulations. Never throw them into regular trash and do not pour waste into water drains. Store cloths soiled with flammable liquids in covered metal containers.

The use of **Sterno canisters** for heating of food during catered events may pose as a fire hazard.

**What do you need to know?**

- No combustible materials (paper, basket, decoration, etc.) may be placed within six inches of a burning fuel container
- Do not move a chaffing dish with a lit sterno
- Be aware of the nearest fire extinguisher
- Never use water on a sterno gel fuel (water may actually spread a fire)
- Do not leave a room unattended when sterno is in use
- Let the catering staff know when a meeting is over so they can extinguish the sterno promptly
- For questions contact, MOB Kitchen x 3826 & Other locations x 6012

**Oxygen Safety**

Oxygen does not burn, but it is part of the combustion process. It causes flammable materials to ignite more readily and burn faster. This is especially true if the oxygen has pre-saturated the combustible material in advance of ignition.

1. Avoid sparks or flames.
2. Post "NO SMOKING" signs outside doors and at patient locations.
3. Remove all patient smoking materials. Caution visitors and others not to smoke.
4. Keep flammables away from oxygen.
5. Use nonflammable liquids for backrubs, disinfectants, etc. Avoid using oil, lotion, alcohol, or other flammable substances.

**IN ORDER TO ENSURE THAT THE OXYGEN ZONE VALVES ARE SHUT DOWN IN AN EMERGENCY WITHOUT COMPROMISING CARE TO PATIENTS OR OTHER AREAS OF THE HOSPITAL, ONLY THE NURSING SUPERVISOR OR CLINICAL SHIFT MANAGER IN CONJUNCTION WITH RESPIRATORY THERAPY MAY TURN OFF THE ZONE VALVES. ENGINEERING IS TO BE NOTIFIED.**



## Handling Utility Failures

### Utility System Management

Utility Systems are designed to keep the environment comfortable for employees, visitors, contract staff, and patients; however, sometimes these systems experience problems. When a disruption in a utility occurs, you must be familiar with procedures for maintaining a safe environment.

#### Utility systems include:

- Nurse Call System
- Telephone
- Paging System
- Beeper System
- Medical Gas System
- Vacuum System
- Domestic Water
- Steam
- Electricity with/without Emergency Power
- Natural Gas
- Dumbwaiters
- Air Conditioning
- Heating and Ventilation System

### Utility Failure

In the event of a utility failure, immediately notify Engineering, your supervisor, and Administration.

### Medical Gas Shut-Off

In the event of failure of the medical gas system, Engineering will shut off the main medical gas equipment. Nursing Administration or House Supervisor will shut off the equipment after hours

### Emergency Power

Generators:

- In the event of a loss of electricity, emergency generators become operational in 10 seconds or less.
- Essential patient-care equipment should be plugged into **RED** plugs for access to emergency power.
- **NEVER** turn red light switches off.

### If emergency generators should fail:

- Patients on ventilators will require manual "bagging,"
- Obtain a flashlight from your department's "Red Disaster bag".
- Respond to the most immediate patient needs.
- Make plans to obtain medical air and vacuum.
- Communication: Hand-held radios and/or cell phones can be delivered to patient care areas.

## Disaster Preparedness/Surge

When there is a disaster within the hospital or community, it is important that there is a plan in place that the hospital will use to operate when the disaster is declared. In order to be prepared to handle a disaster, AHMC ANAHEIM REGIONAL MEDICAL CENTER has adopted the **Hospital Incident Command System (HICS)**. HICS is a standard medical community disaster response. It provides predictability in the manner that the hospital will respond in any given disaster scenario. The medical community can be the community at large, the community and hospital, or just a section of the hospital. HICS provides for flexibility and so is a system that can be expanded or scaled back to meet the particular needs of a specific crisis.

The HICS module gives us:

- Responsibility-oriented chain-of-command
- Prioritization of duties with the use of Job Action Sheets
- Applicability to varying types and magnitudes of emergency events
- Thorough documentation of actions taken in response to emergency
- Expeditious transfer of resources (mutual aid) within a particular system or from one facility to another

It is important to understand that HICS is not the entire disaster plan; but rather the method by which the hospital will operate when a disaster is declared.

"Disaster" has been defined as: (1) any situation in which patients brought to the hospital for treatment are greater in number than can be handled by the use of normal facilities and staffing patterns, and (2) any situation in which the hospital's full-service capacity has been compromised by either internal or external events.

In the event that notification is received (by telephone, pager, ReddiNet, or any other reputable means) indicating that an incident has occurred that may compromise the hospital's capacity to provide service, the person receiving notification should proceed as follows:

1. Complete an Emergency Situation Report, obtaining as much information as possible. This can be found in your Emergency Preparedness Manual under the tab for Disaster Response Guide.
2. Forward the completed form to the highest-ranking administrative person on duty or their designee. This would be the Administrator during normal working days and house supervisor at other times.

Activation of the Hospital Incident Command System (HICS) has three levels:

**Triage Alert:** This alert level is to inform the employees that information has been received that the hospital may possibly receive a number of injured patients or suffer a loss of vital services (i.e., electrical power, water, telephones, etc.).

In the event of notification of a possibility of incoming patients or a possible disruption of services provided to the facility, the Administrator or designee shall instruct the PBX operator to page "**Triage Alert**". This is also to be transmitted to off-site clinics and services by whichever means is available.

All hospital staff, upon hearing the "**Triage Alert**" page, are to be aware of a possible code triage and are to remain available. No one is to leave without their manager's permission.

The person in charge of each department shall go to administration or the house supervisor's office to get necessary information as to what may or may not happen. Those off site will receive information by way of telephone, radio, or e-mail initiated by administration or the house supervisor.

**Code Triage:** This level is to announce immediate activation of the Hospital Incident Command System.



If the situation develops into an actuality, then the highest-ranking administrator on duty shall instruct PBX to page “**Code Triage**”.

The highest-ranking administrative person on duty, or their designee, will be responsible for establishing the Hospital Command Center, as Incident Commander, and will follow HICS protocol.

Upon activation of the plan, the Incident Commander (IC) shall notify all administrative personnel and any outside agency as deemed necessary.

The person in charge of each department, or their designee, shall report to the Hospital Command Center to turn in a completed Personnel Status and Patient Census/Damage Assessment Form and to get the necessary information as to the nature of the situation and shall take this information back to their department and disseminate.

**Code Triage - Decontamination:** This level is only used when we are on alert that multiple decontamination victims may be arriving and activates our **Mass Decontamination Unit**.

If we get word that a major disaster of a bioterrorism nature has happened in the immediate area, this mode will initiate our mass decontamination team into action. The parking lot will be blocked, the doors closed off, and the decontamination team will assemble and don protective equipment, and showers will be activated.

The Hospital Incident Command System will be set up and protocol followed. This will give the decontamination team a quicker response, eliminating the time it takes to report to the Incident Command post, find out the scenario, and return to the area of decontamination.

For further information on HICS, see the Emergency Preparedness Policy located in the hospital Safety/Disaster Manual.

Any employee wishing to participate on the decontamination team should contact Calvin Fakkema, Safety Officer/EOC & Emergency Preparedness Manager, at extension **3878**.

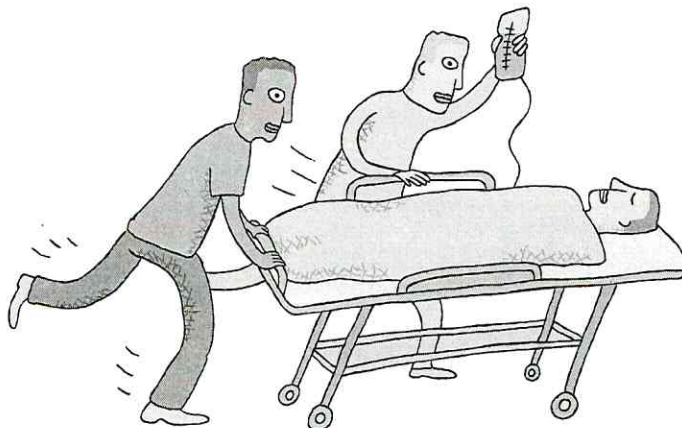
**DETAILED INFORMATION ON THE HOSPITAL’S EMERGENCY OPERATIONS PLAN CAN BE FOUND IN THE EMERGENCY PREPAREDNESS MANUAL IN EACH DEPARTMENT AS WELL AS THEIR DEPARTMENT SPECIFIC EMERGENCY PLAN.**

### **Biologic/Chemical/Radioactive Disaster Preparedness**

#### **BIOTERRORISM**

Bioterrorism is the deliberate release of pathogenic microorganisms (bacteria, viruses, fungi or toxins) into a community. The key to rapid intervention and prevention is to maintain a high level of vigilance. AHMC ANAHEIM REGIONAL MEDICAL CENTER has developed a coordinated bioterrorism response plan. An emergency will be handled using the Hospital Incident Command System (HICS). Drills and exercises will be conducted periodically to assess the level of staff preparation. The decontamination area is located on the loading dock, outside the Emergency Department, and Decontamination Trailer is on-site. Washing with soap and water is the single most important action should contamination occur. The detailed Bioterrorism Response Plan is located in the Emergency Preparedness Manual.

## EMERGENCY EVACUATIONS



**EVERYONE MUST BE ABLE TO UNDERSTAND THE PROCESS FOR EVACUATION.**

### WHAT IS AN EVACUATION?

Evacuation is movement either horizontally or vertically from a dangerous, or potentially dangerous, area to an area of comparative safety.

### WHO CAN ORDER AN EVACUATION?

The **Administrator, Administrator on call, Incident Commander, Safety Officer or sometimes even the Area Fire Marshall** may order evacuation of a particular area if conditions are life-threatening.

Hospital personnel in the vicinity of an incident requiring immediate life-saving action may order the partial evacuation of a particular area when conditions are life-threatening. The objective is to get patients and personnel to safe refuge areas.

### WHAT TYPES OF EVACUATION ARE THERE?

1. Partial - This is the removal of persons who are in the area of immediate danger to an area of relative safety. This could be to another unit or to the outside.
2. Horizontal - This is when all patients, personnel, and visitors in the affected area are moved laterally to the nearest safe area within the facility.
3. Vertical - This is when all patients, personnel, and visitors in the affected area are moved vertically to the nearest safe area within the facility.
4. Total - Evacuation of the entire facility.

### EVACUATION PROTOCOL

When evacuation notification is given, all employees assigned to the unit to be evacuated are to report to their immediate supervisor for assignment.

All patients to be evacuated are to be tagged with Disaster/Triage Tags.

During an evacuation of patient areas, patients should be prioritized for evacuation in the following order:

1. Patients in Immediate Danger; then
2. Ambulatory Patients; then
3. Wheelchairs; then
4. Bed-Bound Patients



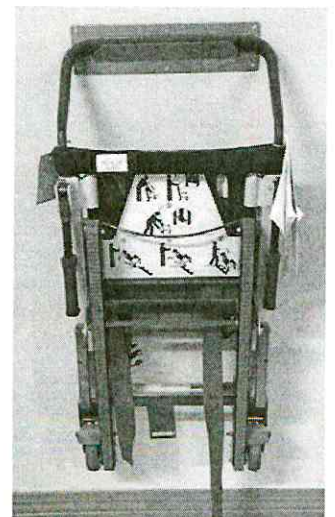
Non-ambulatory patients will be transferred in their beds. Follow posted evacuation routes to either the receiving unit, as instructed, or to the outside. If evacuation to the outside is necessary, as much as possible, and if safe to do so, evacuate patients to the designated triage area (see your Unit Specific Emergency Plan, Safety Plan, and Fire Plan).

The Liaison Officer or Incident Commander will contact the Medical Alert Center (MAC) and establish arrangements for the relocation of patients, as necessary. Hospital Command Center personnel will make the necessary arrangements for the transportation of needed food, linens, medicines, and medical equipment to accompany patients and personnel.

**KNOW YOUR ROUTES OF EXIT (SEE POSTED EVACUATION MAPS). WHENEVER POSSIBLE HAVE AT LEAST TWO WAYS OUT OF EACH AREA OF THE FACILITY. REVIEW YOUR UNIT SPECIFIC DEPARTMENT EMERGENCY PLANS IN CONJUNCTION WITH THIS MATERIAL.**

**EVACUATION - VARIOUS REMOVALS** – Refer to your **EMERGENCY PREPAREDNESS MANUAL** for details of each.

1. Carries for ONE PERSON:
  - A. Pack strap carry (face the head of the bed)
  - B. Hip Carry (face the patient)
  - C. Cradle drop (place blanket parallel to the bed)
  - D. Ankle roll (when the patient is found face-down on the floor)
  
2. Carries for TWO PERSONS (The person at the patient's head gives the commands.)
  - A. Swing Carry
  - B. Extremity carry
  - C. Evacuation Chair – one available on each floor above the first floor.
  - D. Evacuation Sling available in each Red Disaster Bag.
  
3. Carries for THREE PERSON (The tallest at the head, shortest at the foot)
  - A. First rescuer – One arm under the patient at the shoulder, other under just above the waist.
  - B. Second rescuer one arm under the patient at the waist and the other at the upper thighs.
  - C. Third rescuer one arm under the patient just above the knees, the other at the ankle.
  - D. Evacuation Chair – one available on each floor above the first floor.
  - E. Evacuation Sling available in each Red Disaster Bag.



Evacuation Chair

# Medical Equipment Safety

## Electrical Safety

### Basic Rules:

1. Know how to operate each piece of electrical equipment before using it.
2. Verify that all equipment used in patient care areas has hospital-grade (HG) plugs on power cords. These plugs have a green dot and three pins in the plug.
3. **Essential patient-care equipment** should be plugged into **RED** plugs for access to emergency power.
4. Check power plugs and cords before turning on equipment. Damaged equipment should not be used, should be labeled “Do Not Use” or “Defective”, and should be reported to Biomed.
5. Turn equipment “OFF” before removing the plug from the outlet.
6. Always pull the plug, NEVER the cord, to disconnect equipment from an electrical outlet.
7. **Do not use extension cords.** We are not allowed to alter any cords due to the UL listing.
8. **Discourage patient-owned appliances. If absolutely necessary, call Biomed or Engineering to verify safety.**
9. Ensure that all patient-care equipment has a current “PM” sticker and verified patient-owned equipment has a “safety sticker” from Biomed.



## Always Report These Items to Engineering/Biomed

If any of the following conditions exists, **TAG** and remove equipment from service to the designated area.

Fill out the tag completely.

- The device has been dropped or shows physical damage
- Anyone who has received a shock on connection with its use
- Where there is evidence of overheating by smell or touch
- Any wire or power cord has frayed, worn, burned, or cut installation
- Any plug that is broken, bent, or loose
- Cables or connectors, broken or loose
- Switches, knobs, or controls that are broken or loose
- Switches, knobs, or other controls that do not consistently produce expected results

OUT OF SERVICE do not use	
Item	_____
Date	____/____/____ Shift _____
Department	_____
Person	_____
Extension	_____
Specifically What is Wrong	_____ _____ _____
<b>Must be Complete!</b>	
<small>CM-0009A00</small>	

## Malfunction of essential equipment

1. Weekdays from 6:00 a.m. to 4:30 p.m.
  - Remove and call Biomedical Department at ext. 3831.
2. Evenings (after 4:30 p.m. weekdays), Weekends, and Holidays
 

Nursing Units

  - Report to Lead Nurse/clinical coordinator, House Supervisor/manager
  - Identify affected equipment with Red trouble tag and notify BioMed’s voice mail at ext 3831.
  - If the medical equipment required emergency response after hours, call hospital operator and ask to page biomedical technician on call.
  - It is the responsibility of the department manager to forward Service and repair reports to the Biomedical Department.
3. Patient Incident
  - Equipment that contributes to, or is responsible for patient injury will require an Unusual Occurrence Report. Medical equipment that fails that result in serious injury or death to the patient must be treated as outlined in policy BME-02.11 *Corrective Maintenance/Repair*.



### Electrically-Sensitive Patient Areas

1. To avoid micro shock, **DO NOT** touch the patient with invasive intrathoracic conductors AND another person OR equipment case OR metal surface at the same time.
2. Report poor quality tracing on patient monitor screen.
3. When walking on static-forming carpets (if applicable), touch the metal bed frame before touching the patient.

### Pacemakers

1. Handle intracardiac pacer wire only during insertion and removal; wear surgical gloves.
2. Do not touch another person or any equipment item at the same time you handle pacer wires.
3. Place exposed pacer terminal in surgical glove and secure.
4. Use a fresh battery each time a pacemaker is used.
5. If the pacemaker isn't functioning correctly, change the battery or the pulse generator.
6. Remove the items in the room causing electromechanical interference [electric razors, cell phones, etc.] Check the ground wires on the bed and other equipment for obvious damage. Unplug each piece and see if the interference stops.

### Defibrillators

1. Defibrillators are checked every shift using the "USER" test mode.
  - If using paddles verify paddles are installed and pushed all the way into their holders on the side of the unit. If using hands multi function cable, it should be plugged into the unit.
  - When testing the unit, make sure to unplug and test in battery mode. Turn selector switch to Defib and set to **30 joules and press the charge button**.
  - Once charge ready tone sounds if using paddles simultaneously press and hold shock buttons (on both paddles) until discharge occurs. **If using multi-function cable, connect to test port (BLACK)**. Press and hold the shock button on the front panel of the defibrillator until discharge occurs.
  - The strip chart recorder will print a short strip indicating "TEST OK".
  - **All monitors are plugged in when not in use.**
  - **Refer to the testing instructions located in the binders on crash carts.**
2. Report the following to Bio Med:
  - Failed defibrillator tests.
  - Past due preventative maintenance (PM) checks.
  - Pitted paddles.
  - Damaged/cracked cables.
3. Safety Precautions:
  - Must use gel pads or conductive jelly with hard paddles
  - State all clear and make sure no one is touching bed or gurney.
  - Operator only to touch paddle handles during discharge.
  - Do not stand in puddles of liquid when discharging paddles.
  - Remove oxygen from the immediate area before discharging energy.
  - Use correct paddle placement.
  - Do not place paddles over lead wires, implanted devices or medication patches.
  - Place paddles at least four inches from pacemaker.



### Radiation Safety

1. You can encounter sources of radiation from imaging equipment, radioactive material and radioactive waste. Radiation can be found in areas of the hospital:
  - a. The Diagnostic Imaging Departments
  - b. CT Scanner
  - c. Nuclear Medicine
  - d. Mobile X-ray units (portable and c arms)
2. Universal symbol for radiation area
3. Radiation Hazard signs can be found on doors to the departments, hallways, and restricted work areas
4. Techniques used to reduce or prevent radiation exposure
  - a. Standard Precautions at all times
  - b. Time, Distance and Shielding
    - **Time** – less time you spend near a source the less exposure you will receive
    - **Distance**- the more distance you place between yourself and the source, the less exposure
    - **Shielding**- the more shielding that is worn or in place, the less exposure you will receive
  - c. **ALARA** – **A**s **L**ow **A**s **R**easonably **A**chievable. The principle of limiting the radiation dose of exposed person to levels as low as is reasonably achievable, economic and social factors being taken into account
  - d. Common Sense - Do not enter unauthorized areas



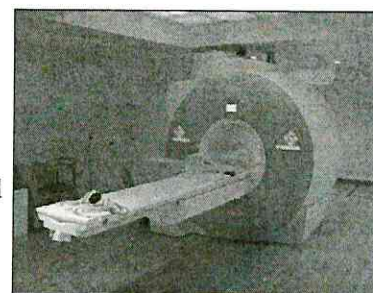
### MRI Safety

Inpatients:

1. The nursing unit completes an order in EMR.
2. The nurse completes the MRI safety check list.
3. The MRI technologist communicates with the nursing unit to arrange for an approximate time for the exam to be completed.

### MRI Environment and Zones

1. The MRI environment is divided into four zones:
  - Zone 1 – waiting room – unlimited access
  - Zone 2 – dressing room/holding area – limited access with staff supervision
  - Zone 3 – MRI control area adjacent to MRI scanner – limited access, authorized and trained personnel only – Patient access under direct supervision only.
  - Zone 4 – MRI scan room – limited access – Appropriately trained staff and appropriately screened patients under direct technologist supervision only



### Patient Screening

1. For an inpatient, the nurse or MRI technologist assists the patient to complete the form, and the patient signs the form. The form is brought with the patient to MRI. If an inpatient is unable to complete and sign the form, the patient's family, a physician who is most qualified to complete the information, or the nurse most qualified to complete the information will complete and sign the form.
2. For an emergency patient, the MRI screening form is completed in the Emergency Department by the patient, a physician, nurse or family member. If the patient is eligible for an MRI, the screening form is brought to the MRI area with the patient. The MRI technologist reviews the screening form before beginning the exam.



3. After the screening form is completed, the MRI technologist reviews the form and conducts a verbal interview with the patient to answer any questions the patient may have.
4. If the patient has any history of a potential ferromagnetic foreign object penetration, the patient is not to be allowed to enter Zone 4 until further screening and investigation is performed. The radiologist will make the final determination whether the patient qualifies to have an MRI exam.

#### **Accessories/Equipment in the MRI Environment**

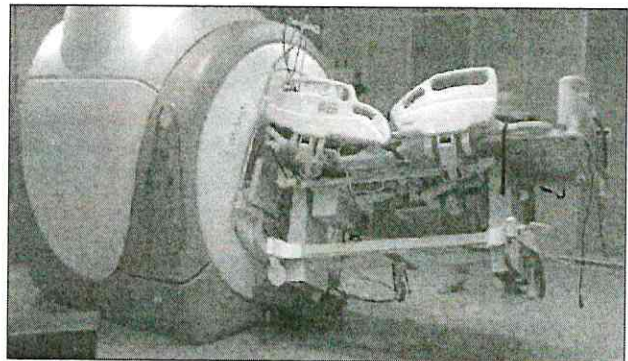
1. All equipment and accessories that enter the MRI environment must be made of non-ferrous materials:
2. Examples of unsafe equipment or accessories in the MRI environment are:
  - a. Stethoscopes
  - b. Life packs
  - c. Regular wheelchairs and gurneys
  - d. Watches
  - e. Wallets, credit cards
  - f. Any metal object
  - g. Cell phones
  - h. Jewelry
  - i. Clothing with metallic fasteners
  - j. Regular IV poles
  - k. Regular Oxygen tanks
  - l. Electrically conducive materials

#### **Hearing Protection for the patient**

1. All patients are offered and encouraged to use hearing protection prior to undergoing an MRI exam.

#### **Rapid Response Team (RRT)/Code Blue at MRI**

1. When a Rapid Response Team/Code Blue is required and the patient is in the MRI scanner:
  - Immediately stop scan process.
  - The MRI technologist removes the patient from the scan room on the MRI table and relocates patient to the in patient holding area and begins CPR.
  - The MRI technologist calls to other staff to report a RRT/Code Blue to the Operator.
  - The RRT/Code Blue cares for the patient in the inpatient holding area.
  - DO NOT quench the magnet.



## Security

To protect patient and staff safety, any unusual or suspicious behavior of a staff member, physician or any other individual, must be reported to an administrative representative immediately, for example, a House Supervisor, Department Director, Manager or CSM.

### Identification Badge

All employees, students, contract employees, volunteers, and vendors will wear a name badge at all times while in the facility. Badges are required for continual security of AHMC Anaheim Regional Medical Center. They ensure that personnel are authorized to be in the hospital.

- Visitors : Look for an AHMC-ARMC visitor bracelet
  - **PINK** for Tower 3 and Tower 5
  - **GREEN** for CVU, CVOU,DOU,ICU
  - **BLUE** for all other areas
- Security officers are available on all shifts. Security can be reached at ext. **5150**.
- Security provides escorts upon request if you are working late or alone
- All thefts are to be reported to the Security department immediately.
- Security officers are authorized to check all bags, packages or boxes brought in or taken from the hospital.
- Security tips include being aware of your surroundings, reporting the “out of place”, violence, and suspicious behavior, keeping your valuables safe, and knowing the CODES and how to report.
- When reporting an incident to Security, you should include the following information: Who (is involved), what (is happening), Where, and When.
- Be aware of telephone and email scams





## Hazardous Materials & Waste Management

### Code Orange - Hazardous Spills

The Spill Contingency Program provides a simple method for the hospital to prepare spill response actions. This is not intended as a disaster plan, but is directed toward smaller spills that can still pose substantial hazards to employees, property, or the environment. Hazardous spills may include chemicals or nuclear products.

Reporting Requirements: All spills should have internal reports completed and kept on file by the Safety Officer. Reports must show that proper action was taken to protect people, that clean up was done, and that the Safety Committee reviewed all actions taken.

When documenting any spill, information should include:

- Chemical(s) spilled,
- Cause of the spill,
- Injury report (name, nature and extent of injury, location of injured person at the time of the spill or leak),
- What first aid was provided and by whom,
- Additional medical aid given and by whom,
- Subsequent action (released from work that day, admitted to hospital),
- Damage to property or environment,
- Response actions taken and by whom,
- Clean up,
- Disposal.

### First Responder - Operations Level - Emergency Response Training

First responders at the operations level are individuals who respond to releases or potential releases of hazardous substances as part of the initial response to the site for the purpose of protecting nearby persons, property, or the environment from the effects of the release. **They are trained to respond in a defensive fashion without actually trying to stop the release.** Their function is to contain the release from a safe distance, keep it from spreading, and prevent exposures. First responders will have received at least eight hours of training and have demonstrated competency.

### How to Request SDS

#### **Online:**

To find any SDS online, go to the intranet home page for ARMC and under "ARMC LINKS" click on the SDS link. A new page will pop-up and from there you can search for any chemical in our hospital using the product name or type of chemical included in the product.

#### **Computer:**

To find any chemical on any computer in the facility, you may go to the U:Drive/Common/SDS to search through our inventory and search for any chemical by product name.

#### **Hard Copy:**

To find any SDS on any chemical we use in our facility, the Emergency Department keeps a Master Inventory in binders in ED1.

To request up to nine SDS: Call Toll-Free: 800-451-8346

To request more than nine SDS: FAX Request Form to: 760-602-8888

**DO NOT FAX EMERGENCY SDS REQUESTS - CALL IMMEDIATELY!**

To request a Safety Data Sheet (SDS), simply complete the SDS request form then call, fax, or mail to 3E Company (contact Engineering for information). To ensure your request is quickly processed, it is extremely important to provide as much of the following product information as possible:

- **Product name**
- **Manufacturer name**
- **Product number**
- **UPC code (if available)**

Please be as specific as possible when requesting an SDS for a product (e.g. Sherwin Williams, clear acrylic paint, #1303). Separate SDS are maintained for products that have even very minor differences from others (e.g. colors, aerosol vs. pourable, concentrated vs. ready-to-use).

#### **How to Receive the Requested SDS**

Upon completion of your SDS request, 3E can fax or mail directly to your facility or to whomever you have specified on your request form (e.g. a customer, client, hospital).

#### **Current SDS are Required by Law**

The Federal OSHA Hazard Communication Standard (29CFR1910.1200) requires that employers provide access to current Safety Data Sheets for all hazardous materials used by employees, and in some cases, customers. Your company, with the assistance of 3E Company, shall accomplish this through online access.

#### **24-Hour Safety Data Sheet Program**

Access by phone or fax to one of the largest SDS databases in the United States, making your business fully compliant with both the federal OSHA Hazard Communications Standard (29CFR1910.1200). The SDS library is constantly updated to ensure the most current SDS is available.

#### **24-Hour Spill & Information Hotline (800-451-8346)**

Expert hazardous material assistance in the event of an on-site incident, protecting employees and customers at all times.

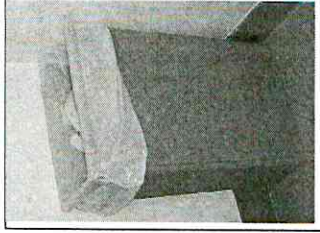



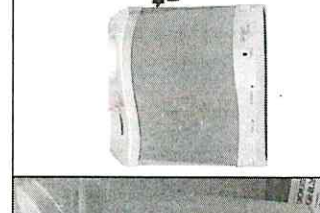

#### **24-Hour Exposure/Poison Control Hotline (800-451-8346)**

3E Company is affiliated with the University of California San Diego Regional Poison Center. Their physicians, toxicologists, and poison specialists are available 24 hours a day to handle exposure/poisoning calls with immediate and often lifesaving guidance.

#### **The Safety Data Sheet will contain 16 easy to read sections**

1. Identification of the substance or mixture and of the supplier
2. Hazard identification
3. Composition/information on ingredients Substance/Mixture
4. First Aid measures
5. Firefighting measures
6. Accidental release measures
7. Handling and storage
8. Exposure controls/personal protection
9. Physical and chemical properties
10. Stability and reactivity
11. Toxicological information
12. Ecological information (non mandatory)
13. Disposal considerations (non mandatory)
14. Transport information (non mandatory)
15. Regulatory information (non mandatory)
16. Other information including information on preparation and revision of SDS

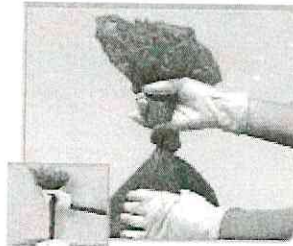


	<p><b>Regular Waste: Clear Bag</b></p> <ul style="list-style-type: none"> <li>• Empty medication vials without PHI, PHI covered or blacked out</li> <li>• Trash</li> <li>• Dressings</li> <li>• Chux</li> <li>• Diapers</li> <li>• Sanitary napkins</li> <li>• Gloves</li> <li>• Empty urinary bags and other Drainage bags</li> <li>• Disposable patient items</li> <li>• Empty IV bags, Piggyback bags/tubing without PHI *, PHI covered or blacked out (Ex. LR, dextrose, saline, glucose &amp; electrolytes can be poured down drain)</li> </ul>		<p><b>Biohazardous Waste: Red Bag</b></p> <ul style="list-style-type: none"> <li>• Blood and all Other Potentially Infectious Material (OPIM)</li> <li>• Blood tubing/ bags/ hemovaes/ pleurevaes</li> <li>• Intact glass or plastic bottles with bloody fluid or OPIM</li> <li>• Suction liners with bloody fluid or OPIM</li> <li>• Soaked/ dripping bloody dressings</li> <li>• All disposable items soaked or dripping with blood or OPIM</li> <li>• <b>When in doubt, use red bag.</b></li> <li>• * OPIM means, human body fluids; semen, vaginal secretions, CSF, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, and body fluid that is <b>visibly contaminated with blood</b>, and all body fluid in situations where it is difficult or impossible to differentiate between body fluids.</li> </ul>	<p><b>Sharps: Sharps Containers</b></p> <ul style="list-style-type: none"> <li>• All sharps</li> <li>• Example: needles, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples, wires</li> <li>• All empty syringes, tubex, carpulect or those with an un-pourable amount of medication</li> <li>• Trocars, introducers, guide wires, sharps from procedures etc.</li> <li>• Objects that are capable of penetrating skin or packaging materials</li> <li>• Use large volume sharps container if needed</li> </ul>	<p><b>Pharmaceuticals: Containers</b></p> <ul style="list-style-type: none"> <li>• Syringes, tubexes, carpulect with pourable meds</li> <li>• IV bags and tubing with pourable meds</li> <li>• Partially used or wasted prescription or over-the-counter medication</li> <li>• Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, ½ tablets, sponges soaked in liquid meds</li> </ul>	<p><b>Pharmaceuticals: Resource Recovery (RCRA)</b></p> <p><b>Hazardous RCRA Pharmaceuticals:</b></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Inhalers-return to pharmacy</li> <li>• Warfarin /Coumadin (include empty wrappers)</li> <li>• Insulin</li> <li>• Unused nicotine gum or patches, (include empty wrappers)</li> <li>• Unused/residual alcohol/acetone</li> </ul> <p><b>RETURN TO PHARMACY:</b> In zip-lock baggie and place in Pharmacy Out Box (Pharmacy will waste in black RCRA container in Pharmacy)</p>	<p><b>Chemo Waste: Yellow Box/Bag</b></p>  <p><b>Trace Chemo:</b></p> <ul style="list-style-type: none"> <li>• All supplies used to make and administer chemo medication</li> <li>• Example: tubing, empty bags/ bottles/ vials, syringes, pads, masks, wipes, contaminated gloves, gowns etc.</li> </ul> <p><b>RETURN TO PHARMACY:</b></p> <ul style="list-style-type: none"> <li>• All unused bulk (pourable) chemo in original pharmacy bag for credit or disposal</li> </ul>	<p><b>Cactus Sink Disposal:</b></p>  <ul style="list-style-type: none"> <li>• Narcotic patches (cut in half)</li> <li>• Example: Fentanyl patch</li> <li>• Partially used or wasted narcotics and/or controlled drugs</li> </ul> <p><b>Pathology Waste</b></p>  <p>Examples:</p> <ul style="list-style-type: none"> <li>• Tissue</li> <li>• Specimens</li> <li>• Body Parts</li> <li>• Placentas</li> </ul>	<p><b>Confidential: Shred-it-Bins</b></p>  <ul style="list-style-type: none"> <li>• ALL MATERIALS CONTAINING PHI* Must be disposed of in locked "Shred-It" Containers</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Handwritten or computer generated Paper</li> <li>• Wristbands</li> <li>• Labels, etc</li> </ul> <p>*PHI: Patient Health Information</p>
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### Category A Waste Handling & Packaging Procedures Guidelines for a Suspected or Confirmed Case of Ebola

- With a suspected or confirmed Ebola case immediately contact Infection Preventionist and follow the chain of command
- All waste generated from a suspected/confirmed patient should be treated as special Category A DOT waste as follows:
  1. Make sure you are utilizing all PPE and following all applicable guidelines as directed by the CDC
  2. Place soft waste or sealed sharps containers into a primary medical waste bag (min 1.25 or 1.5ml – ASTM tested; can be provided by Stericycle).
  3. Apply bleach or other virocidal disinfectant into the primary bag to sufficiently cover the surface of materials contained within the bag; securely tie the bag.



4. Treat the exterior surface of the primary container with bleach or other virocidal disinfectant.
  5. Place the primary bag into a secondary bag and securely tie the outer bag.
  6. Treat the exterior surface of the secondary bag with bleach or other virocidal disinfectant.
7. The double bagged waste should then be placed into special **Category A DOT Waste packaging/drums provided by Stericycle** with the liner tied securely and container closed per the packaging instructions provided. Label the special Category A DOT Waste with provided labels.
  8. Store the special Category A DOT Waste containers separate from other regulated medical waste in the room until Stericycle picks up.
- ❖ Stericycle recommends using disposable sharps containers for suspected/confirmed Ebola cases. The disposable container should be sealed and disposed of as special Category A waste following the instructions above. If a reusable sharps container is inadvertently used that container should also be sealed and disposed of inside the bags with the Category A waste.





## HIPAA/Confidentiality/Patient Rights

### HIPAA (Health Insurance Portability and Accountability Act of 1996)

All healthcare employees are obligated to protect patient privacy rights and PHI (Protected Health Information), including any patient identifiable information that is electronic, paper, oral, CD, diskette, or microfilm. Health Information Technology for the Economic and Clinical Health (HITECH) Act broadens the scope of HIPAA and more specifically defines use of PHI when applied to electronic health record (EHR).

- Employees may **NEVER** access or discuss patient information with anyone unless it is for an approved purpose and necessary to do your job. If you suspect someone is violating a privacy policy you should notify your supervisor immediately. “Think twice” before giving out any information; ask, “Is it necessary” and, “Is it reasonable?”

*Violation of confidentiality is subject to disciplinary action which can include termination.*

Any violation or non-compliance to HIPAA must be reported to your **supervisor** and the **facility Privacy Officer**. The ARMC Privacy Officer is Patti Spittler in Health Information Management (HIM) at ext. 6135.

PHI is (not limited to) name, street, city, state, zip code, names of relatives and employers, birth date, telephone or fax numbers, e-mail address, web URL, IP address, Social Security Number, medical record number, health plan beneficiary number, certificate, license number, any vehicle or device serial number, finger or voice prints, photographic images, any other unique identifying number, characteristic, or code. PHI may be paper records, electronic records, and faxed records. Talking to another individual about PHI is only permissible when carrying out their healthcare duty and when all attempts to maintain privacy have been done. Liability for misuse of PHI can fall on the provider/employee if a breach in this area occurs.

Key provisions of privacy practice standards include:

**Access to Medical Record:** Patients generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes. Patients may be charged for the cost of copying and mailing of the record which should be provided within 5 business days. Patients may request amendments to their written record but that is subject to approval by the covered entity and notifications of the amendments and changes must be retained.

**Notice of Privacy Practices:** Must be provided to the patient with every visit and must include how personal medical information will be used.

**Limits on Use of Personal Medical Information:** The privacy act does not restrict the ability of doctors, nurses, and other providers to share information needed to treat their patients. **Only those doctors, nurses and other health providers; responsible for the direct care of a particular patient are allowed to access that patient’s PHI.** In other situations, though, protected health information generally may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose.

**Protected Health Information Safeguards:** Healthcare providers are to make all efforts to safeguard PHI. **Screens should be LOCKED and charts are to be kept in racks when not in use.** This is to minimize access to information that might identify a patient. Likewise no medical records are to be left open or in any public area. Faxed PHI follows several safeguards as well. The fax number should be confirmed prior to faxing. A test page should confirm the recipient to be faxed to and when the information is faxed, a follow up call should confirm that the PHI has been received.

Patient information such as discharge instructions, reports, etc. are to be verified using two patient identifier. When a common printer is used, there is a possibility of mixing multiple patient information. **Ensure that**



**each and every page of the document is reviewed and patient identification verified before handing over documents to patient or family.**

**Prohibition on Marketing:** An individual's specific authorization must be obtained before disclosing their information for marketing. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.

**Confidential Communications:** Under the privacy rule, patients can request that their doctors, health plans, and other covered entities take reasonable steps to ensure that their communications with the patient are confidential. For example, a patient could ask a doctor to call his or her office rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.

Authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule must be obtained, by written consent from the individual concerned. Protected health information may be disclosed without an individual's consent if required by law.

**HIPAA Penalties:** While HIPAA regulations are federal, an individual may also be punished under state privacy regulations. Individuals may be punished for breaches of the regulations by state and federal authorities, so they may receive two fines for one breach. Penalties for violation of privacy regulations may involve fines, up to \$250,000, which will not be covered by practice insurance policies or by the employer. Penalties range from violations in which the offender didn't realize he or she violated as an individual, to organization wide violations of willful neglect and the organization has not revised its policies and procedures in order to address the violation. The Office of Civil Rights and the Department of Justice address HIPAA violations federally. State violations of privacy are enforced by the California Office of Health Information Integrity.

While HIPAA provisions can be restrictive, they are never intended to inhibit the provision of care to patients.

Patients receive a Notice of Privacy Practice, which is a required by law, to outline how their protected health information may be used.

## **PATIENT RIGHTS**

**The list of Patient Rights is given to all patients on admission.**

*Hospital policies, including patient rights and patient responsibilities, apply to all hospital patients including neonates, children, and adolescent patients, as well as to their parents and/or guardians.*

**Patients have the right to:**

1. Considerate and respectful care and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.
4. Receive information about your health status, course of treatment, prospects for recovery, and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or



- withdrawing life-sustaining treatment.
5. Make decisions regarding medical care and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
  6. Request or refuse treatment to the extent permitted by law; however, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.
  7. Be advised if the hospital/personal physician proposes to engage in, or perform, human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
  8. Reasonable responses to any reasonable requests made for service.
  9. Appropriate assessment and management of your pain, information about pain, pain-relief measures, and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.
  10. Formulate advance directives. This includes designating a decision-maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
  11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
  12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
  13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
  14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
  15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
  16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital. Upon your request, a friend or family member may be provided this information also.
  17. Know which hospital rules and policies apply to your conduct as a patient.
  18. Designate visitors of your choosing if you have decision-making capacity, whether or not the visitor

is related by blood or marriage, unless:

- a. No visitors are allowed,
  - b. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility,
  - c. You have told the health facility staff that you no longer want a particular person to visit. A health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.
19. Have your wishes considered if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household.
  20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.
  21. Exercise these rights without regard to age, sex, economic status, educational background, race, color, religion, ancestry, national origin, disability, medical condition, sexual orientation, marital status, or the source of payment for care.

File a grievance without fear of reprisal. If you want to file a grievance with this hospital, you may do so in writing addressed to the Risk Manager or by calling **(714) 999-6151**.

Your grievance will be reviewed and responded to promptly and in writing. If a grievance will not be resolved within 7 business days, the Hospital shall inform the patient in writing that the Hospital is working to resolve the grievance and will have up to 14 business days to come to a resolution and will follow up with a written response. The written response will contain the name of a person to contact in the Hospital, the steps taken to investigate the grievance, and the results of the grievance process. Grievances regarding an allegation of premature discharge are referred to the Director of Case Management or designee for review and response.

You may also contact the Joint Commission for Accreditation of Healthcare Organizations' Office of Quality Monitoring directly for concerns regarding the quality of care and patient safety at the hospital: Office of Quality Monitoring, Joint Commission One Renaissance Boulevard, Oakbrook Terrace, IL 60181

E-mail: [complaint@jointcommission.org](mailto:complaint@jointcommission.org)

Phone (800) 994-6610 8:30AM to 5PM Central Time

22. File a complaint with the Department of Health Services regardless of whether you use the hospital's grievance process. The Department of Health Services' phone number is: (714) 456-0630



## Population Specific Care

### Age Specific Concerns

- We consider the patient's age and developmental level in identifying special needs for assessment, care, procedures, communication, and safety. With age-specific care, each patient gets the individual care that he or she needs and deserves.
- We consider the patient's specific care and communication needs from *birth to end of life*.
- All attempts are made to accommodate a patient's religious and cultural background as this is an important part of the patient's healing.
- We involve the family in the care of the patient as far as is practicable. This is done by explaining the medical condition, treatments and procedures to the patient, with family present unless expressly indicated otherwise.
- Elderly patients have specific needs due to their current life stage, such as poor skin integrity, poor balance, and diminished sensory capacity. In order to address these elements requires the need for more specific care planning.
- Care is planned with emphasis on physical needs and quality of life to include special aspects of care toward the end of life.
- The care of the dying patient and their family will be focused on comfort and dignity as we recognize and respect the whole person in terms of the spiritual, psychological, physical, emotional, and cultural values and beliefs.



### **EMTALA (Emergency Medical Treatment and Active Labor Act)**

EMTALA defines an emergency medical condition as one where a patient presents with acute symptoms (including pain) of sufficient severity that in the absence of immediate medical attention could reasonably be expected to seriously jeopardize the patient's health or body functions, or cause serious dysfunction of any body organ or part. It also covers women coming to the ED in active labor.

- Passed by Congress in 1986 as part of comprehensive COBRA law
- To combat practice of "patient dumping"
- Requires hospitals to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay

Patient Dumping: Refusal to treat patients because of inability to pay, insufficient insurance, transferring or discharging patients due to high anticipated diagnosis, and treatment cost.

- When any patient presents to the ED (which is defined as coming to hospital property), you are required to provide a medical screening exam to determine the presence or absence of an emergency medical condition, regardless of the patient's ability to pay.
- If an emergency condition is found, then the hospital is required to stabilize the patient within the capability of the facility.
- The hospital may transfer the patient only when it is medically necessary or the patient requests. The medical necessity is defined as when a physician can certify that the benefits outweigh the risks. To transfer a patient, you must expect the patient stabilization to last through the transfer.
- "The 250 Yard Rule" is – Individual "**comes to the hospital's Emergency Department (ED)**" or elsewhere on hospital property. Hospital property refers to the main campus and any area within **250 yards** of the building including parking lots, sidewalks, and driveways. The hospital has the obligation to provide emergency response capabilities and call 911.
- A pregnant woman who presents in active labor must, for all practical purposes, be admitted and treated until delivery is completed, unless a transfer under the statute is appropriate.

#### **Know your obligation**

- To avoid penalties, hospitals must ensure that patients are appropriately attended, screened, prioritized, monitored, and prepared for transfer if appropriate.
- Potential violations of EMTALA can result in fines and malpractice suits.

#### **EMTALA's "D" RULES**

- Don't Delay
- Don't Deny Emergency Stabilization
- Don't Discriminate in providing Emergency Treatment
- Don't delay treatment of pain
- Document... Document... Document (e.g., Don't forget to document AMAs)



**BIOETHICS:****WHEN TO ASK FOR A BIOETHICS COMMITTEE REVIEW:**

- When conflicts have developed between the patient and the patient's family.
- When dilemmas make it difficult to decide how to proceed and/or a consultation might help.
- After you have used reasonable means to resolve the problem.
- NOTE: a physician, patient, family member, surrogate, health team member or other interested person may also request a case review. If a case review is to be performed, you will be contacted.

**HOW TO REQUEST A CONSULTATION:**

- A. Requests or concerns related to Bioethical issues can be referred by any staff member, patient, family, surrogate, agent or physician.
- B. ***The social worker is notified via an order or telephone call/page and will contact the Bioethics Chair to review the request and schedule the consultation.***
- C. The Medical Staff office will contact physicians from the Bioethics Committee to participate in the consultation.
- D. The Consultation Team includes representatives from the following disciplines; Medical Staff, Nursing, Risk Management, Social Services and Pastoral Care. The patient/family members may also attend as appropriate.
- E. All formal case consultations will be reviewed by at least three members to include one MD and one non-MD.
- F. The case should be reviewed and responded to within seventy-two (72) hours. The team may convene telephonically for emergent cases.
- G. A consultation form will be completed and submitted for the next Bioethics Committee review. Notes regarding the recommendations from the Committee will be entered into the Social Work Flow Chart notes.
- H. If someone other than the attending physician requests a review, the attending MD will be informed of the review. He/she will also be advised of any recommendation(s) the Consultation Team may make.

# INFECTION PREVENTION

Infection prevention is everyone's responsibility!

## DEFINITIONS:

**Infection** - a pathological condition produced by invasion of body tissues by micro-organism(s).

**Nosocomial Infection/Healthcare Associated Infection** - Nosocomial is derived from Greek roots meaning "In the hospital" or hospital acquired, so therefore a nosocomial infection is an infection that develops after admission to the hospital.

**HAND HYGIENE** - The single most important factor in preventing the spread of infection and/or disease is **effective hand washing and/or sanitizing.**



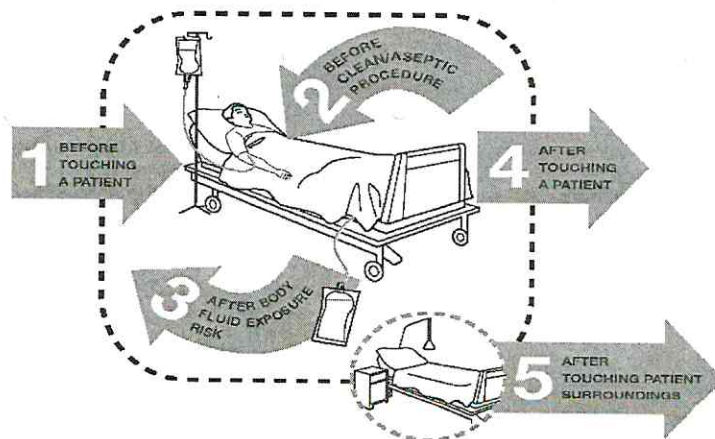
- Before patient contacts
- Before aseptic tasks
- After body fluid exposure or risk
- After contact with a patient
- After touching patient's surroundings
- After using the restroom
- Before eating



When washing your hands with soap and water, use warm running water and vigorous motion for a minimum of **15-20 seconds** per CDC, World Health Organization (WHO) and Department of Health Service requirements. When using alcohol based hand sanitizers **rub hands until dry.**

Hand Hygiene Reminder:

## Your 5 Moments for Hand Hygiene



Alcohol based hand sanitizers are not effective against *C. diff*. After caring for a patient with *C. diff*, hands are to be washed for 20 seconds with soap and water. Cleaning with Clorox 10% bleach wipes kills *C. diff* microbes within 3 minutes.



## ISOLATION PRECAUTIONS

At Anaheim Regional Medical Center, we follow transmission based precautions which are based on the latest CDC Guidelines and are based on two tiers of precautions, **Standard Precautions and Transmission based Precautions**.

For your convenience, we now have fully stocked Isolation carts/cabinets, which are kept outside the room of any patient who is in isolation. We also have a **Safe Zone** for all patients in isolation. This is a 3 foot square where you don't need to wear PPE when you are within this safe zone, you still need to comply with hand hygiene. Tape extends approximately 3 foot into the room and out of the room. **White tape** is for *C. diff* and **Orange tape** is for all other patients requiring isolation, EXCEPT airborne isolation does not have the Safe Zone.

1. **STANDARD PRECAUTIONS:** Standard Precautions are the most important type of precautions used in the hospital and are precautions that are applied to **ALL** patients.
  - a. Engineering Controls - Such controls include sharps disposal containers and needleless systems.
  - b. Work Practice Controls - Such controls address not eating or drinking in work areas, the proper biohazard labeling of clinical specimens and containers, and the appropriate decontamination and biohazard labeling of equipment to be repaired.
  - c. Housekeeping functions involve protocols for cleaning and decontaminating environmental surfaces, work surfaces, and equipment.
  - d. Standard precautions require one to consider what is being done and to wear the appropriate precautions based on the job.
  - e. Hazard Communication involves specific labeling requirements to identify and warn hospital personnel of potentially biohazardous materials or items contaminated with such. A red "Biohazard" label or a red-colored container is the only acceptable means of communicating the presence of potentially biohazardous materials. Biohazardous containers must be kept under a lock and key.
2. **TRANSMISSION-BASED PRECAUTIONS** - Is the second tier of prevention and consists of precautions designed only for the care of specified patients known or suspected to be infected by epidemiologically important pathogens spread by **Airborne, Droplet, and/or Contact** Transmission. Gown, gloves, mask and eye protection must be removed prior to exiting the patient room or in the anti-room when applicable.
  - a. **CONTACT PRECAUTIONS** - This is the most common type of isolation, it requires that gown and gloves be worn prior to entering the room, add mask for drug-resistant organisms cultured in the patient's sputum and the patient has a lower respiratory infection, for example Methicillin-Resistant *Staphylococcus aureus* (MRSA) pneumonia. (If the patient had MRSA in the sputum with an active infection of the lungs then they should be in Contact and Droplet isolation.) Examples: Scabies, MRSA, CRE,ESBL and VRE.
  - b. **DROPLET PRECAUTIONS** - Requires a mask be worn while in the room. Example: Bacterial Meningitis, Seasonal Influenza, MRSA in the sputum if the patient has pneumonia. A Powered Air Purifying Respirator (PAPR's) must be readily available to staff should the patient require a high hazard procedure such as a sputum induction, intubation, bronchoscopy and aerosolized breathing treatments. The nurse caring for a patient placed in droplet precautions should notify the respiratory

department immediately for proper delivery of PAPR equipment should it become necessary. Additional PPE is required when you suspect possible contact with respiratory secretions or body fluids.

- c. **AIRBORNE PRECAUTIONS**- Requires a N95 respirator to be worn while in the room. A negative pressure room with a door is necessary; the door must be maintained closed. Infection Prevention or nursing unit to notify Engineering when a patient is placed on Airborne Precautions in a room with an alarm. Engineering will verify the room has negative airflow upon admission and monitor room daily for proper negative air flow. PAPR's must be readily available should the patient require a high hazard procedure such as administration of aerosolized medications, a sputum induction, intubation, or bronchoscopy. The nurse caring for a patient placed in airborne precautions should notify the respiratory department immediately for proper delivery of PAPR equipment should it become necessary. Gown and gloves to be worn when entering the patient's room with the exception of a patient with rule out or active MTB (*Mycobacterium tuberculosis*).

### **HEALTHCARE ASSOCIATED INFECTION**

#### **Multidrug-Resistant Organisms (MDRO's)**

- Microorganisms resistant to two or more classes of antimicrobial agents
  - MRSA (Methicillin-resistant *Staph aureus*)
  - VRE (Vancomycin-resistant *enterococci*)
  - ESBL (Extended spectrum beta – lactamase producing organisms)
  - Other Gram-negative bacilli (e.g., *Acinetobacter*, *Pseudomonas*)
  - CRE (Carbapenem resistant Enterobacteriaceae)
  - VRSA (Vancomycin resistant staphylococcus aureus)
- Limited treatment options
- Increased length of stay, costs, mortality
- Possibly more pathogenic/virulent

#### **Transmission of MDROs**

1. Touching the skin or secretions of a person
2. Touching objects or surfaces that have germs on them then transferring these germs to eyes, nose, or mouth
3. In healthcare settings, MRSA primarily transmitted from patient to patient on "unwashed hands of healthcare workers"

#### **Prevention and Control of MDRO's and other healthcare associated infections**

- Patients in isolation must stay in isolation until authorized by Infection Preventionist
- a. **Screening and Implementation of Care for the Suspected Tuberculosis Patient**
- Provide patient education and *place a surgical mask on the patient when out of room* and implement airborne precautions including *N95 mask* for the caregivers *who are fit tested*. When performing a high hazardous procedure on a confirmed or suspect TB case, use a PAPR.
  - **Notify Infection Preventionist** of Rule Out or suspected Tuberculosis patient. Notify House Supervisors and Clinical Shift Managers for placing patient in a negative airflow room.
  - **Infection Prevention or nursing unit to notify Engineering** when a patient is placed on Airborne Precautions in a room with an alarm. Engineering will monitor room daily for proper Negative air flow. Place an airborne precaution sign at the entrance.



## b. Seasonal Influenza

Influenza is a contagious respiratory disease that may require outpatient health care visits or hospitalization. Influenza vaccination of both health care personnel and patients combined with basic infection prevention and control practices can help prevent spread and outbreaks. **Flu** season is an annually recurring time period characterized by the prevalence of outbreaks of **influenza (flu)**.

### Prevention and Control Measures

- a) When an employee and/or other healthcare workers who decline the influenza vaccination, they must wear a mask in patient care areas during influenza season. The mask can be worn for four hours long or until the mask is wet, if either one of these occurs the mask must be replaced. The mask must be discarded and be replaced with a new mask.

### Respiratory Hygiene/Cough Etiquette

- a) Posting visual alerts instructing patients and persons who accompany them to inform healthcare personnel if they have symptoms of a respiratory infection
- b) Providing tissues or masks to patients and visitors who are coughing or sneezing so that they can cover their nose and mouth. Mask for all visitors with symptoms, it would be best not to allow the visitor in with symptoms.
- c) Ensuring that supplies for hand washing are available where sinks are located; providing dispensers of alcohol-based hand rubs in other locations
- d) Providing space for coughing persons to sit at least 3 to 6 feet away from others, if feasible

## 2. Environmental Cleaning

Environmental cleaning and/or disinfecting plays a big part in preventing cross contamination, i.e.; from a surface to the hands of a worker then to other patients or from a patient to surface. All equipment is to be cleaned and disinfected after use of the equipment with hydrogen peroxide wipes. Upon completion of cleaning and disinfection the item is to be tagged and identified as being cleaned. If the item is not tagged then the object is deemed to be dirty.

Terminal cleaning is done when isolation patients are discharged from one area of the hospital to another area or out of the hospital. Terminal cleaning is also done at the end of the day in OR suites and Pharmacy.

## 3. Communication and staff education

It is the responsibility of the staff to review and adhere to policies, protocols related to infection prevention.

## 4. Patient transfer (Proper Hand Off)

When a test is ordered and the patient is required to go to another department or out of the hospital, they need to know the patient is on isolation and the type of isolation required.

## 5. Use of Personal Protective Equipment (PPE)

(See attached PPE poster)

## Ebola

1. Personal Protective Equipment requirement is based on the patient presentation, wet or dry. Wet is a patient that is vomiting, bleeding and having diarrhea. Whereas dry is a patient with no symptoms of vomiting, bleeding or diarrhea.
2. Patient is questioned upon admission regarding travel history in the past 30 days.
3. There are 5 hospital's in the state considered to be a center of excellence who have been chosen to care for patients with Ebola:

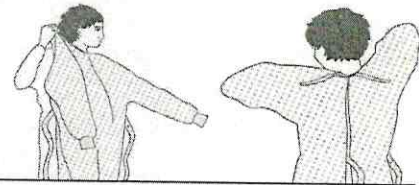
- a. UC Davis
  - b. UC San Francisco
  - c. UCLA
  - d. UC Irvine
  - e. UC San Diego
4. Patients may still come to our Emergency Room. The patient will then be transferred to one of the chosen hospitals within 72 hours or less, if available.

## SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

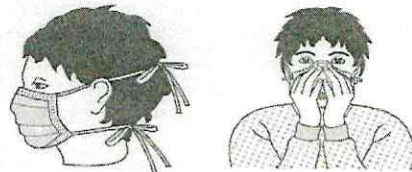
### 1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



### 2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator



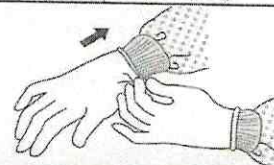
### 3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



### 4. GLOVES

- Extend to cover wrist of isolation gown



## USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene



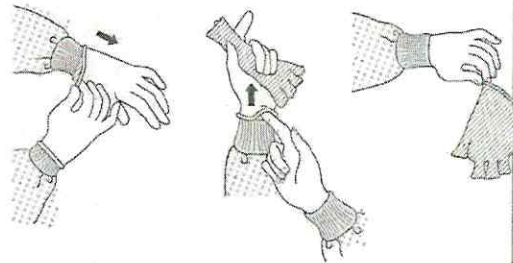


## SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)

Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing door.

### 1. GLOVES

- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist
- Peel glove off over first glovet
- Discard gloves in waste container



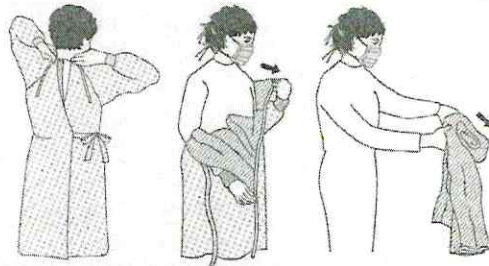
### 2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield is contaminated!
- To remove, handle by head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container



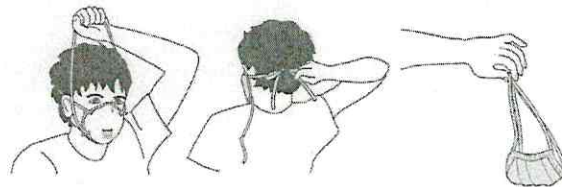
### 3. GOWN

- Gown front and sleeves are contaminated!
- Unfasten ties
- Pull away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard



### 4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove
- Discard in waste container



**PERFORM HAND HYGIENE BETWEEN STEPS  
IF HANDS BECOME CONTAMINATED AND  
IMMEDIATELY AFTER REMOVING ALL PPE**



© 2007 CDC

## **PATIENT SAFETY**

- All hospital employees are responsible for the National Safety Goals as they pertain to their job responsibilities.
- All hospital employees are responsible for patient, visitor and staff safety. If you see someone who needs help or may seem ill, ask if they need help, have them sit down, and call medical personnel for assistance.
- All staff is responsible for appropriate reporting of all patient safety issues or quality of care issues immediately to their managers, or to an administrator, without fear of disciplinary action or retaliation.

## **REPORTING SAFETY AND QUALITY OF CARE CONCERNS**

**Accreditation Participation Requirement 17: The hospital educates its staff that any employee who has concerns about the safety or quality of care provided in the hospital may report these concerns to The Joint Commission.**

E-mail: [complaint@jointcommission.org](mailto:complaint@jointcommission.org)

Fax: 630-792-5636

Mail: Office of Quality Monitoring

The Joint Commission

One Renaissance Boulevard

Oakbrook Terrace, Illinois 60181

The Joint Commission encourages anyone who has concerns or complaints about the safety or quality of patient care to first bring those concerns to the attention of the organization's leaders. If this does not lead to a resolution, anyone may contact the Joint Commission with their concerns directly, without the risk of retaliation from the organization.

## **RISK MANAGEMENT**

### **Incident Management Portal (Unusual Occurrence Reporting)**

“Occurrences” or “incidents” can be defined as any event that is not consistent with the routine operation of the facility/hospital or the routine care of a particular patient.

Injury does **not** have to occur for an event to be considered an occurrence. “Near misses” are also to be reported. The hospital’s review of these events allows us to identify systems and processes for improvement. The following are some examples of occurrences which should trigger the completion of an unusual occurrence report. Use your best judgment or ask your supervisor:

- A patient slipping or falling
- A patient leaving AMA or eloping
- A physician or staff exhibiting disruptive behavior
- A patient having contraband (drugs, alcohol, weapons)
- A patient acting adversely (being assaultive or dangerous)
- A patient injuring his/her self
- A patient who did not consent for a procedure done
- A patient or a patient's family complaining about the staff
- Surgical complications
- Performing the wrong test on a patient



- Surgery performed on the wrong site
- A patient developing a stage III ,IV or unstageable pressure ulcer
- A patient losing possessions or having possessions stolen
- Equipment malfunction that adversely affects a patient or employee
- Code blue is called on a patient, supplies are missing, or team is late
- Line disconnections or misconnections

When an incident occurs, the person who witnessed the event should fill out an incident form, factually, clearly and completely.

Medication errors and adverse drug reactions are reported using Incident Management Portal, and forwarded to pharmacy for the review of the medication safety committee.

Use facts only and be objective. Report quotes from witnesses and be sure to include who, what, when, where and how. Do Not make a copy of an incident/occurrence report. Do not share or review them with members of the medical staff.

If an occurrence affects a patient, do not chart on the medical record that an incident report was filled out, just record the facts in the patient's medical record. If a patient falls, the "fall" is documented in the medical record (this is a fact). Use the Incident Management Portal (slip/trip/fall) to document the details (including contributing factors).

### **Sentinel Events**

A Sentinel Event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase, "or the risk thereof", includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

These adverse events include, but are not limited to, the following:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient or body part
- Unanticipated death of full term infant
- Maternal death
- Unanticipated death or permanent loss of function from hospital-acquired infection
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Rape
- Suicide of any individual receiving care, treatment, or services in a staffed-around-the-clock care setting or within 72 hours of discharge
- Abduction of any individual receiving care, treatment, or services
- Infant abduction or discharge to the wrong family

If a Sentinel Event is detected, contact your supervisor immediately. If a sentinel event is suspected, the Risk Manager is to be notified immediately. If an event is categorized as a sentinel event, the Risk Manager will coordinate a Root Cause Analysis. This process involves investigation and identification of the processes that may have failed and implementation of strategies to prevent a reoccurrence of a similar event.

**Falls:**

- All patients that are admitted to the hospital are at risk for falls.
- Patients' risk is assessed on admission, every shift, change of condition, and after a fall.
- Patients found to be a moderate risk will have a SAFE armband, SAFE sign on their door, and yellow socks. A high risk patient will have a yellow gown on in addition to the other identifiers.
- Strategies to prevent falls on all patients include, but not limited to, call light within reach, bed in low position, having wheeled equipment locked, education, and proper fitting non-skid footwear.
- Moderate risk strategies include all low risk strategies plus the use of the bed alarm and supervision and assistance with ADL's.
- High risk patients will require all the low risk and moderate risk strategies plus they will require to be moved closer to the nurse's station if possible, frequent observation, use of gait belt during ambulation, and are not to be left alone while out of bed.
- A way for non-clinical staff to aid with fall management is to remind moderate and high risk patients to call before getting out the bed when leaving the room.
- High risk patients (identified by wearing a yellow gown) are never to ambulate in the hallway on their own. If you do see a high risk patient alone you are to assist patient back to room and notify the patient's nurse.
- After a fall you are required to fill out the IMP, complete a post fall debriefing form, reassess your patient's fall risk (automatically high risk after fall), and update the care plan to reflect the date of fall and new risk.
- Educate patient and family on Fall Prevention.

**Restraints**

- The goal of AHMC Anaheim Regional Medical Center is to reduce restraints as much as possible; recognizing that the use of restraints places the patient in a more dangerous situation, requiring ongoing observation and vigilance. Restraints are used only after other methods have been tried, and were unsuccessful.
- Alternatives to restraint use include, but are not limited to, verbal de-escalation, reality orientation, frequent monitoring, offering time-out, environmental modification, decreased stimulation, room change, medication administration.
- Patient care staff will give input to the process of determining alternatives to restraints and document.
- All patient care staff will be able to demonstrate fast release of restraints in the event of an emergency.
- All patient care staff will observe awareness of side rail entrapment dangers.
- All patient care staff are responsible for competency related to restraint application to include, but not limited to, release, ongoing patient assessment, physical comfort, nutrition, hydration, elimination, behavioral intervention, de-escalation and documentation.
- The Emergency Department requires specialty training in Management of Assaultive Behavior on a regular basis.
- The Emergency Department and the Critical Care units are the only departments that allow the use of hard restraints.

**Abuse Recognition & Reporting**

Abuse can be physical, emotional, or sexual. All AHMC Anaheim Regional Medical Center employees are required to notify their manager or supervisor, or the patient's nurse or social worker and Risk Manager immediately if abuse or neglect of any patient is suspected. All hospital employees are mandated reporters, however, the patient's nurse or the patient's social worker, will assess and report to authorities as mandated by law.



The following are general categories of abuse for which reporting is required:

- Suspected child abuse/neglect, including prenatal maternal substance abuse (once the child has been born),
- Suspected elder/dependent adult abuse/neglect,
- Injuries inflicted by assaultive or abusive conduct, including domestic violence,
- Injuries inflicted by gunshot wound, whether self-inflicted or inflicted by another.
- Suspected abuse cases of a patient during their hospitalization at ARMC such as physical abuse, sexual abuse, medical neglect, neglect of basic needs, emotional abuse or intimidation, and financial abuse.

A verbal report must be made immediately or as soon as practically possible and a written report must follow.

### **Requirements for Hospital Reporting of “Never Events” to the California Department of Health Services**

#### **(CA DHS)**

“SB1301 requires each hospital to report specified **adverse events** to the CA DHS within five (5) days or within 24 hours if the event is an ongoing urgent or emergent threat to the welfare, health or safety of patient, personnel or visitors.”

It is imperative that you report any of these events, or if you suspect that an event meets these criteria, notify immediately to the CSM, Manager or Director of your unit. These reportable adverse events include:

#### Surgical Events:

##### Surgery or other invasive procedure performed on the wrong body part

1. Surgery or other invasive procedure performed on the wrong patient
2. Wrong surgical or other invasive procedure performed on a patient
3. Unintended retention of a foreign object in a patient after surgery or other procedure.
4. Intraoperative or immediately post-operative death in an American Society of Anesthesiologists Class I patient

#### Product or Device Events

5. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
6. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
7. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

#### Patient Protection Events

8. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
9. Patient death or serious disability associated with patient elopement (disappearance)
10. Patient suicide, attempted suicide or self-harm resulting in serious disability, while being cared for in a healthcare facility

#### Care Management Events

11. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)

12. Patient death or serious disability associated with unsafe administration of blood products
13. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting
14. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
15. Artificial insemination with wrong donor sperm or wrong egg
16. Patient death or serious disability associated with a fall while being cared for in a healthcare setting
17. Any stage 3, stage 4 or unstageable pressure ulcers acquired after admission/presentation to a healthcare facility
18. Patient death or serious disability resulting from the irretrievable loss of an irreplaceable biological specimen
19. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

#### Environmental Events

20. Patient or staff death or serious disability associated with an electric shock in the course of a patient care process in a healthcare setting
21. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances
22. Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
23. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

#### Radiologic Events

24. Death or serious injury of a patient or staff associated with introduction of a metallic object into the MRI area

#### Criminal Events

25. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
26. Abduction of a patient/resident of any age
27. Sexual abuse/assault on a patient within or on the grounds of a healthcare setting
28. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

(Serious Reportable Events 2011, National Quality Forum)

#### Quality

Quality is a reflection of both the best and value for money. In the same way, when patients come to our facility we want them to consider the care they get to be the best and of good value.

AHMC Healthcare believes:

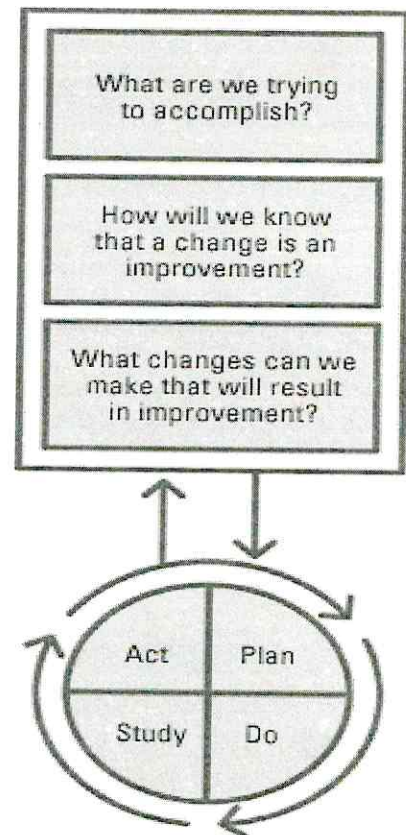
- Every individual is responsible for quality. Everyone who provides care or other services within the organization has the responsibility to contribute to the efforts for Performance Improvement as reflected in our Mission, Vision and Values.
- To be relevant to the communities we serve, our expertise and motivation must be evident in how we refine, redirect, and remodel care delivery to consistently meet the challenges of the healthcare environment and the individual patient.
- A culture of Performance Improvement is essential to an innovative, efficient organization.



- *Pursuing excellence through Performance Improvement creates a sense of urgency within the organization.*
- Spreading knowledge and innovation through Performance Improvement provides opportunities for the organization to strengthen and grow.
- Shared accountability capitalizes on the organizations' collective talent for Performance Improvement.

### Performance Improvement (PI)

- AHMC Anaheim Regional Medical Center has a systematic process, designed to measure, assess, improve, and evaluate the performance and appropriateness of care/services provided to patients, and to improve organizational performance/patient outcomes.
- The Quality Services Department is responsible for performing reviews (audits), coordinating and aggregating data, preparing and presenting reports, providing education about the PI process and regulatory standards, and acting as a resource for the hospital's PI process. Reviews (audits) may also be performed by individual departments.
- The PI methodology includes the following steps:
  - **PLAN:** Develop a plan to test the change
  - **DO:** Carry out the change
  - **STUDY:** Analyze the results. Look at lessons learned
  - **ACT:** Make modifications, plan for our next test of change, and implement change.



### Performance Improvement/Patient Safety (PIPS)

PIPS committee is a hospital committee which oversees performance improvement and patient safety within the hospital environment. Its members comprise department directors and managers and its primary function is to identify patient safety issues and develop ways in which the hospital can improve performance.

The PIPS committee reviews patient safety data, performance measures and reviews upcoming changes in regulations and procedures.

The PIPS committee is responsible for:

- Reviewing and approving ARMC's Patient Safety Risk Management Plan
- Reviewing patient safety data and reports
- Monitoring implementation of corrective actions for patient safety events
- Making recommendations to eliminate future safety events

A patient safety event includes any significant adverse event or potential adverse event ("Never Events", e.g. wrong site surgery); unexpected occurrence involving patient death or serious physical or psychological injury or risk thereof ("Sentinel Event's"), or any event that causes patient harm. Other unusual patient occurrences that do not result in patient harm, including "near misses", are reviewed as potential patient

safety events. *Patient safety events are reported immediately or as soon as possible, when the event has been recognized, to a direct supervisor, manager, director or to the Hospitals Risk Manager.*

### The Joint Commission (TJC)

The Joint Commission is an independent not for profit organization that surveys healthcare facilities to assess them for patient safety, quality of care and regulatory compliance. TJC survey is an unannounced survey every 3 years. AHMC Anaheim Regional Medical Center participates in these surveys to validate its commitment to high quality patient care. This also allows the organization to participate in managed care contracts and the federal Medicare program.

Prior to survey TJC survey team will gather and review all data available on the hospital. Data includes, data submitted directly to TJC, external sources such as CMS and CDPH. The survey is then customized in order to center on Priority Focus Areas (PFA's). PFA's then serve as a priority for the survey team as they begin their survey of the healthcare facility. By concentrating on PFA's TJC is ensuring that the organization is making system wide improvements to directly impact patient care.

The TJC survey is conducted using the "Tracer methodology" in which a patient is selected and followed as they move through the organization so that the evaluation of the organization can be made in a systematic way. Organizational compliance with selected standards can be assessed when measured and applied to the specific patient care received. Interdepartmental functioning can also be assessed when applied to the patient care.

Active patients who have received active or complex services are selected to be candidates for the Tracer activities. As the surveyors trace the patient, and the specific care received, the surveyors are able to observe the care, and talk to staff and to patients in the areas where the patient is received. Compliance with TJC standards is assessed as the surveyors review the organizations systems for delivering safe, quality healthcare.

As the tracer is reviewed, there will be opportunities for the surveyor to identify compliance issues with one or more elements of performance. Identification of system wide trends may be determined in this way and if the opportunities present themselves, education of staff and leaders is able to be done in order to inform of best practices from other similar health care organizations.

As part of the Joint Commission accreditation and Medicare Pay for Performance initiative, AHMC Anaheim Regional Medical Center also has agreed to collect and publicly report our compliance with **Core Measure indicators**. These standardized measure sets of evidence-based indicators are applied across all accredited healthcare organizations and are reported on a quarterly basis.

Organization-wide Core Measures include **Acute Myocardial Infarction (AMI), Stroke (STK), VTE prophylaxis (VTE), Immunization (IMM), Sepsis and Emergency Department. Outpatient Chest Pain, Pain Management, Stroke, ED through put and Colonoscopy measures.**

### CDPH Patient Safety Licensing Survey

CDPH survey is an unannounced survey conducted every three years. The areas of focus are Patient Safety & Infection Prevention, Hospital Services, Discharge Planning, Immunizations, End of life Care & Brain Death, Dietary Services, Fair Pricing/Debt Collection. Surveyors review medical records, hospital documents & policies, Interviews hospital staff & leaders; patients & families. They also observe staff and patient care

### Medication Error Reduction Plan (MERP Survey)

MERP Survey is conducted by CDPH every three years, unannounced. At ARMC, a formal MERP Plan is established, reviewed and approved by a multidisciplinary team each year to identify strategies to reduce medication-related errors at ARMC. CDPH monitor facility's MERP plan upon survey, including requirement for licensure (Title 22).



## PATIENT CARE STAFF ONLY

### Assessment/Reassessment

- All patients will be assessed & documented by RN within two hours of admission and beginning of shift.
- All patients will be reassessed in the following patient situations:
  - Transfer or move between units, services, or department
  - After undergoing invasive, surgical, or special procedure on or off the unit
  - Significant changes in condition or diagnosis
  - Change of RN assigned to patient
  - Evaluation of intervention effectiveness
  - Satisfaction of legal or regulatory requirement
- All disciplines have the responsibility to contribute input to the assessment process through data collection specific to job role and scope of practice.
- Assessment, problem identification or nursing diagnosis, planning of care, implementation of plan (medical or nursing), evaluation, and reassessment are the ongoing responsibilities of the nurse carrying out the nursing process.
- A systems approach or head-to-toe assessment as appropriate to scope of practice and data collection specific to patient populations served.
- Refer to Administrative Policy and Procedure Manual, department specific policy manual(s), and Nursing Policy and Procedure Manual as appropriate for scope of practice and department specific guidelines.

### Methods of Assigning Patient Care

- AHMC Anaheim Regional Medical Center uses a Patient Acuity (Classification) System: Patient care requirements are assessed by an RN (within the Couplet Care Unit, Neonatal Intensive Care Unit, Medical Surgical Unit, Telemetry Unit, Cardio-Vascular Unit, Cardio-Vascular Observation Unit, Intensive Care Unit, and Definitive Care Unit) *4-5 hours before the end of the shift (1300-1400 on day shift and 0100-0200 on night shift) and documented on the Flowchart.* Acuity numbers are collected and reported to staffing office by USMT prior to staffing.

### Delegation

Delegation is designed to make the work of patient care more efficient. A RN must use good judgment in deciding what aspect of care can be delegated and in what situation so that ultimately all patients are cared for effectively and efficiently. Delegation is not assigning a task without considering the specific patient and whether it is appropriate for an assistive personal to perform a task. Delegation is also not assigning a task without explaining to assistive personal possible variation based on patient status.

Delegation must be driven by RN assessment of a patient. The RN then decides what tasks or aspects of care are appropriate for the assistive personal to perform for that patient. Ultimately it allows the RN and assistive personal to work as an effective team. The RN's final responsibility is to evaluate whether assistive personal performed a task properly and whether desired outcomes were realized.

Efficient delegation requires constant communication- sending clear messages and listening so that all participants understand expectations regarding patient care. As the RN becomes more familiar with a staff member's competency, trust builds and fewer instructions may be needed, but clarification of patient's specific needs will always be necessary.

### The five Rights of Delegation

- Right Task : The right task in one that is delegable for specific patient, such as tasks are repetitive, require little supervision, and are relatively noninvasive.

- **Right Circumstances:** The appropriate patient setting, available resources, and other relevant factors are considered. In an acute care setting, patients conditions can change quickly. Good clinical decision making is needed to determine what to delegate.
- **Right Person:** The right person is delegating the right tasks to the right person to be performed on the right person.
- **Right Direction/Communication:** A clear, concise description of the task, including its objective, limits, and expectations, is given. Communication must be ongoing between RN and assistive personnel during a shift of care.
- **Right Supervision:** Appropriate monitoring, evaluation, intervention as needed, and feedback are provided. Assistive personnel should feel comfortable to ask questions and seek assistance. Provide constructive feedback.

### **Effective Communication**

To improve patient safety through effective communication, AHMC Anaheim Regional Medical Center staff should adhere to the following policy guidelines:

#### ***SBAR Report to the Physician***

**Situation, Background, Assessment, & Recommendation (SBAR) is a standardized way of communicating with other healthcare workers.** The use of SBAR promotes patient safety as poor communication leads to mistakes which can lead to poor patient outcomes. The use of the SBAR format is useful as it can lead to information being conveyed in a clear and concise format.

- **Situation:**  
State your name, hospital & unit, patient name & diagnosis. **NEVER USE ROOM NUMBER** as a patient identifier. Briefly state the problem, what it is, when it happened or started, how severe it is, and code status if necessary.
- **Background:**  
State the date of admission, medical history, and a brief synopsis of the treatment from admission to present.
- **Assessment:**  
Relate the physical assessment pertinent to the problem especially any changes, include vital signs, Lab values or diagnostic test.
- **Recommendation/Response:**  
State what you would like to see done, transfer the patient, come to see the patient at this time, talk to the family, ask a consultant, plan of care.

#### ***Hand-Off Communications:***

Hand off communication is performed in the following situations:

- Calling / Reporting to a physician
- Bedside Shift-to-shift report
- Relief for breaks
- Patient's going for diagnostic testing
- Surgery, Cath Lab, GI Lab procedures
- Patient's being transferred internally and externally
- Change in patient condition.
- Other situations when handing off information is required to assure patient safety.

#### **Bedside Shift-to-Shift report includes:**

- Introduction
- Quick assessment of patient and environment
- Whiteboard update



### Consistently use AIDET when caring for patients

- Acknowledge
- Introduce
- Duration
- Explanation
- Thank you

**Hourly rounding** is another way that direct patient staff can provide great service to the patients in their care. Hourly rounding addresses the most common causes for patient dissatisfaction. It relies on the healthcare team member asking the patient if they have any **pain**, whether they need their **position** changed, whether they need to go to the bathroom, whether they require any other **personal needs** to be met and also **placing** personal items within patients reach. Hourly rounding is not intended to be disruptive or disturb the patient, so if a patient is sleeping the caregiver will simply continue to the next patient and ask them the same questions. Hourly rounding has been shown to dramatically reduce nurse calls, as well reduce patient falls and increase patient satisfaction.

### Medication Orders:

- Verbal orders are accepted only in an emergency situation or breaking a sterile field/scrub procedure; the order must be read back.
- Phone (RBTO) or verbal (RBVO) orders are entered in Evident completely with drug name, dose, route of administration and frequency. If the order is “PRN,” there must be a PRN indication in the order. Make sure you read back the order and document it as read back in the entry.

Doses:  
RB?:Y Stop Info ROUT  
Pt's Own?:N

Indicate “Y” next to “RB?” to document the order was read back. Do not enter “Y” next to “Pt’s own?” unless the order is for patient’s own medication.

Enter PRN indication under “Instructn:” for ALL PRN orders. The indication must be specific and not duplicating any other PRN indications already on patient’s medication list. For example, multiple PRN pain medication orders must have different PRN Indications with clear and specific circumstances when the medication can be given.

Use of “blanket orders” are **not allowed**. Each medication must be addressed individually in the order. Examples of prohibited “blanket orders” include:

- Continue all home meds
- Resume pre-op meds
- Discontinue all previous orders

Instructn: Type instructions below:  
For itching MAX RATE FOR I

Some examples to help specify PRN pain indications:

- Type of pain** – “chest pain”, “headache”, “incision pain”, etc.
- Severity of pain** – “mild pain”, “moderate pain”, “severe pain”, etc.
- Situation for use** – “once patient can take PO”, “for dressing change”, “when NPO”, etc.

- **Due to a known problem with Evident, RBTO Insulin orders do not link to the Diabetic Record. ALL RBTO ORDERS FOR INSULIN MUST BE WRITTEN ON PAPER!!**

**Medication Reconciliation:**

- Home medication list must be confirmed to be correct by clicking “Reviewed”.
- If the home medication list needs to be modified after medication reconciliation has already been done, you need to:
  - Update the home medication list in Evident
  - Correct the previously ordered medications from medication reconciliation
  - Notify Pharmacy

**Administration:**

- Barcode scanning of the patient armband and medication must be done prior to administration at patient’s bedside. It is unsafe to do it ahead of time or later.
- Do not rely only on bedside barcode scanning only. You still need to follow the 5-rights of medication administration.
- If an alert is triggered at scanning, read the alert fully to understand the warning given.
- New eMAR entries from written orders must be verified to be accurate before administration (compare paper order to the eMAR entry).
- High Alert Medications – Requires independent double check by 2 RNs to confirm correct dose and correct IV pump setting
  - IV Chemotherapy
  - IV Insulin
  - IV heparin
  - PCA
  - IV argatroban

**Documentation and Monitoring:**

- All medications given must be documented on the eMAR even if they are already documented somewhere else in patient record (e.g., flowchart). **Why?** Medications are charged upon administration which means it is automatically charged when it is documented given on the eMAR. Medications are not charged at time of dispensing.
- Sedation level (POSS) and pain scale must be monitored and documented prior to giving a pain medication and after the dose is given (e.g., Norco, Morphine, Dilaudid, Percocet, etc.).
- Before you discharge a patient, make sure the patient does not leave behind any of their own medications (in pharmacy or in medication cassette).
- To ensure a safe culture, please take the time to report any potential medication errors (near misses), actual medications errors, and suspected adverse drug reactions. Report them online using the intranet site via the Incident Management Portal (IMP).



**APPROVED ABBREVIATIONS AND UNACCEPTABLE ABBREVIATIONS**

HIM Policy: Provides a standardized list of abbreviations approved for use at ARMC.

<b>UNACCEPTABLE ABBREVIATIONS AND DOSE DESIGNATIONS</b>			
<b>Abbreviation/ Dose Expression</b>	<b>Intended Meaning</b>	<b>Misinterpretation</b>	<b>Correction</b>
<i>U or u</i>	Unit	Read as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "0" or 4u seen as "44")	Write out the word: <b>"unit"</b>
<i>IU</i>	International unit	Misread as IV (intravenous)	Write out the word: <b>"unit"</b>
Zero after decimal point (1.0)	1 mg	Misread as 10 mg if the decimal point is not seen.	Do not use terminal zeros for doses expressed in whole numbers. Correct example: <b>1 mg</b>
No zero before decimal dose (.5 mg)	0.5 mg	Misread as 5 mg	Always use zero before a decimal when the dose is less than a whole unit. Correct example: <b>0.5 mg</b>
<b>q.d. or QD</b>	Every day	Mistaken as q.i.d., especially if period after the "q" or the tail of "q" is misunderstood as an "i."	Write out the words: <b>"daily"</b> or <b>"every day"</b>
<b>q.o.d. or QOD</b>	Every other day	Misinterpreted as "q.d." (daily) or "q.i.d." (four times daily) if the "0" is poorly written.	Write out the words: <b>"every other day"</b>
<b>MgSO4 MSO4 MS</b>	Magnesium sulfate Morphine sulfate Morphine sulfate	Confused for one another. Can mean morphine sulfate or magnesium sulfate	Use complete spelling for drug names: <b>Magnesium sulfate</b> <b>Morphine sulfate</b>

**Pain Management**

AHMC Anaheim Regional Medical Center respects and supports the patient's right to effective pain management.

- Patient's report of pain is the only valid measurement of the experience of pain.
- 1. Assessment and management of pain is required for all patients to include infants, cognitive-impaired, and other non-verbal patients. The RN assessing the pain will identify a **Comfort-Function Goal** upon admission, or presentation for care, and revise the goal as needed based on patient experience with pain, ability to function, and response to interventions.
- 2. AHMC Anaheim Regional Medical Center's pain management includes initial and regular assessment of pain, education of patients and families as appropriate regarding their roles in managing pain, as well as the potential side-effects of pain treatments, and consideration of patient's personal, cultural, spiritual and/or ethnic beliefs.
- 3. AHMC Anaheim Regional Medical Center uses the Universal Pain Assessment Tool/FLACC Tool/NIPS.
- 4. Assess Sedation Level prior to the administration of opioids: Use the **Pasero-Opioid Induced Sedation Scale (POSS)**, for patients receiving opioids for pain management in which sedation may occur as an adverse effect.

5. Reassess Sedation Level to evaluate a change in alertness or arousability (guidance for reassessment intervals include: IV: 30 minutes or less; Subcutaneous: 30 minutes or less ; PO/PR: 60 minutes or less).
6. Pain interventions include medications, massage, application of heat or cold, and cognitive-behavioral interventions such as relaxation, distraction, provided through referral to the appropriate service or department, as long as there are no contraindications. The effect of the medication must be documented and done so in a timely manner.
7. Assessment and monitoring of pain will be performed on admission; before, during, and after surgery/procedures; each time vital signs are assessed; with each new report of pain; after pain-relieving intervention; sudden onset of intense pain; and at the time of discharge.
8. Reassess Pain to evaluate the effectiveness of Pain Management interventions (guidance for reassessment intervals include: IV: 30 minutes OR less; Subcutaneous: 30 minutes or less; PO/PR: 60 minutes or less).
  1. Compare Pain Level to Comfort-Function Goal to determine intervention effectiveness for patients able to provide a self-report.
  2. If behavioral indicators decrease or resolve, the RN may “Assume Intervention Effective” for patients unable to provide a self-report.
9. Examples of behavioral cues for pain are frowning, restlessness, moaning, jaw clenching.
10. **Notify the physician** if any of these are present:
  1. If the Comfort-Function Goal (Pain Goal) is not achieved after implementation of interventions
  2. If behavioral indicators do not decrease or resolve after implementation of interventions
  3. Pain becomes persistent or changes in location or characteristics
  4. Patient preference for pain management is inconsistent with orders

**C. diff bundle:**

- a) Isolate patient when patient is suspected of having *C. diff* greater than 3 watery stools in 24 hours or being admitted with diarrhea.
- b) Pharmacist to review antibiotic regimens and to work with the patient’s physician to stop inappropriate antibiotics
- c) Observe all healthcare workers for proper removal of PPE (gloves and gowns) after each *C. diff* patient care activity.
- d) Infection Preventionist to check with patient’s environment that their room has been cleaned daily with bleach wipes.
- e) Healthcare workers to perform hand hygiene with liquid soap and water after leaving a *C. diff* patient’s room.
- f) Only liquid stools to be sent for testing of *C. diff*.
- g) Bristol Stool Chart to be used for identifying type of stool the patient is having and chart accordingly. Stool sample type 6 or 7 on the Bristol Stool Chart is sent for *C. diff* test if there is a minimum of 3 watery stools within 24 hours. If patient is on medications for stools, you can’t send a specimen until the patient is off of the medication/s for 72 hours or longer and the stool must meet the rest of the above criteria.
- h) Isolation may not be discontinued until patient is discharged.

**Isolation Precaution:** Use Standard Precaution with “Contact Plus Precaution” if symptomatic (diarrhea or loose stools and tests positive for *C. diff*).



**Transporting Patient: Notify receiving department that patient has *C. difficile* and that Contact Precaution Plus is required.**

- a. Before transporting a patient with *C. difficile* have the patient wash hands.
- b. If transporting in a wheelchair put a clean sheet/bath blanket over the wheelchair and wipe chair after use with hospital approved disinfectant wipe.
- c. If transporting in patient's bed, wipe down bed rails with hospital approved disinfectant wipe and cover patient with clean sheet/bath blanket.
- d. If transporting in a gurney, wipe down gurney after use with a hospital approved disinfectant wipe.
- e. Maintain "wet" time as written on disinfectant wipe containers
- f. Ensure items are cleaned or discarded after use in an isolation room and that no item is used from room to room without being clean/disinfected.

**Use proven guidelines to prevent infection after surgery**

Patients with Surgical Site Infection (SSI) are twice as likely to die, five times more likely to require readmission and have a 60% increased probability of spending time in the ICU

- ▶ Prevention of SSI
  - a) Using Chlorhexidine gluconate for bathing night before and morning of surgery
  - b) Removal of hair with clipping and not shaving
  - c) Maintain Normal body temperature with use of Bair huggers
  - d) Surgical Prophylactic antibiotics
  - e) Use CHG for Surgical prep
  - f) Nicotine use delays wound healing and may increase the risk of SSI
  - g) Blood glucose >180 before, during and within the first 48hrs post-op may contribute to a SSI
  - h) Education regarding wound care instruction is vital for preventing SSI
  
- ▶ Additional guidelines just out from WHO:
  - a) Adult patients to receive 80% fraction of inspired oxygen intraoperatively and immediate postoperative period for 2-6 hrs if undergoing general anesthesia
  - b) Surgical antibiotic prophylaxis administration should not be prolonged after completion of the operation
  - c) Patients with known nasal carriage of *S. aureus* should receive perioperative intranasal application of mupirocin 2% ointment with or without a combination of CHG body wash
  - d) Mechanical bowel preparation alone (without the administration of oral antibiotics) should not be used in adult patients undergoing elective colorectal surgery

**Homeless Patients**

Here at ARMC we service and take care of a large homeless population. Some key things to remember when caring for a homeless patient.

- 1) Please make sure there is a Social Work order put in so the patient can be seen and community resources can be offered.
- 2) Often times patients come into the hospital and their clothing has been soiled or ruined. If the patients clothing is not wearable upon discharge, there is a clothing closet with necessities such as clothes, shoes and undergarments. If the clothing closet does not have the size or necessary garments for the patient and all other avenues have been exhausted, then we do have the ability to wash and dry the patient's clothing. Again this is available on a case by case basis. Contact your Social Worker, CSM or the House Supervisor to get clothing.
- 3) When the discharge plan is a shelter - be aware that the patient needs to be discharged by 2:00pm in order for him/her to make it to the shelter and stand in line for the shelter. Patients are not placed at

shelters, they must go to the shelter on their own and there is no guarantee for a bed unless they are in line early.

- 4) If the patient is in need of discharge medications and the patient does not have the money or does not have insurance to pay for the medication, contact unit Case Manager. The Case Manager can fill charity prescriptions on a case by case basis. ARMC does not fill prescriptions for any narcotic medication.
- 5) House Supervisor and Social Services have bus passes for patients who do not have a residential address to be discharged to. If the patient has a verified residential address, House Supervisor can provide a taxi voucher.

### **2017 National Patient Safety Goals**

The Patient Safety Advisory Group advises The Joint Commission on the development and updating of NPSGs

#### **Patient Safety Advisory Group**

- Comprised of a panel of widely recognized patient safety experts, including nurses, physicians, pharmacists, risk managers, clinical engineers, and other professionals with hands-on experience in addressing patient safety issues in a wide variety of healthcare settings
- Advises The Joint Commission how to address emerging patient safety issues in NPSGs, *Sentinel Event Alerts*, standards and survey processes, performance measures, educational materials, and Center for Transforming Healthcare projects

#### **NPSG: Identify patients correctly**

- **01.01.01:** Use at least two ways to identify patients. This is to ensure that each patient gets the correct medicine, treatment and documents.
- **01.03.01:** Make sure that the correct patient gets the correct blood when they get a blood transfusion.
- ARMC uses *patients name and date of birth* as two identifier. Medical record number is used as a third identifier and for lab samples. We also verify specimen samples with another employee and enter employee ID's on medact.

#### **NPSG 02.03.01: Improve Staff Communication**

Get important test results to the right staff person on time.

- Critical results of tests and diagnostic procedures are defined in policy PCS: C-001.
- Results of critical tests need to be reported to the licensed care provider that ordered the test within 60 minutes from the time the test ordered.
- Critical results/values are reported to the responsible licensed care provider (MD) within **45 minutes** from the time the critical result/value is known.
- The nurse documents the result of the critical result/value in the medical record, use critical value sticker during downtime. The sticker is then placed on the physician orders section of the medical record. If no order or other intervention was received or is needed that is indicated on the medical record or/critical value sticker.

#### **NPSG 15.01.01: Identify patient safety risks**

The hospital identifies patients at risk for suicide.

- ARMC policy is to identify patients at risk for suicide (behaviorally distressed) regardless of psychiatric diagnosis and provide care in order to preserve the patient's safety until medically cleared. When medically cleared, and if still apt, psychiatric assessment will determine appropriate care, treatment & if necessary placement. Policy: PCS:P-010 Psychiatric/Behaviorally Distressed Patient



Care. The Social Service Department is contacted. **\*\*\*If patient is combative or deemed at risk for potential violence, call Code Gray. At no time will the patient be left unsupervised until the problem has been resolved.**

Patient admitted with attempted suicide or 5150 are admitted to unit assigned per unit admission criteria with continuous observation from a caregiver.

Medically cleared patients in need of psychiatric evaluation and management must be appropriately assessed and transferred to a facility that is so designated by the County of Orange. Anaheim Regional Medical Center maintains a formalized agreement with **College Hospital's PET** for evaluation of the medically cleared patient for 72 hour holds. Medically cleared inpatients can be assessed by the Psychiatric Emergency Team (PET) in order to expedite psychiatric treatment. Contact PET at **1-800-773-8001**

**NPSG: To improve safety in medication use.**

1. **03.04.01:** Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
  - a. If you prepare a medication ahead of time and do not use it immediately (you put it down), the medication must be labeled with medication name, strength, quantity, diluent/volume, and expiration date/time, and expiration time when expiration occurs is less than **24hrs**.
2. **03.05.01:** Take extra care with patients who take medications to thin their blood.
  - a. Pharmacy follows a protocol to dose and monitor warfarin, heparin and argatroban based on specified indication when they are ordered "per pharmacy."
  - b. Education on anticoagulant therapy is provided to prescribers, staff, patients, and families.
    - i. Importance of follow-up monitoring
    - ii. Compliance
    - iii. Drug-food interactions
    - iv. The potential for adverse drug reactions and interactions.
3. **03.06.01:** The hospital maintains and communicates accurate patient medication information.
  - a. The hospital compares the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital to identify and resolve discrepancies (**Admission Medication Reconciliation**).
  - b. The hospital provides the patient written information on the medications the patient should be taking when he/she is discharged from the hospital or at end of outpatient encounter (**Discharge Medication Reconciliation**).
  - c. Institute for Healthcare Improvement (IHI) defines "Medication Reconciliation" as the process of creating the most accurate list possible of all medications a patient is taking and comparing that list against the admission, transfer (**Transfer Medication Reconciliation**) and/or discharge orders.

**NPSG 06.01.01: Use alarms safely**

**Clinical alarm systems:** Make improvements to ensure that alarms on, medical equipment are heard and responded to on time.

- Monitoring equipment has established default settings to ensure safe monitoring practices. Prior to use of designated equipment clinical staff check to confirm PM stickers are current. Additionally, as part of the set-up, alarms are tested for proper function and audibility.
- Alarm limits are set per specific physician order or per clinician clinical judgment.
- Suspend or deactivate clinical equipment alarms only when a competent individual is readily available to assess the patient, validate the parameter alarming and take appropriate action.
- Alarms are responded to immediately by the closest competent staff member.
- Alarms are not to be turned off.

Document "Alarm on" each shift as part of patient assessment

### Prevent mistakes in surgery

**UP.01.01.01:** Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

- a) Conduct a preprocedure verification process
- b) Informed consent is done by the procedural MD or Surgeon
- c) Make sure correct procedure is on the consent form
- d) No abbreviations or shortened forms are used for the procedure
- e) Ensure that consent is signed, dated and timed
- f) Lock the consent e-form once it is signed

**UP.01.02.01:** Mark the correct place on the patient's body where the surgery is to be done

- a) Must be performed by the surgeon or procedural MD and initial the site
- b) Must be performed with a permanent marker

**UP.01.03.01:** Pause before the surgery to make sure that a mistake is not being made.

- a) A time-out is performed before the procedure
  - Reconfirms correct patient, procedure and site.
  - All staff are actively involved in the time-out process.
  - Scans, x-rays and diagnostic reports are used for patient, procedure and site verification.
  - Time-out is performed immediately prior to cutting of skin.

### Oxygen Safety

#### Policy: PCS O-004 Oxygen Therapy for additional information

#### Safety in Ordering

- Oxygen is a drug and as such requires an order for administration. The order should include the following information.
  - **Mode:** ie-mask, nasal cannula etc
  - **FiO<sub>2</sub>**-for those modes of administration which can deliver specific FiO<sub>2</sub> –ie Venturi mask
  - **Liter Flow**-for nasal cannula
  - **Prn** application for SOB
  - **A limiting order** –ie “not to exceed \_\_\_\_\_ lpm”
- Adjustment Of Oxygen to maintain a range of oxygen saturation



#### Safety in Delivery

- Increased fire hazard. Do not use petroleum (oil) based lubricants on patients face or hands
- Ensure O<sub>2</sub> tubings are securely connected to flow meters (green labeling)
- For correct flow, read at center of ball on flow meter
- O<sub>2</sub> masks require a liter flow of at least 6 lpm to clear CO<sub>2</sub>
- Keep O<sub>2</sub> tubings clear of entanglements such as rails, wheels etc.
- Non-breather masks requires a flow at least 15 lpm, additionally the flow must be sufficient that the reservoir bag does not completely collapse on inhalation
- Monitor frequently all documented CO<sub>2</sub> retainers receiving O<sub>2</sub> therapy

#### Safety in Storage (*policy: CS-135 Oxygen Cylinder Storage/Handling for additional information*)

- Oxygen cylinders (Green) must be secured upon receipt, during transport, in each area of use, on wheelchairs, gurneys and beds throughout the hospital.
- Oxygen supports combustion and must not be stored or utilized in the presence of flammable or combustible materials.
- Oxygen cylinders should only be stored in approved storage devices, such as a cylinder rack or cart.





- Full and Empty cylinders are stored separately (Green painted racks or rack areas painted green for Full tanks and Red painted racks are areas for In-Use & Empty tanks).
- Cylinders are assigned to a specific storage area. The area should be dry, well ventilated, and of non-combustible material.
- Oxygen cylinder should **never** be left on the floor or propped in a corner.
- A tank with a broken or sheared valve is an unguided missile and could cause serious injury.
- During transport, oxygen cylinder must be secured.

### Discharge Planning

- Discharge planning is begun at the time the patient is admitted. Advance Directives are communicated to appropriate staff.
- Discharge planning and documentation is a multidisciplinary responsibility.
- Discharge planning is a component of the patient care plan.
- Discharge patient and family teaching is a requirement and must be documented.

### End-of-Life Care

- End-of-life care addresses, as appropriate, death and grief. End-of-life care applies to all dying patients, not just hospice patients, admitted to the hospital for care, treatment, and services. Comfort and dignity are optimized during end-of-life care. Patients at or near the end of their lives have the right to physical and psychological comfort.
- Discussions about end-of-life issues can be difficult because dying and death are not openly discussed in many cultures, and issues of life and death are deeply personal, tapping our most basic human values.
- Perhaps the most difficult decisions confronting people at the end of life are those about discontinuing life-extending treatment. Decisions to withhold or discontinue treatment are determined by a variety of factors, including judgments of medical futility; the emotional status and coping styles of the family members and the dying person; culture; legal, ethical, social, and economic issues.
- Barriers to inadequate end-of-life care include communication failure, bias, cultural incompetence.
- Patients may have different individual goals when facing death; healthcare providers should focus on maximizing comfort and minimizing their burden, by enlisting the *support of pastoral care, case managers and/or social workers as is appropriate*.
- AHMC Anaheim Regional Medical Center supports compassionate care. To the extent possible and as appropriate to the patient's and family's needs, the necessary hospital services and interventions address patient and family comfort, dignity, psychosocial, emotional, and spiritual needs.
- Cultural and spiritual differences in the approach to death and dying are always met with reverence and respect.
- Financial services are available to discuss costs of treatment options, availability/eligibility for insurance coverage, and services that require payment out-of-pocket, as the need arises.
- If the **patient's physician or provider** does not choose to comply with the patients and/or family wishes, *a bioethics review* can be initiated and information can be given on how to transfer medical care.

### Advanced Healthcare Directives

“Advanced Directive” is a general term for a written document in which instructions are given by a person regarding his/her future health care. Within that directive patients may designate a healthcare surrogate (an individual with durable power of attorney for healthcare) to represent them in the event that they cannot speak for themselves.

If our patients do not have an Advanced Healthcare Directive, we need to offer them the opportunity to consider one. Consider utilizing other healthcare team members or resources to facilitate this process. The patient's physician, social workers, family members, clergy or other spiritual advisors can all assist the patient in making an informed decision.

Advance directives not only give the patient a degree of control over their healthcare when they cannot speak for themselves, they also help families at a time when painful decisions may have to be made. It should be remembered that the patient has the right to modify their advance directive at any time.

**POLST (Physician Orders for Life-Sustaining Treatment)**

POLST is a form that a patient fills out in conjunction with their physician, in order to indicate medical intervention and treatment preferences. POLST forms are normally filled out in the community and are meant to stay with the patient regardless of healthcare setting. When a patient is admitted to hospital with a POLST their primary physician needs to be informed in order to ensure that the patient's appropriate code status is defined.

**Brain Death**

Consult OneLegacy within **ONE HOUR**  
To Preserve the Opportunity of Organ Donation  
**800-338-6112**

**VENTILATOR DEPENDENT PATIENT**  
with a non-survivable illness or injury

**With One or More of These Triggers**

Anticipated discussion of  
withdrawal of ventilator  
or End-of-Life care

Loss of one or more  
brainstem reflexes

To Preserve the Opportunity of Organ, Eye & Tissue Donation Call  
**EVERY Death within ONE HOUR**

 OneLegacy 

saving lives through organ, eye & tissue donation

- **Organ Donor Criterion (Donation After Brain Death):** A patient who has suffered brain death, has an intact heartbeat, is maintained on mechanical ventilation, and is deemed medically suitable to donate any or all vascular organs and can also potentially be a tissue donor.
- When a ventilated patient has fulfilled the criteria for brain death, (above) One Legacy is to be contacted as soon as possible. This does not require a physician order.
- Prior to a brain death declaration, the patient's family is to be informed of the primary physician's intention to test for brain death.
- Brain death occurs when 2 licensed physicians, non procurement or transplant related, independently identify the patient as brain dead.
- A declaration determining brain death, must be dated, timed and signed by the determining physicians.
- **Organ Donor (Donation After Cardiac Death [DACD]):** Also called Non-Heart-Beating Organ Donation. Circulatory-respiratory criteria are used to determine death prior to organ donation. DACD is a planned event involving family, surrogate, or patient directives. Patients who are either severely ill or have suffered an irreversible neurological injury and are on hemodynamic/ventilatory support may be suitable for DACD. Organ procurement is done following heart and respiratory cessation and pronouncement of death.



The physician discontinues life support (extubate) in the OR and monitors the patient's cardiac status. Pronouncement of death follows standard medical practice, using current hospital policy and procedures:

- a. the patient shall be apneic and unresponsive to all stimuli
  - b. five minutes in ventricular fibrillation is suitable to allow pronouncement
  - c. five minutes of pulseless electrical activity (PEA) is suitable to allow pronouncement
  - d. any combination of the above is suitable to allow pronouncement.
- Write a note in the Physicians Progress Notes with the date and time the patient is pronounced dead.
  - The Attending physician signs the death certificate. If a coroner's case, One Legacy contacts the coroner with the time of death and obtains a coroner's case number.
  - The transplant team is not brought into OR until death has been pronounced.
  - If a patient does not expire within a reasonable period of time that provides viability of organs, (approximately 60 minutes); the recovery effort may be abandoned by the transplant team. If Heparin was administered it may be reversed with Protamine Sulfate.
  - In the event of abandonment of the organ donation process, the patient is returned to a predetermined room where palliative care and comfort measures continue as ordered, under the care of the attending physician. A critical care bed is not required.
  - Provide comfort measures throughout the process

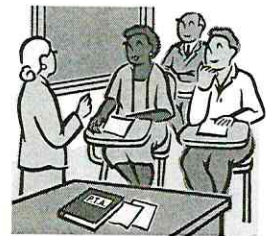
#### **Downtime Procedures for Electronic Medical Record (EMR)**

1. The Downtime Procedure Policy is implemented for periods longer than 1 hour or as recommended by nursing leadership in a case by case basis.
2. If downtime is expected to be more than 6 hours, it is recommended that paper documentation for patient care is used for the 12 hour shift.
3. For scheduled downtime, Pharmacy department prints Medication Administration Records (MAR) one hour prior to scheduled downtime time. Nursing prints all necessary patient history and information required to care for the patients, including 24 hour summaries, medication records, patient's home medication lists... etc.
4. Caregivers document on paper using documents provided on the units until the EMR is operational. Twelve hour shift bedside caregivers document on paper flowsheets for the 12 hour shift. After EMR is fully operational, the oncoming shift resumes EMR documentation on electronic flowcharts and eforms. Paper forms are part of the patient's permanent medical record and are scanned into the EMR at a later date. Paper forms are filed in the patient medical record (Nursing Notes are filed under Nursing and MAR are filed under the Medication tab).
5. In the event of an indefinite downtime (confirmed by ISD Director), printed copies of the nursing notes and the MAR are printed out from the back up PC by a designated ISD systems administrator.
6. All paper MARs are copied at the end of the downtime for patient charge. Unit secretaries use census report as the patient check off list.
  - The original copy is kept in the patient chart behind the Medication tab.
  - For patients who discharged during downtime, unit secretaries need to copy all MARs before sending the chart to medical record.
  - Each Department CSM is responsible for sending the copied MARs with patient check off list to Pharmacy.
7. During downtime, the unit secretary creates a folder with department specific ancillary requisitions. All the order are manually written on the requisition form and faxed to the respective ancillary department. When the computer system is restored, referrals/orders are entered into the system and verified by the nurse assigned to the patient.

### **Patient Education**

Education is provided and coordinated in a multidisciplinary manner.

- Identify and assess patient's initial educational needs pertaining to self-care within 24 hrs of admission
- Information provided is appropriate to the age, understanding, and language of the patient and is appropriate to the population served. Interpretation services are provided as necessary.
- All caregivers will assess and address the needs of those with vision, speech, hearing, language, and cognitive impairments. Teaching methods accommodate various learning styles. Comprehension is evaluated.
- The educational plan includes instruction in the specific knowledge and/or skills needed by the patient and/or when appropriate his/her family to meet the patient's ongoing health care needs, as indicated, but not limited to:
  1. Diagnosis, Co-morbidities
  2. The safe and effective use of medication
  3. Pain Management
  4. The safe and effective use of medical equipment
  5. Instruction on potential drug-food and interactions
  6. Instruction/counseling related to nutrition/diet and oral health education
  7. When and how to obtain further treatment
  8. Access to community resources
  9. Rehabilitation techniques
  10. The purpose, risks, benefits, and alternatives treatments, invasive or diagnostic procedures
- Patients at risk (i.e., AMI, CHF, and Pulmonary Disease) will all be informed regarding smoking risks and cessation.
- Patients should be taught about risks for pneumonia and influenza and vaccine prevention.
- Academic educational services will be provided to children and youth as appropriate.
- Multidisciplinary caregivers will document patient education appropriately on inpatient and discharge forms.
- ***Teaching the patient is a part of the responsibility to the scope of practice for all Registered Nurses.***
- All patients to be discharged will be informed of any medication reconciliation issues. (Medications taken at home prior to hospitalization and medications ordered or to be continued after discharge – see Policy and Procedure for Medication Administration Reconciliation & National Safety Goals).





## Nursing at ARMC

### Nursing Philosophy at ARMC

- Patient and Family is the center all service provision
- The clinical practice of nursing is built on a scientific base
- Evaluation of nursing practice is a professional responsibility
- Critical thinking and scientific inquiry are essential to the improvement of practice
- Essence of nursing practice is caring, which is an art and a science; deliverable, teachable, researchable; accomplished with wisdom, knowledge, compassion, and competence

**Has the Screen  
Been Completed?**  
Look for the results of the screen documented in discipline specific areas of the EMR and/or patient Chart

### Nurse Practice Act

The Nurse Practice Act is a set of state laws that define nurse practice within the state of California. Title 16 of the California Code of Regulations defines nurse practice in the state of California and may be viewed on the Board of Registered Nursing website [www.rn.ca.gov](http://www.rn.ca.gov)

### Scope of Practice

- Board of Registered Nursing
- Board of Vocational Nursing
- Job Description
- American Nurses Association
- Professional Organizations
- Hospital Policy

### Nursing Process

- Framework for describing the essential elements of Nursing Practice
- Used to describe the scope of practice
- The Joint Commission looks for evidence that the nursing process is used on each patient
- Supported by professional organizations and State Board of Registered Nursing

### Age Appropriate Screening Infants and Children

Screening includes developmental age, length, height, weight, head circumference, education needs, daily activities and immunization status.

### Adults and Geriatrics

Screening includes home status, functional status, nutritional status, skin risk and fall risk assessments.

### Pathway to Excellence

ARMC is a Pathway to Excellence designated Organization since 2012. The American Nurses Credentialing Center's (ANCC) Pathway to Excellence® Program is a new organizational credential to recognize healthcare facilities that have created positive work environments where nurses can flourish. Pathway-designated organizations are deemed the best places to work for nurses, with high nurse satisfaction and retention. We practice **Shared Governance model** where bedside nurses are actively involved in scheduling staff, educating new staff, or implementing evidence-based practice. It also encourages teamwork, problem-solving, and accountability, with the goals of improved staff satisfaction, productivity, and patient outcomes. It is working together with other disciplines to improve nursing practice and Patient Satisfaction.

### ARMC Policies & Procedures (MCN Program)

Policy manuals are divided up into:

#### **Organizational Manual (ORG)**

#### **Patient Care Service Manual (PCS)**

Standardized Procedures

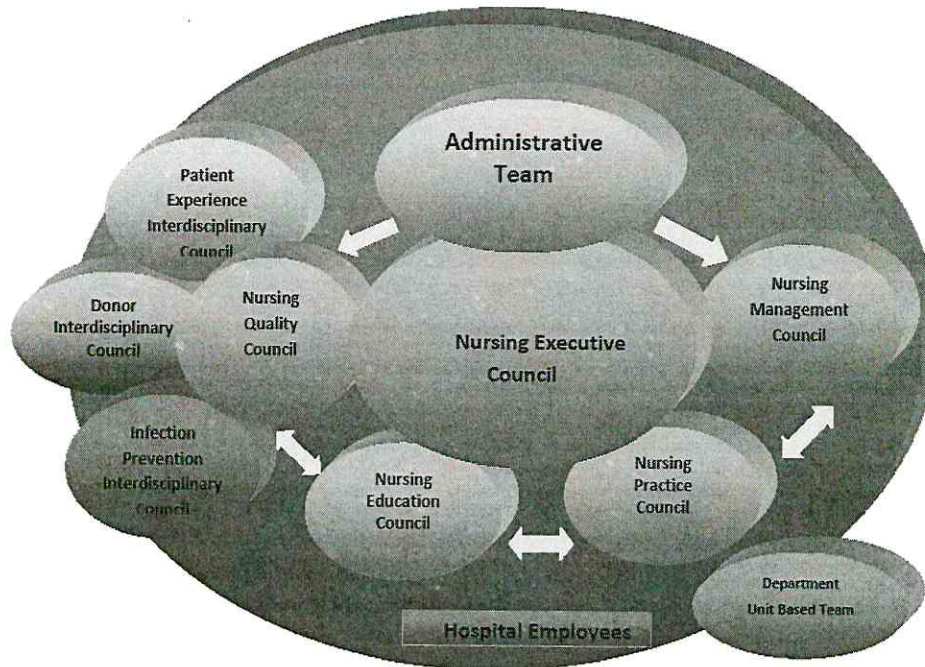
#### **Nursing Lab Manual**

Covers policies for lab tests

#### **Departmental Manual**

Cover specific department policies

## PTE: Shared Governance Model-2015



### Administration of Blood Products

#### **Consent for Blood Transfusion**

- According to the Paul Gann Act, it is the responsibility of the physician to inform the patient of the possibility of a blood transfusion prior to elective surgery or medical procedure.
- It is the responsibility of the nursing staff to validate the consent is complete and it's in the patients' medical record.

#### **Type & Crossmatching for Blood Transfusion**

- Patients with no previous transfusion history have 2 specimens collected at 2 separate times for verification of patient identification and blood type

#### **Administration of Blood Transfusion**

Transfusions of blood/blood components are completed within four (4) hrs of issue from the Blood Bank. There are **three** (3) checks of the blood or blood product required prior to administering these products:

- The first check is performed at the time the product is dispensed from the Blood Bank by a laboratory CLS and the trained ARMC health care provider picking up the blood or blood product.
- The second check is performed outside the intended patient's room/OR Suite between **two** (2) qualified (Licensed/Certified) personnel who are trained in blood administration.
- The third check is performed at the intended patient's bedside/OR table by each of two (2) qualified individuals, listed below, both of whom must sign the Transfusion Record:
  - The Licensed/Certified personnel transfusing the component and
  - The Licensed/Certified personnel confirming all information on the component/Transfusion Record are in agreement

The entire blood transfusion cannot continue after 4 hours. The transfusion needs to be finished before 4 hours have elapsed and documented. Documentation includes the time the transfusion completed, the patient's vital signs and whether there was a transfusion reaction following the transfusion



### **Key Points Of Medication Labeling**

1. For prior-to-use preparations, medications which are drawn up, set up, or removed from the original package, in anticipation of impending use, must meet the following label requirements:
  - a. Name of medication/solution
  - b. Strength or concentration of medication/ solution
  - c. Expiration date and time of **exact 1 hour**, if not administered immediately.
  - d. Label must adhere or attach to the medication syringe, container, basin or cup and be visible at all times.
2. All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

#### ***Check the Medication Label 3 Times***

1. As it is removed from the cassette or automated dispensing device.
2. As it is placed in the medication cup or drawn up into a syringe.
3. As the unit-dose or ready to administer package is opened at the bedside or after the medication is drawn into the syringe.

**Before administering a medication, scan the barcode on the patient identification armband and the medication to be administered.**

#### **IV Bag and Tubing Changes**

##### ***12 hours***

Propofol infusions

##### ***24 hours***

D10W, Fat emulsions, blood, TPN or any IV containing MVI.

##### ***96 hours***

Peripheral lines, PCA tubing, IVPB tubing, manufactured bag, PA line pressure tubing and bag, arterial line pressure bag and tubing, Central line and PAL

### ***Medication safety practices***

- Use proper hand hygiene before the med pass
- Never store medications in your pocket
- Never administer medications from the same syringe to more than one patient, even if the needle is changed
- Do not give repeat administration of doses from the same carpject syringe
- Single-use vials should never be used more than once
- Multi-use vials assigned to a single patient should never be used for more than one patient.
- Bags or bottles of intravenous solution not be used as a common source of supply for more than one patient
- Absolute adherence to proper infection control practices is maintained during the preparation and administration of injected medication
- Follow specific medication administration guidelines for Isolation patients
- Continuous Pulse oximetry monitoring when patients on PCA

### **HEALTHCARE ASSOCIATED INFECTION**

#### **Multidrug-Resistant Organisms (MDRO's)**

- Microorganisms resistant to one or more classes of antimicrobial agents
  - MRSA (Methicillin-resistant *Staph aureus*)
  - VRE (Vancomycin-resistant *enterococci*)
  - Other Gram-negative bacilli (e.g., *Acinetobacter*, *Pseudomonas*)
  - CRE (Carbapenem resistant Enterobacteriaceae)
- Limited treatment options
- Increased length of stay, costs, mortality
- Possibly more pathogenic/virulent

### Transmission of MDROs

1. Touching the skin or secretions of a person
2. Touching objects or surfaces that have germs on them then transferring these germs to eyes, nose, or mouth
3. In healthcare settings, MRSA primarily transmitted from patient to patient on "unwashed hands of healthcare workers"

### Prevention and Control of MDRO's and other healthcare associated infections

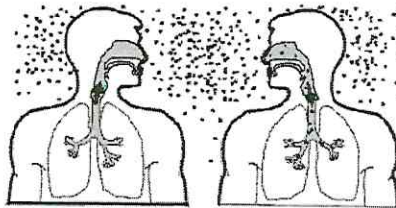
#### 1. Screening, isolation, early identification

- a. **Methicillin Resistant *Staphylococcus aureus* (MRSA) & Carbapenem Resistant *Enterobacteriaceae* (CRE)** : ARMC performs screenings for MRSA which consist of performing a single swab of both anterior nares including septum and bilateral nares. This is done upon admission to the facility using criteria as outlined by SB1058. CRE screening is performed to preemptively isolate patients with history of CRE and to prevent healthcare associated transmission of CRE from one patient to another. A perirectal swab is taken for CRE colonization. Patients with MRSA only of the nares DO NOT need to be placed on Contact Precautions, use Standard Precautions. For details refer Policy: PCS-SP-008 MRSA AND CRE Screening Active Surveillance Culture

#### b. TUBERCULOSIS

MTB is a bacterial infection caused by *Mycobacterium tuberculosis*. MTB is easily spread in crowded conditions, and among people who are ill or have weakened immune systems.

Respiratory Tuberculosis (TB) is a contagious infectious disease which can have either active or inactive forms. Although it can affect many organ systems, it primarily affects the lungs and presentations can range from no symptoms to critical illness, and even death.



### Screening and Implementation of Care for the Suspected Tuberculosis Patient

- Patients with cough equal to or greater than three weeks require assessment using the **Triage for Tuberculosis Assessment Tool**.
- If the score is less than five, no further action is required
- When scores are greater or equal to five, patients are considered suspect for tuberculosis. The registered nurse consults the patient's physician when there are questions regarding the initiation of a diagnostic test.
- Provide patient education and **place a surgical mask on the patient when out of room** and implement airborne precautions including **N95 mask** for the caregivers **who are fit tested**. When performing a high hazardous procedure on a confirmed or suspect TB case, use a PAPR.
- Contact Respiratory Therapy Department for assistance in inducing sputum samples, if necessary.
- **Notify Infection Preventionist** of Rule Out or suspected Tuberculosis patient. Notify House Supervisors and Clinical Shift Managers for placing patient in a negative airflow room.



- **Infection Prevention or nursing unit to notify Engineering** when a patient is placed on Airborne Precautions in a room with an alarm. Engineering will monitor room daily for proper Negative air flow. Place an airborne precaution sign at the entrance.
- Administer a tuberculin skin test (TST) 0.1 ml of 5 TU of purified protein derivative (PPD) into the inner surface of the forearm (intra-dermal) .The injection should be made with a tuberculin syringe, with the needle bevel facing upward. When placed correctly, the injection should produce a pale elevation of the skin (a wheel) 6 to 10 mm in diameter. The skin test reaction should be read between 48 to 72 hours after administration, if not you will need to repeat the test on opposite arm. The test can be repeated a minimum of one week between each injection.

#### How Are TST Reactions Interpreted?

Skin test interpretation depends on two factors:

- Measurement in millimeters of the induration
- Person's risk of being infected with TB and of progression to disease if infected

#### Classification of the Tuberculin Skin Test Reaction

<p>An induration of <math>\geq 5</math> or more millimeters is considered positive in</p> <ul style="list-style-type: none"> <li>-HIV-infected persons</li> <li>-A recent contact of a person with TB disease</li> <li>-Persons with fibrotic changes on chest radiograph consistent with prior TB</li> <li>-Patients with organ transplants</li> <li>-Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of <math>&gt;15</math> mg/day of prednisone for 1 month or longer, taking TNF-<math>\alpha</math> antagonists)</li> </ul>	<p>An induration of <math>\geq 10</math> or more millimeters is considered positive in</p> <ul style="list-style-type: none"> <li>-Recent immigrants (<math>&lt; 5</math> years) from high-prevalence countries</li> <li>-Injection drug users</li> <li>-Residents and employees of high-risk congregate settings</li> <li>-Mycobacteriology laboratory personnel</li> <li>-Persons with clinical conditions that place them at high risk</li> <li>-Children younger than 5 years of age</li> <li>- Infants, children, and adolescents exposed to adults in high-risk categories</li> </ul>	<p>An induration of <math>\geq 15</math> or more millimeters is considered positive in any person, including persons with no known risk factors for TB.</p>
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- Collect **three sputum (AFB) samples**: Upon arrival to ARMC hospital and every eight hours times two (for a total of three samples), preferably one of them a morning sample.

#### c. **REDUCING CATHETER ASSOCIATED URINARY TRACT INFECTIONS ( CAUTI ) –**

Catheters are to be used when the patient's clinical condition requires a urinary drainage device, and are **NEVER** to be used as a convenience to staff.

**Foley Catheter Bundle decreases Catheter associated Urinary tract Infections (CAUTI's) following this bundle will result in the reduction elimination of CAUTI's:**

- a) Reconcile catheter placement-Indwelling catheters placed prior to admission requires a Physician's order to maintain or change the catheter upon and after admission.
- b) No routine catheter changes-Indwelling catheters are never changed routinely or on a fixed schedule.
- c) Maintain urine flow-Maintain urinary flow through the catheter and tubing to prevent unobstructed urine output
- d) Maintain closed system-Maintain a sterile, continuously closed urinary catheter system.
- e) Secure catheter-Secure the catheter with a securement device to the patient's thigh. Avoid a taut catheter securement to prevent tugging. Example: Stat-lock.
- f) Aseptic handling-Hand hygiene is performed and follow strict aseptic technique for insertion of catheter when handling the urinary catheter system..
- g) Low Drainage Bag-Keep the urinary drainage/collection bag below the level of the bladder and off the floor. No kinks or loops in the urinary collection tubing prevent back flow and obstruction of flow.
- h) Catheter Care twice daily-Peri care and catheter care is completed each shift and after incontinence of stool. Soap and water is used for catheter and perineal care.
- i) Daily catheter necessity assessment-Review of catheter necessity is done daily and a catheter is promptly removed if deemed unnecessary. The catheter remains if the patient does meet the criteria for removal.
- j) Consider using a portable ultrasound device to assess urine volume in patients undergoing intermittent catheterization to assess urine volume and reduce unnecessary catheter insertions.
- k) Use external (condom style) catheter when appropriate in men.
- l) Nursing to follow urinary catheter policy that is nursing driven for insertion and removal of foley catheters.

*Post-op patients with an indwelling catheter will have the catheter removed as soon as possible postoperatively, if SCIP protocol applies to the procedure by midnight POD#2.*

#### **d. REDUCING CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTIONS**

Listed below are the expectations for central lines:

- a) Hand hygiene, Maximal barrier precautions (Gown, gloves mask, hat and full body drape) for insertions. Sterile gloves and mask are required for dressing changes. Patient wear mask while the dressing is changed. Anyone in the room for insertion or dressing changes are to wear a surgical mask and limit the number of people in the room.
- b) Chlorhexidine skin antiseptics (Back-and-forth friction scrub for at least 30 seconds). Do not wipe or blot, let dry completely approximately 2 minutes prior to skin puncture.
- c) Optimal catheter site selection, with avoidance of using the femoral vein for central venous access in adult patients.
- d) Apply stabilizing device or "chevron" tape/steri strip, CHG impregnated pads and transparent dressing. Change dressing every 7 days unless damp, soiled or loose.
- e) All ports with central lines require alcohol impregnated caps.
- f) ***Daily review of Medical Line necessity*** (which also applies to Central Lines), with prompt removal of unnecessary lines. Physicians are required by law to give an order each day in order for the central line to remain in.

***\* Central line insertion practices (CLIP) are reported to the CDC through The National Health Safety Network (NHSN). CLIP is part of "Bedside Procedure" eForm.***

### **QUALITY INDICATORS - CORE MEASURES**

#### **Department Specific Performance Improvement**

Each department tracks and reports a minimum of two quality indicators. Employees are to be familiar and participate by being familiar with the department-specific indicators and assist with the process.



### Core Measures

Core Measures are a standardized set of evidence-based measures that are applied across all accredited healthcare organizations. Data collected will be used to improve quality of patient care. List of Inpatient Core Measure indicators includes:

- **Acute Myocardial Infarction (AMI)**
  - Aspirin at arrival
  - Aspirin at discharge
  - ACEI/ARB at discharge for LVSD <40%
  - Beta Blockers at discharge
  - Fib/Thrombolytic therapy received within 30 min of arrival
  - PCI received within 90 minutes of hospital arrival
- **Immunization (IMM)**
  - Influenza vaccination
- **Stroke (STK)**
  - Dysphagia Screen prior to any PO intake ( for Stroke Certification)
  - Venous Thrombosis (VTE) prophylaxis by end of day 2 from arrival (ED or Direct Admission)
  - Antithrombotics at discharge
  - Anticoagulation therapy for h/o or current atrial fibrillation/flutter at discharge
  - IV rt-PA by 2<sup>nd</sup> hour – treat by 3 hour
  - IV rt-PA by 3<sup>rd</sup> hour – treat by 4.5 hour
  - Antithrombotics by end of day 2 from arrival (ED or Direct Admission)
  - Discharged on Statin medication (LDL 100 or ND)
  - Written Stroke Education during stay prior to discharge
  - Assessed for rehabilitation
  - Smoking Cessation (for Stroke Certification)
- **Venous Thromboembolism (VTE)**
  - VTE prophylaxis on arrival (non-ICU)
  - VTE prophylaxis on arrival (ICU)
  - Confirmed VTE patients receive overlap therapy for at least 5 days and the INR needs to equal to or > 2 before discontinuing. If patient is discharged they need to continue overlap therapy at home
  - VTE patients on heparin have platelet counts monitored
  - VTE patients discharged home on Warfarin have written discharge instructions on discharge
- **Sepsis**
  - Within the first 3 hours of presentation of severe sepsis:
    - Lactate level drawn
    - Obtain blood culture
    - Administer antibiotics
    - Fluid bolus completed
  - Within 6 hours of presentation of severe sepsis:
    - Repeat lactate only if initial lactate level is elevated
  - Only if septic shock presents-
  - Within the first 3 hrs of presentation of septic shock:
    - Resuscitation with 30ml/kg crystalloid fluids
  - Only if hypotension persists after fluid administration:
    - Vasopressors
    - Repeat volume status and tissue perfusion assessment consisting of a focused exam or any two of the following four:

- Central venous pressure measurement
- Central venous oxygen measurement
- Bedside cardiovascular ultrasound
- Passive leg raise or fluid challenge
- **Outpatients**
  - Chest pain
    - ASA on arrival
    - EKG on arrival
  - Pain Management
    - For long bone fractures
  - Stroke
    - Head CT or MRI scan results for Acute Ischemic stroke or hemorrhagic stroke
    - CT or MRI interpretation within 45 minutes of ED arrival
  - ED Throughput
  - Colonoscopy
    - Screening
    - Surveillance

**tubing Misconnections**-- A serious adverse patient safety resulting in harm and possible death.

**Here's what you can do:** (risk reduction strategies)

- Know how to use/operate each piece of equipment before using it
- Turn on the light in a darkened room before connecting or reconnecting tubes or devices
- Label all tubes and catheters , especially high risk catheters( arterial, epidural, and intrathecal) and do not use catheters that have injection ports
- Trace lines back to their origins when initiating any new devices or infusion
- Recheck connections and trace all patient tubes and catheters to their sources upon the patient's arrival to a new setting or service as part of the hand-off process ( line reconciliation process)
- Route tubes and catheters having different purposes in different sides of the patient body or in unique and standardized directions; (e.g., IV lines routed toward the head; enteric lines toward the feet). This is especially important in the care of neonates.
- Inform non-clinical staff, patients and their families that they must get help from clinical staff whenever there is a real or perceived need to connect or disconnect devices or infusions.
- Never use a standard Luer syringe for oral medications or enteric feedings

## Monitoring Blood Glucose Point of Care Testing

### Policy

### Reference:

(Nursing Lab Manual)

- **NLM 6.20**

(Patient Care Services Manual)

- **PCS: SP-006**
- **PCS: H-003**

*Treatment of Severe Hypoglycemia at ARMC is a Standardized Procedure, which allows a licensed nurse who has received training and competency validation, to perform certain treatment measures or medical functions beyond the usual scope of practice.*

*It is ARMC's Policy that all nursing staff be validated for competence in Glucose monitoring prior to performing. Students please see your Clinical Instructor for validation and access codes if not received at orientation. Registry RNs please check with your unit Clinical Shift Managers for the access code.*



## PATIENT NUTRITION ORDERS AND MEAL DISTRIBUTION

- All diet orders are ordered by the physician
- The RN requests nutrition and speech therapy evaluation and assessments if needed. The physician orders a swallow evaluation on patients with potential aspiration tendencies.
- All meals are checked by nursing personnel before delivery to patient rooms to ensure accuracy of the diet. The caregiver checks the two patient identifiers on the meal ticket with the two patient identifiers on patient's name band to ensure the patient receives the correct meal tray. When the patient is finished with the meal return trays to the food carts.
- Nursing health care providers record food and fluid intake from trays.
- After hours' meals:
  1. Extra nutrition/HS Snacks are available in the Patient Nutrition refrigerator on each unit.

### Pastoral Care Services

When in need of Pastoral Care Services contact Social Services. Social Service will organize the Chaplain visit.

Spiritual access is the right of every patient. No patient shall be denied access to a clergy visit.

The chaplain provides a variety of devotional materials including Bibles.

### Interfaith Chapel

The chapel is located off the main lobby next to the administrative offices.

### Hearing Impaired Patients

#### For Sign Language

Contact the Dayle McIntosh center at:  
1- (800) 422-7444; (24 hour access)  
Response time 30-45 minutes.

