



Orientation and Annual Review

You can access the information packet and test questions from any computer by logging on to www.etenet.com.

If you need to complete this review for REORIENTATION, Click on the “Hospital” tab at the top of the screen. Then click on the “HR & Benefits” header. Select “Annual Reorientation”, and then select “Reorientation Test”.

MISSION STATEMENT

PLACENTIA-LINDA HOSPITAL

“Quality Healthcare with a Personal Touch”

Our Standards of Conduct reflects our basic values. These values are to:

- Meet the needs of each and every patient whose care is our primary purpose and mission
- Maintain and enhance cooperative relationships with affiliated physicians to better serve the health care needs of our community
- Forge strong partnerships with those who share our values
- Achieve standards of excellence which become the benchmark of industry practices
- Use innovation and creativity to identify and solve problems
- Apply quality management and leadership principles to foster continued employee development
- Treat each other, our patients, and our business partners with respect and dignity
- Hold integrity and honesty as our most important principles, uphold ethical standards at all times and comply with all applicable rules and regulations
- Achieve competitive return for our investors
- Strive for improvement day in and day out in everything we do.



We welcome you and appreciate your commitment in caring for our patients. Here are some essentials to assist you in meeting these patient-centered goals.

- We are very committed to patient and family satisfaction. Our goal is to have our patients and their family members **ALWAYS** satisfied with the care and services we provide.
- TEAMWORK** is our motto – there is no job that is not my job, no patient that is not my patient.
- Each patient has a white communications board near their bed with space to write the date, nurse, and aide name, plan of care for the shift, and pain management goal. It is important that these are consistently up-to-date.
- The pain management section of the white board should be updated by each shift, indicating an expected pain goal for that shift, i.e. 3/10. We also provide the patient with a “Managing Your Pain” brochure.
- Should your patient experience a change in his/her condition, notify the charge nurse immediately.
- Patients identified as fall risks will be indicated by a yellow gown, yellow armband and signage in the room.
- Observing proper hand washing/sanitizing techniques as well as glove usage is a key part of the National Patient Safety Goals. Please ensure that you always follow the proper guidelines.
- COURTESY** is expected at all times – escort visitors and patients instead of giving them directions. Acknowledge all visitors and patients with a greeting and a smile.
- You are expected to dress professionally and wear hospital identification badge at all times while on duty.
- Artificial nails are not allowed for any healthcare personnel providing clinical health care to patients.
- All employees are required to park in the upper parking lot where the bank is located, and to utilize behind the Medical Office Building only when this is full to maximize parking availability in front of the hospital for patients/visitors.
- Placentia-Linda Hospital is a smoke free campus.
- It is everyone’s responsibility to keep their work area and hospital clean.

Miscellaneous Helpful Information:

- Security is provided 24 hours/day and 7 days/week. If you wish to have an escort when leaving, ask the operator to contact security.
- All non-exempt employees must clock in and out each shift including in and out for lunch breaks. Rest periods are paid and do not require in/out clocking. You are not to clock in earlier than 7 minutes before the start of your shift unless requested by supervision/management to do so. All overtime must be authorized.
- Cafeteria is open for 3 meals a day M-F. Breakfast and lunch are available on the weekends. Employee meals may be obtained at a discounted price when the employee is wearing an identification badge. Meal tickets may be purchased in the cafeteria at the cashier. Vending machines are available in the cafeteria.

Required Education and Training

Requirements within 30 days of hire for all employees:

- ✓ Ethics and Compliance General Initial Training (this is a live Ethics class offered once a month)
- ✓ Any compliance related .edu course – the due date is 30 days from your hire date – the compliance officer will detail the names of these courses in the live Ethics class held on the 2nd Tuesday of the month – if you have questions regarding compliance courses, please feel free to contact the compliance officer at ext. 4236.

Requirements within 30 days of hire for all clinical, licensed staff:

- ✓ It will appear in your .edu assigned list with a due date 30 days from your hire date.

Requirements within 30 days of hire – Failure to attend within 30 days of hire will result in suspension until requirement is met.

- ✓ Hospital Orientation for all staff.
- ✓ Nursing Orientation for all nursing (RN, CNA) personnel.

Requirements within 90 days of hire – Failure to complete within 90 days of hire will be reflected in 90 day evaluation.

- ✓ .edu courses assigned to you by the Education Department. These courses will appear in your “Assigned” section of your “My Courses” page. Please see page 5-6 of this packet for full instructions.

Required Annual Updates

- ❖ Health and Tuberculosis screening
- ❖ Refresher ethics class (offered several times per month during refresher training period)
- ❖ Employee evaluations/reviews
- ❖ Reorientation education packet
- ❖ N95 mask fit testing

.edu education is provided for all employees through eTenet on the internet. Courses address clinical and non-clinical subjects. Many courses have CEUs provided. All staff must maintain current required license/certification and certifications and submit copy to Human Resources.

.edu Log-In Instructions

1. Open the internet explorer. *If you have an Apple/MAC at home, you will not be able to access .edu from home.*

2. If you are at home, in the address row, type in “etenet.com” and hit the Enter key.

If you are at work, bring the mouse cursor to the top of the page to make the drop down menu appear. Click on the eTenet button.

3. If you are at home, it will prompt you to type in your user ID and password. Do so and hit the Enter key.

If you are at work, it should automatically do this for you. If not, type in your user ID and password, and hit the Enter key.

4. Your next screen will be either the eTenet main page or the Placentia-Linda page.

If it is the eTenet page, locate this icon and click on it:



If it is the Placentia-Linda page, locate this icon () at the top right of the screen and click on it.

5. It will bring you to a screen that has 5 tabs near the top of the page:

My Learning My Transcript Catalog Hospital Direct My Profile

6. Go to the “My Learning” page, which is divided into 4 sections. The main 2 sections to pay attention to are:

Assigned Learning

These are the courses you HAVE to complete. There are due dates for these classes listed next to the course name.

Elective Learning

Any classes you self-enroll in will be listed underneath this header.

.edu Instructions – (continued)

7. To self enroll:
 - Left click once on the “Catalog” tab near the top of the screen.
 - It will automatically prompt you to type into a blank field.
 - Type in one or two KEY words of the title of the course you need to take and click the “Search” button once.
 - Left click once on the title you want. It will bring you into another screen, and now you left click once on “Enroll in this course”.
 - If you click on the “My Learning” tab near the top of the screen, you will now see this course you just enrolled in under the “Elective or Enrolled Courses” section of that page.

8. ***IMPORTANT!!!***
All staff must complete the Compliance courses that are due 30 days from your hire date. These courses are in the Assigned Learning section of your My Learning page.

If you do not complete this on time, you will be placed on immediate suspension until you complete these assigned courses.

9. All other courses listed under the “Assigned” section have a due date 90 days from your hire date. You must complete these particular courses before your 90 day evaluation. Again, the due date will be listed next to the course name.

If you have **ANY** questions, please call 714/524-4823 or email us:

If you are at work: Isaac, Hannah or Lewallen, Carole

If you are at home: hannah.isaac@tenethealth.com or carole.lewallen@tenethealth.com.

**ADMINISTRATION AND MANAGEMENT WELCOME YOU
AND ARE PLEASED TO HAVE YOU JOIN OUR TEAM**

Chief Executive Officer	Kent Clayton
Chief Operating Officer	Dwayne Richardson
Chief Nursing Officer	Judith Chabot
Chief Financial Officer	Charles Natcher
Director of Business Development	Mary Ann Railey
Chief Human Resources Officer	Diane McCluskey
Hospital Compliance Officer	Rob Coe
Director of Quality Management	Fred Valtairo

**INSERTED
ORGANIZATIONAL
CHART**

**TEAM EXCELLENCE/
COMMITMENT TO QUALITY (C2Q)**

Corporate Service Excellence

True service excellence exceeds the customer’s expectations and is the key component that can differentiate one company from another in the marketplace. This can only be accomplished by a relentless focus on identifying and understanding customer needs and continuously implementing service and quality improvements.

Team Excellence has five pillars that provide the framework for strategic and business planning, communications and day to day operations. The five pillars are:

	Service	Quality	People	Cost	Growth
Service:	<i>I will treat everyone I work with as my customer, striving for exceptional service satisfaction.</i> <i>I will be responsive to all customer inquiries.</i> <i>I will anticipate and respond to my customers’ needs.</i> <i>I will have appositve attitude when interacting with my customers.</i>				
Quality:	<i>I am committed to continuous improvement in everything I do.</i> <i>I will incorporate change and new ideas with integrity and accuracy.</i> <i>I will deliver value through my contributions and innovative spirit.</i> <i>I know my role in the organization and how that role integrates with others.</i> <i>I am a team player and during crunch times take on duties outside my assigned tasks.</i>				
People:	<i>I recognized that PL’s most valuable asset is its people – who are due my degree of respect, support & cooperation.</i> <i>I will not waste other people’s time on activities with little value.</i> <i>I will act ethically and treat others the way I want to be treated.</i> <i>I will establish and maintain effective relationships with all my customers.</i>				
Cost:	<i>I will use PL’s resources as I would my own.</i> <i>I will responsibly use the equipment and supplies that are provided to me.</i> <i>I will look for effective alternatives when submitting requests for purchased supplies while adhering to my department’s budget.</i> <i>I will perform my duties in an efficient manner to ensure productivity at the highest level.</i>				
Growth:	<i>I will foster economic growth for the company by promoting personal and professional development and innovation.</i> <i>I will always be on the lookout for cost-saving and revenue-building ideas.</i> <i>I will make the most out of the special training and education made available to me by PL.</i> <i>I will help train and develop my fellow employees, focusing on the strengths and special talents of each individual.</i>				

In order to achieve our goal of 100% patient satisfaction we have retained services from an outside agency to survey our discharged patients randomly. Patient Satisfaction Measurement System (PSMS) is how we are rated weekly, monthly, quarterly and annually. Our PSMS goal is to be 5 Star in Inpatient, Outpatient, Emergency and Total Score. We provide our managers with weekly updates on the scores and areas to focus on.

C2Q Initiative:

This initiative is designed to enhance the overall quality and productivity of our care delivery process. It introduces a series of targeted initiatives in the areas of quality and patient safety, nursing practice, medical staff governance and patient throughput. There are six teams that serve C2Q that meet bi-weekly to improve processes. The six teams are:

**Nursing
Emergency Department
Quality**

**Continuum of Care (COC)
Admitting
Operating Room (OR)**

AIDET is a communication style that is utilized at PL to reflect basic fundamentals of service and quality and is a differentiating factor when comparing organizations. This style of communication keeps patients informed, helps alleviate fear and anxiety, positions the hospital as a quality organization and reflects compassion, respect, and dignity in all interactions. AIDET is an acronym that describes the dimensions of this communication style.

A =Acknowledge ~ includes greetings and making eye contact, try to address patient with their name

I =Introduce ~ include name, role and skill set

D =Duration ~ includes time expectations

E =Expectation ~ includes protocols to educate pt, invite questions, & keeps pt informed, always ask if they have any questions

T =Thank you ~ includes respectful and courteous closure to conversation

Leader Rounding for Outcomes:

This is a defined strategy for two-way communication with employees, physicians and patients that will guide actions to achieve specific outcomes. This is done on a daily basis to make sure we are achieving our goals. This helps us receive 100% satisfaction by addressing the needs of the patient, physician and employee immediately.

Mission Statement: “Quality Healthcare with a Personal Touch”

Vision: “Placentia-Linda Hospital will be recognized as the community leader in healthcare”

Values:

“As a service organization, the goal of service is primary. Every effort shall be made to provide the best possible care to the sick or injured. The needs of the patient are paramount and shall be met. The patient is an individual and shall be assured every reasonable protection of personal safety and property”.

You are welcome to contact your Team Excellence Leader and Guest Services, Marilyn Mandas, Extension 5923.

Placentia-Linda Hospital - Cultural Diversity

Commitment to Quality – Cultural Diversity Standard

“Placentia-Linda Hospital recognizes and respects the cultural, physical and social differences among our staff, associates, patients and their families, and visitors. We realize that each individual comes from a different background and brings a range of talent and opinions, which enrich our environment. The hospital attempts to mirror the community it serves and strives to appreciate cultural differences”.

Diversity is the difference that makes each of us unique. In the past, our country was considered the “great melting pot”; and, we were expected to blend together. Today, our society is a great mosaic, reflecting and accepting many cultures and differences.

Awareness of cultural factors can improve patients and family education, meet our community needs, and ensure that our patients receive quality care. When we factor the patient’s cultural views on health and wellness into the plan of care, the outcome is more likely to have a favorable outcome.

The values and beliefs of Placentia-Linda Hospital include treating each patient and employee as an individual. In accordance we then consider other factors that may affect the patients care. Below is an example of typical cultural assessment factors to consider.

- Where was the patient born? If an immigrant, how long has the patient lived in this country?
- What is the patient’s ethnic affiliation and how strong is the patient’s ethnic identity?
- Who are the patient’s major support people: family members, friends? Does the patient live in an ethnic community?
- What are the primary and secondary languages, speaking and reading ability?
- How would you characterize the nonverbal communication style?
- What is the patient’s religion, its importance in daily life, and current practices?
- What are the patient’s food preferences and prohibitions?
- What is the patient’s economic situation, and is the income adequate to meet the needs of the patient and family?
- What are the health and illness beliefs and practices?
- What are the customs and beliefs around such transitions as birth, illness, and death?

Cultural competent nursing care has been defined as being sensitive to issues related to culture, race, gender, sexual orientation, social class, and economic situation, among other factors.

As an employee of Placentia-Linda Hospital, we ask that by signing and dating the signature line on the “Orientation/Reorientation Verification Form”, you are affirming the fact that you will take the time to research patient’s cultural and ethnic beliefs when developing or contributing to the patient’s plan of care, while they are being treated at Placentia-Linda Hospital.

WORK SMART

Placentia-Linda Hospital Orientation

Body Mechanics and Office Ergonomics

Introduction:

Working in the modern health care environment can be a physically demanding job. Health care workers perform a variety of movements, including standing, sitting, reaching, bending, turning, lifting, pushing and pulling. Some jobs require repetitive motion such as keyboarding and mousing on the computer.

In any job function it is important to “work smart”.

Injuries can be avoided by using good posture and maintaining your physical condition through regular physical activities to maintain your flexibility and strength. The following information is provided as a foundation for safety and comfort over time in the performance of your job duties at Placentia-Linda Hospital. Any concerns about your work place should always be reported to your supervisor and/or safety officer.

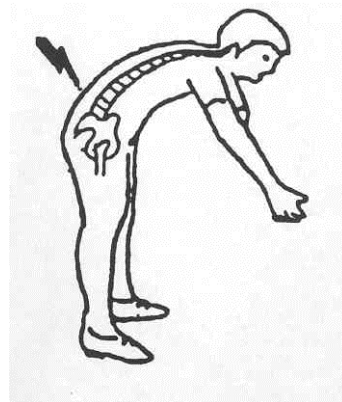
1) Poor Posture

The upper body is supported by the spine, which in turn is supported by the pelvis.



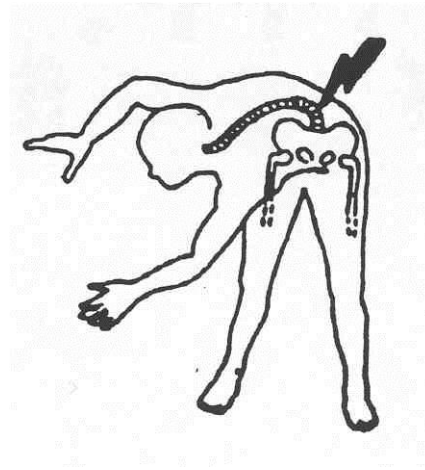
When you lean forward, your lower back supports up to 2/3 of your body's weight:

Head and neck	9%
Arms	11%
Trunk	46%
<hr/>	
Total	66%



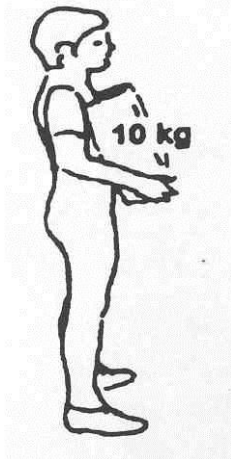
Certain extreme movements (bending and twisting together) are extremely hard on the back, for instance bending over and turning to one side.

These two types of movements can result in BACK INJURY in the short or long term (repetitive strain injury).

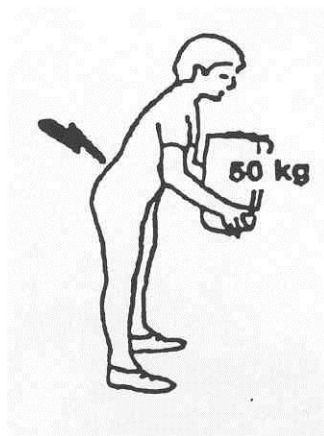


DISTANCE INCREASES STRESS ON THE BACK

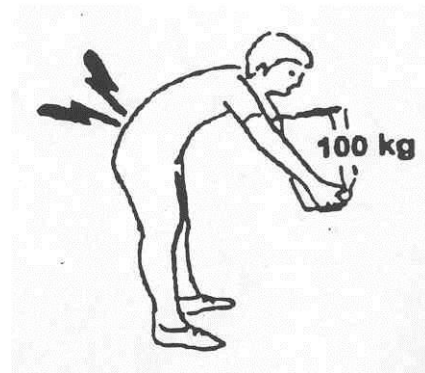
- ◆ Common sense dictates that it is very hard on your back to work while holding something at arm's length, especially when carrying a heavy load.
- ◆ The farther you hold the load from the pivot point (lower back), the longer the lever arm.
- ◆ When you bend forward, the pressure on your spinal disks (lower back) is approximately 10 times greater than the load being lifted.
- ◆ Hold the load as close as possible to your chest (reduce the length of the lever) to reduce stress on your back, particularly your lower back.



1 time the load



5 times the load

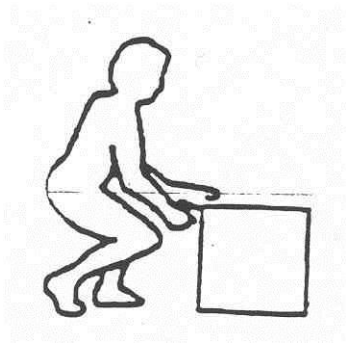


10 times the load

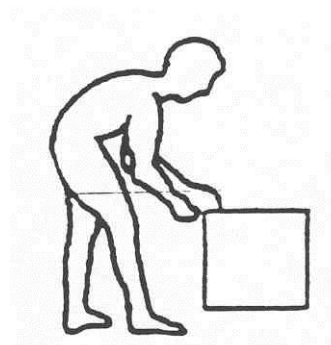
BACK SAFETY

Lifting

When lifting an object, it is important that the weight being moved or lifted is as close to the body's center of gravity as possible. The closer to the body's center of gravity the additional weight is, the more apt the additional weight is to be evenly distributed. The most frequent error made while lifting is that of bending over the weight. The act of bending over eliminates the lumbar curve, encourages the chin to be lowered and the shoulders rolled forward during the lift. This causes the body weight (2/3 of it) plus the additional weight of the load to be concentrated on the back.

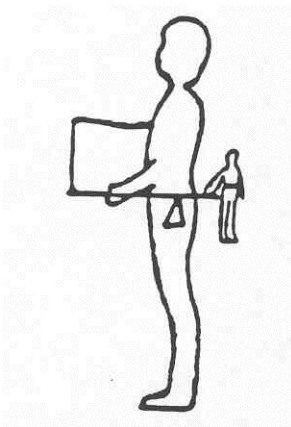


Right

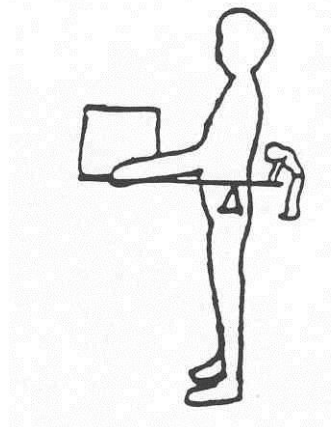


Wrong

Another principle to keep in mind when lifting is that the closer the weight is to your body, the less effort you must exert to lift the weight. For example, if you lift and carry 10 pounds away from your body, you are exerting 100 pounds of pressure on your lower back. However, if you lift and carry the 10 pounds close to your body, you are exerting only 10 pounds of pressure on your lower back.



Right

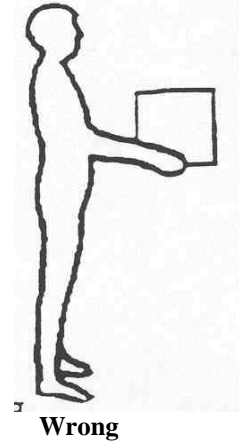
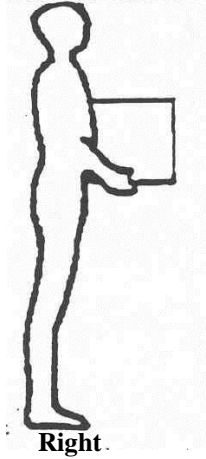


Wrong

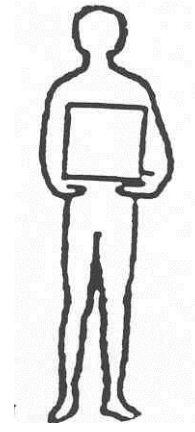
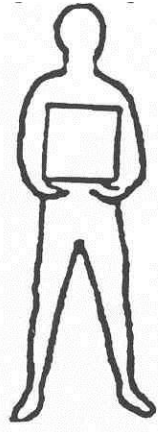
Rules for Safe Lifting

People often injure or re-injure their backs by lifting heavy objects improperly. These nine rules will teach you the proper way to lift and decrease your chances of back injury.

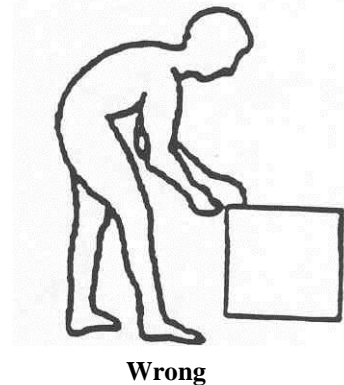
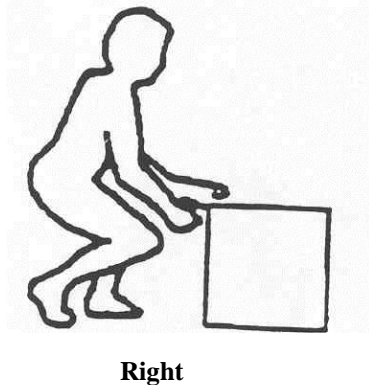
1. Look at the load. Size it up. Can you lift it by yourself, or do you need help?
2. Hold the load close to your body. Do not lift with outstretched arms. It increases the stress on your back.



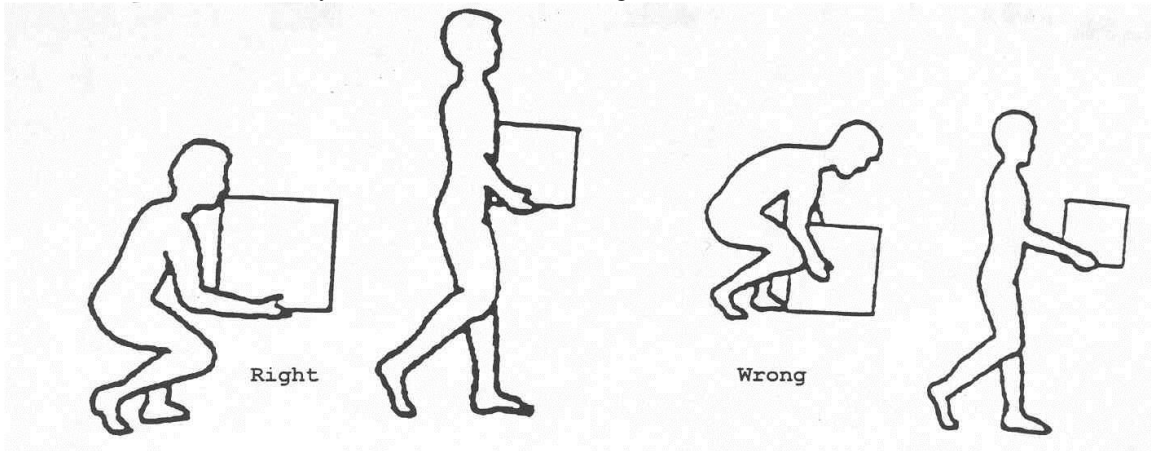
3. Keep your feet spread apart to give you a good base of support for lifting.



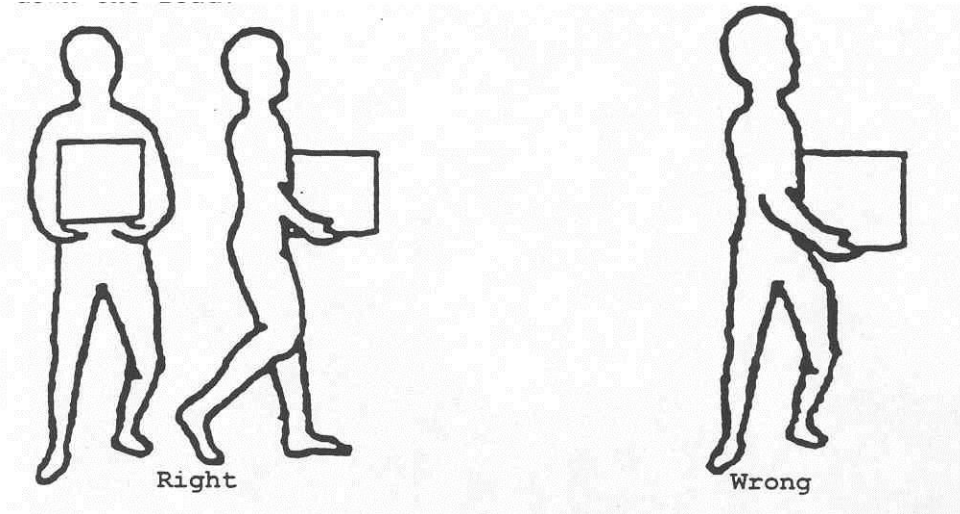
4. Keep your back straight. Bend your hips and knees to lower your body to the object.



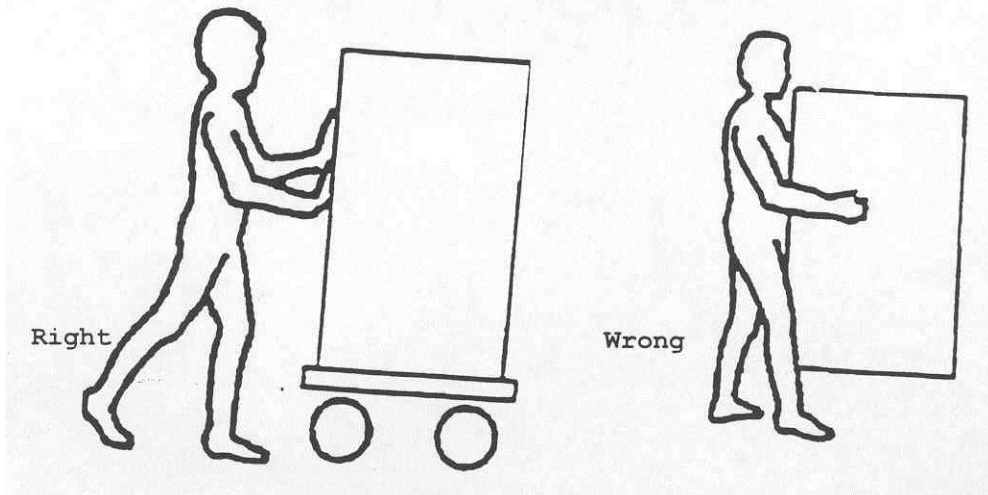
5. Always come to standing with your head and shoulders first, as you straighten your legs to lift. Always maintain the inward curve of your lower back while lifting.



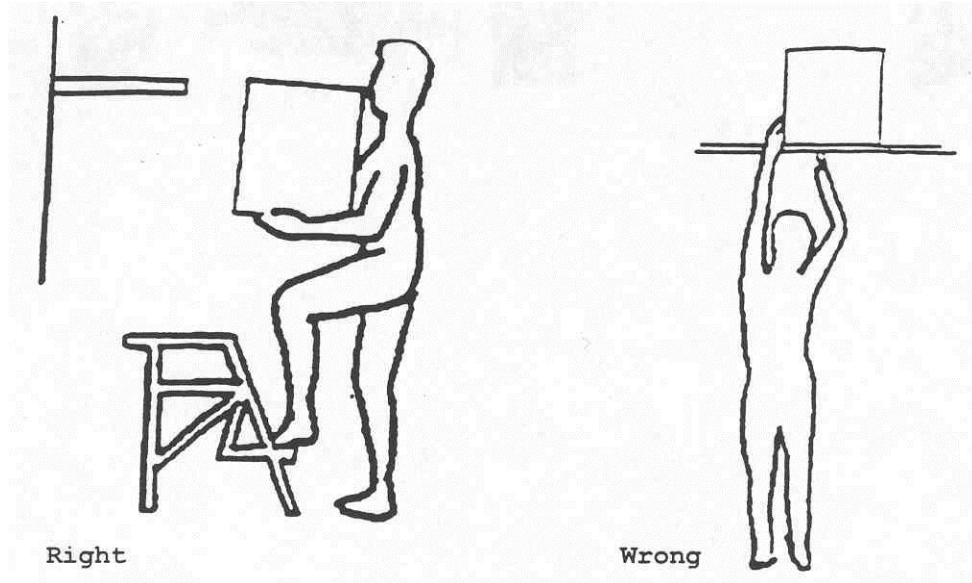
6. Do not twist while lifting. If you must turn, pivot and then set down the load.



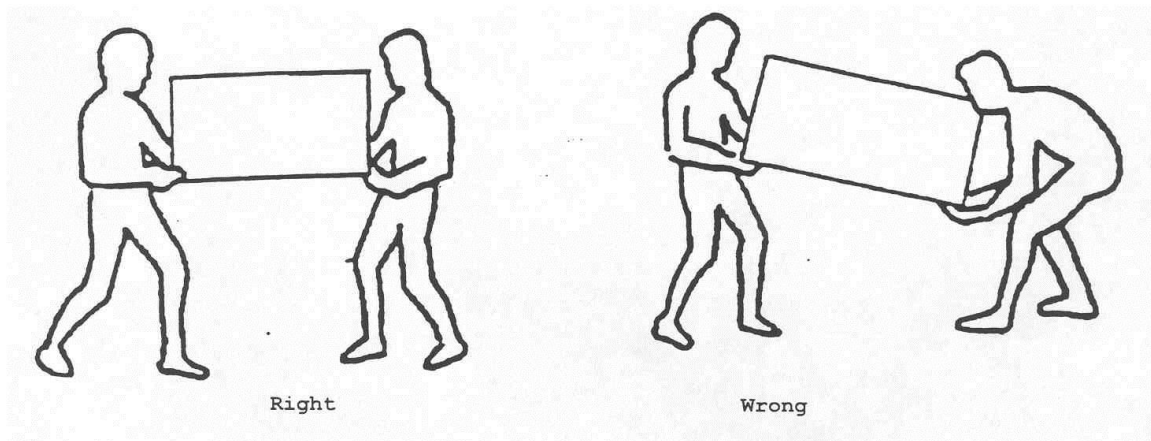
7. Anytime you can, roll or scoot a heavy object. Do not lift a heavy load unless necessary.



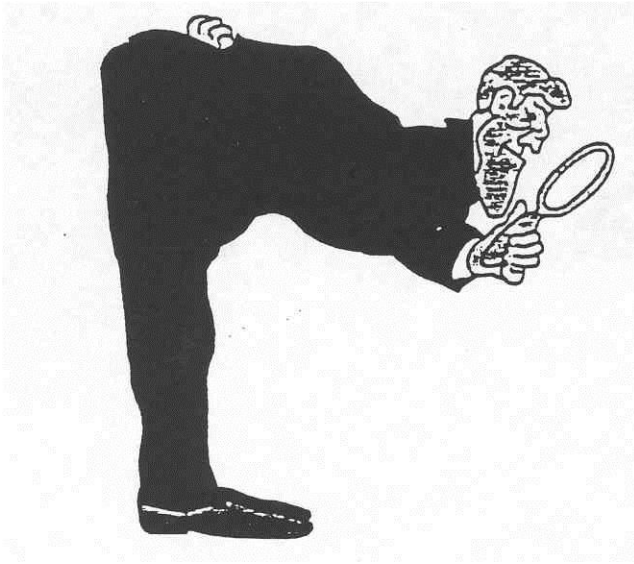
8. Do not lift a heavy object over your head. Use a stepladder or stool.



9. If someone is helping you with the lift, work together. Count to three before lifting.



Following these rules for lifting keeps your body in good alignment as you lift. This protects your back.



“What do you mean I’m not using proper body mechanics!”

BACK CARE TIPS

- Change position often while at work or at home – get up every 30 minutes.
- Avoid stools and benches without backs.
- Eat properly and keep your weight down.
- Sit in a well fitting chair with feet on the floor and thighs parallel to each other.
- Used a rolled towel if your chair does not support the normal curvature of your lower back.
- Lift properly. Use bent legs and keep back straight. Do not twist your trunk.
- Plan ahead. Clear your path before you start.
- Avoid the forward stooping position. Work levels should allow for this. When standing for a prolonged period, lift one foot onto a stool.
- During your break – don’t sit!
- Allow yourself to get enough rest at night – 6-8 hours.
- Avoid sudden maximal physical effort when you are out of shape.
- Choose a recreational activity and do it 2 or 3 times a week for 30 minutes.
- Do abdominal strengthening exercises 6 days a week. This will help to support your spine during lifting and promote good posture.
- Practice stress reduction techniques such as relaxation, deep breathing, imagery, and yoga.
- Do back extensions 4-5 times after sitting and before lifting.

OFFICE ERGONOMICS: WORKING WITH COMPUTER TERMINALS

ADJUST THE CHAIR

- Adjust the height of the chair's seat so thighs are horizontal, feet rest flat on the floor and arms and hand are comfortably positioned at the keyboard.
- If the chair is too high, adjust the chair first and use a footrest. This takes pressure off the back of the thighs.
- Adjust the backrest so that it supports the lower back and fits the curvature of your spine.

ADJUST THE DISPLAY

- Position the screen to minimize glare and reflections from overhead lights, windows, and other light sources.
- Adjust the display so that the top of the screen is slightly below eye level when sitting at the keyboard.
- Set the contrast or brightness of the screen to a comfortable level.
- Where it is impossible to avoid reflections or adjust lighting, an anti-glare filter placed over the screen can be helpful.



ADJUST THE LIGHTING

- Draw the drapes or adjust blinds to reduce glare.
- Adjust desk lamp or task light to avoid reflections on the screen. Light sources should come at a 90-degree angle, with low watt lights rather than a single high watt.
- The task lighting should not be less than light at screen.

ADJUST THE DOCUMENT HOLDER

- Position document holder close to screen and at the same level and distance from the eye to avoid constant changes of focus.
- Rotate position of document holder to opposite side of screen periodically.

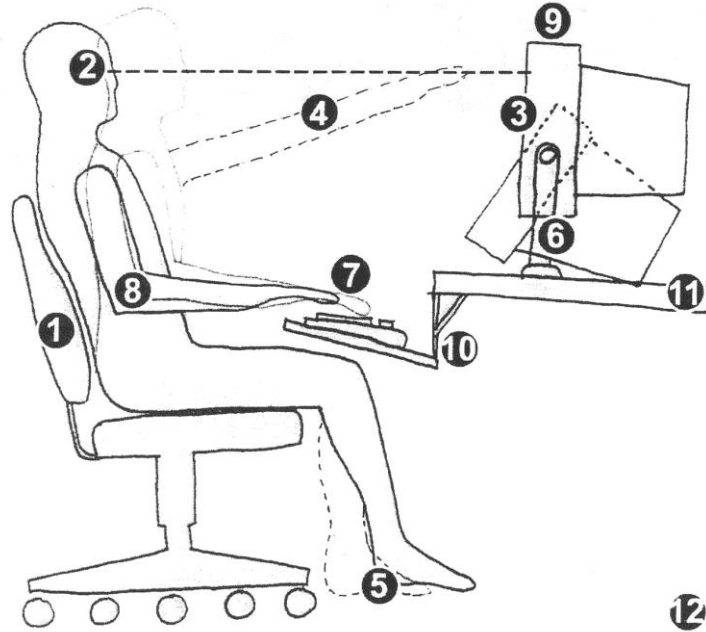
WORK SMART

- Change positions, stand up and stretch periodically. Touch on the keyboard lightly, keeping hands and fingers relaxed, and wrists and body in neutral positions.
- Become aware of other tasks such as manual stapling, sorting through large volumes, and mail sorting where repetition and awkward positions may contribute to repetitive motion injuries. Seek alternate ways to perform the tasks, reduce the load, or rotate jobs.

COMPUTER POSTURE

- The head should be straight and balanced over the spine while looking forward at the screen. Eliminate the flexed-neck position.
- Elbows should be bent at 90 degrees when hands are on the keyboard.
- Wrists should be in a neutral position. Utilize wrist rests at the edge of the keyboard for support.





12 tips for an Ergonomic Computer Workstation

1. Use a good chair with a dynamic chair back and sit back in this
2. Top of monitor casing no more than 2-3" (5-8 cm) above eye level
3. No glare on screen, use an optical glass anti-glare filter where needed.
4. Sit at arm's length from monitor
5. Feet on floor or stable footrest
6. Use a document holder, preferably in-line with the computer screen
7. Wrists flat and straight in relation to forearms to use keyboard/mouse/input device
8. Arms and elbows relaxed close to body
9. Center monitor and keyboard in front of you
10. Use a negative tilt keyboard tray with an upper mouse platform or downward tilt able platform adjacent to keyboard
11. Use a stable work surface and stable (no bounce) keyboard tray
12. Take frequent short breaks (micro breaks)

Remember:

- ✓ **If you feel that your computer work station requires adjustment to meet your needs and safety, please notify your supervisor and/or safety officer so we can provide an ergonomic assessment.**
- ✓ **If you injure yourself on the job, or feel that you are suffering from a work-related injury notify your supervisor immediately.**
- ✓ **Placentia-Linda Hospital is committed to keeping the workplace injury-free.**

EMPLOYEE HEALTH

Immunizations: vaccines are available to staff to protect against certain communicable diseases

- Hepatitis B
- MMR
- Tetanus/Pertussis
- Varicella (chickenpox)
- Influenza
- Pertussis

Annual Updates are required for all employees

Annual Tuberculosis screening:

- Employees with negative skin tests: TB skin test and Health screening history questionnaire
- OR
- Employees with history of positive skin test will perform a symptom review. Need for chest x-ray to be decided by Employee Health Nurse.

Respiratory protection oversight

- N95 mask fitting (for all employees who may have the potential to work with “rule out” or confirmed tuberculosis or SARS patients)
- Full-face respirator fitting (for employees working with fume or vapor producing chemicals)
- PAPR (powered air purifying respirator) for employees who perform high hazard procedure for patients with suspected or confirmed airborne diseases or for those who were not able to be fitted for N95 respirator.

Employee Health Oversight

- **Worker Injury Prevention for:**
 - repetitive motion
 - sprains/strains
- All exposures to blood or other potentially infectious materials must be reported to your supervisor after flushing or washing the exposed area with soap and water.
- **All work injuries** including blood or body fluid exposure) report to your manager STAT, your manager will refer you to the Employee Health nurse (First Responder) or to the Nursing Supervisor in the absence of the EH nurse for evaluation and work-up
- If you work nights and do not have an immediate manager, report to the House supervisor STAT for an evaluation (the House Supervisor functions as the First Responder when Employee Health nurse not available).

Worker Safety

- Employee Health is focused on injury prevention
- Use correct body mechanics when lifting, pushing, or pulling.
- Size up the weight of the load you are about to lift, push, or pull. Ask for assistance as needed..

INFECTION CONTROL

Standard Precautions

You should protect yourself from all body fluids, from all patients, at all time utilizing standard precautions.

Hand hygiene: term by CDC to indicate the 2 types of hand cleansing for care givers

- Hand washing: soap/water/friction for 15 seconds, rinse well, pull off a disposable towel from the dispensary, pat hands till dry then turn off the faucet with that towel.
- Waterless hand sanitizers are available throughout the facility (such as Purell): use for quick hand de-germing; one push of dispenser, rub the solution all over the hands, especially between the fingers and under fingernails: allow to air dry, wash hands with soap/water after 6 - 10 uses of the waterless hand sanitizer.
- **Hand hygiene before putting on and after removing gloves.** Gloves are to be changed between the care and handling of every patient.
- If hands are visibly soiled, always wash your hands with soap and water.
- Good hand washing techniques keep you from transferring contamination to other areas of your body and the environment.

Personal Protection Equipment (PPE) must be used when there is a chance of exposure to blood or body fluids (evaluate every patient interaction for risk). PPE includes:

- Gloves, Mask/Goggles, Gown

Personal Protection Equipment (PPE) supplies

- Located in specific patient care rooms and in specific yellow isolation carts
- Restocked by central services as needed

Isolation Precautions

Airborne Precautions - Use for tuberculosis (TB), varicella (chickenpox), measles, SARS

- Patients should be in special negative air room (300-1, 215, 226, ED room 8) and GI Lab. Door(s) must be closed at all times.
- Special N95 mask is required when in contact with patients with tuberculosis and SARS. Remove mask after exited the room.
- Only care givers immune to varicella and measles should care for patients with varicella and measles
- Patient must wear a surgical mask if taken out of his isolation room
- Infection Preventionist must be notified of a patient admitted with TB, chickenpox, measles or SARS as soon as possible

Droplet Precautions – Use for haemophilus influenzae meningitis; Neisseria meningitis; pertussis, influenza, mumps, rubella, group A strep pharyngitis (strep throat)

- Patients may be in any room; door does not have to be closed
- Organisms do not travel more than a few feet from patient
- Wear surgical mask prior to entry into the room. Remove mask prior to exiting the room.

Contact Precautions – Use for MRSA, VRE, C. difficile, RSV, Gram negative bacilli ESBL, MDRO Acinetobacter, Carbapenem-resistant Enterococcus, shingles, impetigo, highly contagious skin infestations: scabies, lice etc

- Patients may be in any room; door does not need to be closed
- Wear gown and gloves prior to entry into the room
- In addition, wear surgical mask if MRSA is present in the sputum to prevent colonization of care giver's nose
- Consult infection control for guidance on discontinuing isolation for resistant organisms, as requirements are different for the different resistant organisms

Special Precautions - used for SARS (Severe Acute Respiratory Syndrome) which may be transmitted by both airborne and contact

- Initial assessment is very important: travel history or association with someone exhibiting same symptoms who recently traveled to Far East or Toronto, within 10 days of onset of symptoms
- Patients need to be placed in a negative air flow room; doors closed at all times
- Wear a mask (N95), eye protection, gown, and gloves. PAPR is used in lieu of N95 mask during high hazard procedure.
- Limit transport of patient - if patient must leave room, mask patient
- Use dedicated non-critical equipment (BP cuff, thermometer, stethoscope) that can remain in patient room

Protective Isolation: Neutropenic Precautions - used for patients with very low white counts as defined in the policy

- Physician's order is required
- Fresh flowers or plants **are not allowed in room**
- Inform dietary patient is on Neutropenic Precaution
- All persons, including visitors, entering room **MUST** wash hands prior to touching the patient
- All persons entering room **MUST** be free of communicable illnesses, such as the common cold, influenza, cold sores etc.

MRSA (methicillin resistant Staphylococcus aureus)

- A resistant strain of Staphylococcus aureus)
- Now noted to be several resistant strains, one identified as “community-acquired”, and for which the antibiogram is different than for what we see in hospitalized patients
- Shown to settle on hands and in nose (colonization), so gloves and good hand hygiene are essential
- Notify infection control for guidance on testing for colonization and discontinuation of isolation
- **Requires contact precaution and use of mask when present in sputum**, so that care giver does not become colonized

VRE: Vancomycin Resistant Enterococcus

- VRE is a “gut” organism, which contaminates the patient’s surrounding environment, especially if patient has diarrhea
- VRE is a hearty organism; lives on inanimate objects for several days
- Put patient on Contact Precaution
- Notify infection control for guidance on testing for colonization and discontinuation of isolation

Patient Care and Infection Prevention

Aseptic technique

- Keep the work area and personnel as free from microorganisms as possible with the intent of protecting the patient and the caregiver
 - The care giver must know what is clean, disinfected or sterile
 - Clean, disinfected and sterile items must be kept separate from contaminated items
 - Take immediate action if contamination occurs
 - Avoid eating at the nurses station or at your work stations in the hall, break rooms are available for your use
- Practiced for any invasive sites
 - Insertion, dressing changes, accessing central lines
 - Insertion, accessing of indwelling urinary catheters
 - Surgical incisions: dressing changes
 - Venous access, insertion of chest tube, paracentesis, thoracentesis, etc
 - Dialysis access
- Hands must be washed or hand sanitized before and after applying clean patient gloves. Gloves, isolation gowns, or mask cannot be worn outside the immediate patient care area. (i.e. in the halls)

Turn, cough and deep breathe or ambulate as soon as possible

- Prevention of pneumonia for all post-op and bed-ridden patients
- At least every two hours provide position changes
- Encourage patients to take very deep breaths to promote lung expansion and move legs by bending at knees several times, moving feet by rotating ankles
- If incentive spirometry is ordered, ensure patient uses as ordered (10 times per hour is standard)

Oral care for prevention of ventilator-associated pneumonia in patients on ventilators, and for those patients who cannot do own activities of daily living (ADLs) for prevention of hospital acquired pneumonia, and for patients with NG tubes, to prevent hospital acquired sinusitis

- Use of Sage 24 hour oral care pack for ventilated patients (all nurses hired to Critical Care Unit will be oriented to this protocol as part of their unit orientation)

Ventilator-associated Events (VAE): prevention strategies...

- Head of bed up at least 30 degrees, if not contraindicated
- Turn and position every 2 hours
- Oral care protocol
- Frequent suctioning of oral pharynx
- If on enteral feedings, aspirate for gastric residual every shift
- Maintain adequate ventilation and ET tube cuff pressure
- Close attention to HAND HYGIENE
- Provide DVT prophylaxis per MD order.
- Protocol for identification, administration, and documentation of pneumonia and/or influenza vaccines
- Daily assessment of readiness to wean

Skin checks

- Important nursing function upon admission of patient to rule out communicable skin conditions such as SCABIES, LICE, IMPETIGO, as well as pressure areas already present
- Skin must be assessed every shift for early detection and prevention of pressure skin break down
- Target patients from long term care and who are homeless
- Notify Infection Control if suspicious skin condition noted and place patient into CONTACT precaution STAT, then notify MD of your findings/actions
- If any breaks or tears in skin on admission ESRM needs to be completed.

Catheter-related Urinary Tract Infection Prevention

- Use sterile technique for insertion. Perform pericare prior to use of betadine swab. Perform foley catheter care after insertion
- Remove indwelling urinary catheter ASAP
 - evaluate your patient daily for necessity.
 - do not leave in for convenience as it will harm the patient by causing an infection, extend the patient's stay and can lead to other hospital acquired infections or conditions related to treatment of the UTI
- Handling of the urinary catheter and collection bag
 - Wash hands then put on gloves prior to handling any part of the securement device and/or the foley catheter drainage system
 - position tubing so that the flow is downward, not back toward the bladder. Do not allow tubing to loop.
 - keep collection bag off the floor.
 - access for specimens aseptically (port is needle less), use alcohol prep pad to disinfect access port prior to specimen collection
 - when emptying bag, do not allow drainage spout to touch measuring cup
 - date of the foley insertion to be written on the drainage bag and tag the patient's chart
- Care: Peri-care followed by foley catheter care once a shift and after each bowel movement. Use prepackaged perineal wipes or a clean bath basin/soap/water
- Encourage patient to drink, if not contraindicated, water is best fluid for UTI prevention

Peripheral IV and central line sites dressing changes

- Peripheral IV site q 96 hours, unless otherwise indicated
- Central line sites is weekly, unless otherwise indicated
- Aseptic technique with handling IV sites and iv management
- Use of central line dressing kit which contains chlorhexidine for central lines

Odds and Ends

Cultures for determining presence of infection

- Require use of aseptic technique to obtain
- Require an MD order
- DO NOT Draw blood specimen from central line for convenience. Requires specific order from MD and only if patient does not have any venous access.
- These help MD determine type of antibiotic to start empirically, once the final culture result is issued.

Culture results and sensitivities

- The final culture will identify the organism(s) and provide sensitivities to the antibiotics that are effective to kill the organism(s)
- Just because there are organisms identified on the culture, does not mean there is an infectious process going on; that is for the MD to determine, based on the area cultured, amount and type of organism(s) identified and other signs and symptoms of infection

Preventing Central Line-related Blood Stream Infections (this includes PICC lines)

- Quality monitor for Tenet facilities
- High risk of infection for patients with central lines
- Costly in mortality and morbidity for the patient, as well as in time in hospital and treatment
- Sterile insertion technique of utmost importance
- Aseptic accessing of ports of utmost importance

Safety Sharps Products

- Needleless IV System: luer lock system
- Blood collection, various safety devices for ER, CCU and Lab
- ABG collection
- Surgery

Latex sensitivity

- For patients who state they have a latex allergy or sensitivity use the latex free products which is available by contacting central service.
- Read the label of all packaged products that you may have to use on your patients; **law states if latex in product, must label with these words: “this product contains natural rubber latex which may cause allergic reactions” or “this product contains dry natural rubber”**

Never drink, eat, apply cosmetics, lip balm, or handle contact lenses in work areas where you may be exposed to infectious materials. These activities are allowed only in the break rooms or cafeteria.

NATIONAL PATIENT SAFETY GOALS

1. Improve the accuracy of patient identification.
 - Use at least two patient identifiers when providing any care, treatment or services.
 - Ask the patient what their name is and date of birth and have them tell you.
 - Our two patient identifiers are name and date of birth and validate this by using a source document against their arm band.
 - Eliminate transfusion errors related to patient misidentification – before initiating a blood or blood component transfusion
 - Match the blood or blood component to the order
 - Match the patient to the blood or blood component
 - Use a two-person verification process

2. Improve the effectiveness of communication among caregivers.
 - For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information write down then "read-back" the complete order or test result.
 - Write down the order and read it back to the physician
 - For ancillary departments communicating a critical test result, document date, time, first/last name, title of person, and that read back was performed.
 - For nursing departments, write down the result and read it back to the person who is giving you the result.
 - Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization by any healthcare professional.
 - DO NOT USE ABBREVIATION LIST below.
 - Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
 - List of critical test results for lab, respiratory, and radiology are approved by Medical Staff annually.
 - Per policy, critical test results must be received by the physician within 30 minutes of when the result is made available.
 - For nursing departments, document the date/time you receive the critical result from the ancillary department, when you contacted the physician, and when the physician called back to receive the critical result.
 - Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.
 - SBAR (situation, background, assessment, recommendation) is the standardized approach we use to hand off a patient.
 - Face to face contact between staff during the “hand off” is done to allow an opportunity to ask and respond to questions.


3. Improve the safety of using medications.
 - Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.
 - Look-alike/sound-alike list reviewed annually by Pharmacy & Therapeutics Committee.
 - Tall man lettering used to distinguish certain drugs from each other and stored separately.
 - Alert labeling used on medications and eMAR.

NATIONAL PATIENT SAFETY GOALS (Continued)

- Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field that are not immediately administered (no break in the process).
 - Medication or solution labels include the following:
 - Medication name
 - Strength
 - Quantity
 - Diluent and volume (if not apparent from the container)
 - Expiration date when not used within 24 hours
 - Expiration time when expiration occurs in less than 24 hours
 - Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.
 - Baseline INR for initiation of Warfarin, Current INR for monitoring/adjusting
 - Use approved protocols for initiation/maintenance of anticoagulant therapy
 - Heparin infusion must use a Smart pump
 - Patient/family education to include (i.e. compliance, drug-food interactions, potential for adverse drug reactions and interactions)
4. Reduce the risk of health care-associated infections.
- Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
 - Monthly hand hygiene audits done by the Patient Safety Champions within each department.
 - Wash hands if patient has diarrhea or hands are visually soiled, otherwise, alcohol gel may be used.
 - Wash hands or use alcohol gel:
 - Before and after patient contact
 - Before an aseptic task
 - After body fluid exposure risk
 - After patient contact
 - After contact with patient surroundings
 - Implement evidence-based practices to prevent health care associated multi-drug resistant organisms – MRSA, VRE, C diff
 - Implement evidence-based practices to prevent Central-Line Associated Blood Stream Infections, Surgical Site Infections, and indwelling Catheter-Associated Urinary Tract Infections
5. Accurately and completely reconcile medications across the continuum of care.
- There is a process for comparing the patient's home medications with those ordered for the patient when admitted
 - Medication Reconciliation is done when the patient is transferred to or from Critical Care or after Surgery (change in level of care).
 - A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. **The complete list of medications is also provided to the patient on discharge from the facility.**

NATIONAL PATIENT SAFETY GOALS (Continued)

6. Reduce the risk of patient harm resulting from falls.
 - Implement a fall reduction program including an evaluation of the effectiveness of the program.
 - Hospital tracks fall rates and severity of falls (CalNOC used as a benchmark).
 - Fall reduction strategies include:
 - Diuretic times changed (last dose @ 1800)
 - Bed alarms are used
 - Fall risk symbols used at the head of bed or outside door
 - Yellow gown and armband
 - Patients placed in rooms near nursing station
7. Encourage patients' active involvement in their own care as a patient safety strategy.
 - Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.
 - Patient safety brochure given to patients on admission
 - Patients/families can initiate a medical response team if no response from staff nurse or charge nurse
8. The organization identifies safety risks inherent in its patient population.
 - The organization identifies patients at risk for suicide
 - Suicide risk screen is done upon admission by nursing
 - If patient is screened to be at risk then a suicide risk assessment is done by a LIP (licensed independent practitioner) or social worker
 - Address the patient's immediate safety needs and any environmental issues that may increase that risk
9. Improve the recognition and response to changes in a patient's condition
 - Medical response team rolled out house-wide for any staff to initiate
 - Medical response team protocols in place and approved by the Medical Staff.
10. Universal protocol - Intended to prevent Wrong Site, Wrong Procedure, Wrong Person surgery.
 - Conduct a pre-procedure verification process (checklist)
 - The procedure site/side is marked by the person performing the procedure with "yes" when laterality is at issue. Involve the patient if possible.
 - Time out
 - Correct patient identity
 - Confirm that the correct side and site is marked
 - An accurate procedure consent form
 - Agreement on the procedure to be done
 - Correct patient position
 - Correct implants present. Special equipment present
 - Site marking is visible after prepping/positioning//draping
 - Safety precautions based upon patient's history and/or medication use
 - Appropriate selection of antibiotics given within 60/120 minutes of incision and/or fluids for irrigation purposes
 - Essential imaging properly labeled and displayed

 Placentia-Linda HOSPITAL™	Nursing Policies & Procedures	No.	Page: 1 of 1
	Subject: Unapproved Abbreviations “Do NOT Use List”	Original Date: 4/04	
		Revised: 1/12	Reviewed:

I. PURPOSE:

- A. The purpose of this Policy and Procedure is to provide an organization-wide drug safety policy designed to prevent medication errors caused by the use of dangerous abbreviations and dose designations as recommended by the National Coordinating Counsel for Medication Error Reporting and Prevention (NCCMERP), The Joint Commission (TJC) and the Institute for Safe Medication Practices (ISMP).

II. PROCEDURE:

- A. If an unapproved abbreviation is used (making the order ambiguous) that is not on the Approved Abbreviation List, the order will be verified with the prescriber prior to the order being carried out.
- B. If a “Do Not Use” Abbreviation is used, the nursing or pharmacy staff will carry out the order unless verification/clarification is required to ensure patient safety. If a staff member obtains verification/clarification of the order, proper documentation will be made in the patient’s medical record
- C. Compliance with this policy shall be monitored and corrective action shall be taken if necessary to ensure compliance.

III.

"Do Not Use" Abbreviation List:

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write “unit”
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	“Write International Unit”
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other. Period after the Q mistaken for “I” and the “O” mistaken for “I”	Write “daily” Write “every other day”
Trailing zero (X.0 mg) Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium sulfate. Confused for one another.	Write “morphine sulfate” Write “magnesium sulfate”

Management of the Environment of Care

The goal of this function is to provide a safe, functional, supportive, and effective environment for patients, employees, physicians, volunteers and visitors in the hospital. This is crucial to providing quality patient care and achieving good outcomes.

Environment of Care Committee

The Environment of Care Committee is a standing, multi-disciplinary, hospital-wide committee appointed by the Chief Executive Officer. The purpose of the Environment of Care Committee is to monitor and evaluate the activities of the hospital-wide safety/risk management program.

This committee has oversight responsibility for the **six Environment of Care Plans**:

- Safety Management
- Utilities Management
- Equipment Management
- Hazardous Materials and Waste Management
- Security Management
- Fire Safety Management

Fire Safety Plan

The Fire Safety Management Plan provides guidelines for the establishment of policies, procedures, and protocols necessary to provide a fire-safe environment of care. This plan covers aspects related to compliance with the Life Safety Code as articulated in the NFPA 101, NFPA 99, NFPA 72, and other pertinent regulations with respect to methods of construction, protection systems, and individual education in life safety measures.

Joint Commission Overview

IN CASE OF FIRE, “R.A.C.E.”

1. **RESCUE** - Rescue anyone in danger – patient, visitor or staff
2. **ALRM** - Pull the fire alarm or have someone nearby do it. This will notify others in the hospital and the fire department.
3. **CONTAIN** - Close all doors in the area to protect others and **CALL “2020”** for assistance.
4. **EXTINGUISH / EVACUATE** - Use a fire extinguisher only if it is safe to do so. Evacuate the area if fire and smoke are present by using the evacuation procedures found in the disaster/safety manual located in hospital departments. **Do not attempt** to open any door that is “hot to the touch.”

USE OF FIRE EXTINGUISHER

Types of fire extinguishers

- A – Used for ordinary combustibles
- B – Used for flammable liquids
- C – Used on electrical equipment fires
- ABC – A combination of the 3 types of extinguishers

P.A.S.S. (Pull pin, Aim at base of fire, Squeeze handle, Sweep side to side)

Responding to Fire Alarm

All available staff members should respond to **ALL** fire alarm location with portable fire fighting equipment.

Staff will be notified of a **“CODE RED”** by:

- Activation of the fire signal system
- The PBX shall utilize the overhead paging system to notify staff of the location.

Nursing supervisor shall notify the Administrator-on-Call if applicable.

Staff members not responding to the fire location shall close patient room doors, corridor doors and ensure clear egress for exiting in an emergency situation.

OXYGEN SHUTOFF

When a fire occurs, oxygen in the affected area may need to be shut off to prevent the fire from spreading. Every patient care unit within the hospital is equipped with a “zone shut-off valve.” This valve will shut off oxygen only to the areas indicated by signage next to the valve.

The charge nurse, unit manager, nursing supervisor, respiratory therapist or engineer are authorized to turn off.

The unit supervisor and/or Respiratory Therapist will have the most knowledge about how oxygen is being used by patients on the unit and what steps must be taken to ensure the continuation of appropriate patient care.

Safety Management Plan

The Safety Management Plan is an organization-wide plan designed to provide a safe environment for patients, physicians, employees, volunteers and visitors. The purpose of the plan is to:

- Minimize risks of injury or loss while promoting our Commitment to Quality Patient Care
- Identify and analyze incidents/occurrences that have the potential for the risk of injury or loss in order to reduce or minimize such injury/loss.

Safety Management Implementation

- Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants and internal physical systems on patient and public safety
- Safety issues are examined by appropriate representatives from administration, clinical and support services
- All incidents of property damage, occupational illness, and patient/personnel/visitor injuries are reported and investigated
- Heavy or breakable objects should be replaced when possible, secured safely and stored on lower shelves

Radiation Safety

Our Radiation Safety Officer is Dr. Michael Brand, Medical Director of Radiology. During a portable x-ray, all visitors and/or non-essential personnel are to leave the area during the procedure. Otherwise, a safe distance from the radiation main beam during a portable x-ray exposure is **6 feet**.

Electrical Safety

Discontinue use of equipment that has any wire or power cord that shows fraying, extreme wear, cut in insulation or evidence of burning. Equipment removed from use must be reported to Engineering Department.

Proper procedure for connecting and disconnecting electrical plugs:

- Never disconnect plug from the electrical outlet by grasping and pulling the power cord
- Grasp the plug itself and disconnect

Hazard Surveillance

The Safety Officer and designees conduct monthly hazard surveillance rounds. Clinical and non-clinical areas are surveyed to assure that we maintain a safe work environment. Hazard Safety education is provided to insure that employees are advised of potential hazards in their work place, including hazardous spills, use of toxic substances and needle/sharps safety. Findings are reported to the EOC Committee for appropriate action and follow-up.

Emergency Codes – Dial “2020”

Policies are in the Administrative and Safety Manuals and can be found on the internet at plh.ellucid.com.

CODE RED	Fire or smoke in any area
CODE TRIAGE	Response to an external or internal disaster
CODE ORANGE	Chemical spill
CODE YELLOW	Bomb threat
CODE PURPLE	Child Abduction
CODE PINK	Infant Abduction
CODE BLUE	Adult medical emergency
CODE WHITE	Child medical emergency
CODE GRAY	Combative person
CODE SILVER	Person with a weapon or hostage situation
CODE GREEN	Patient on legal hold or with confusion, a danger to self or others, has left/escaped from their room

Safety Officer

Director of Facility Services, Valerie Laktash, is assigned as the Safety Officer of Placentia-Linda Hospital.

Employee Accidents

All employee accidents are to be reported to their respective supervisor/manager immediately. House Supervisor or Employee Health Nurse (First Responders) will take the report if the immediate supervisor/manager is not available.

Utilities Management Plan

The objective of the Utilities Management Plan is to establish, maintain and continually provide a reliable program to promote a safe, controlled and comfortable environment of care for patients, visitors, and hospital personnel. The plan provides for the assessment and minimization of risks of utility failures and to ensure the operational reliability of the utility systems. Any disruption to utility services must be reported to Facility Services department immediately.

Utilities Management Implementation

- Continuous surveillance of all utility systems through a systematic program of preventative and corrective maintenance
- Labeling and instructions for use of shutdown controls
- Reporting process for utility system problems, failures and user errors

Utility Types

Utilities are systems considered to be critically necessary to support safe reliable treatment, diagnosis, or monitoring of patients in a safe, controlled and comfortable work environment for employees, volunteers and medical staff. These systems include:

- Life support systems
- Infection control systems
- Environmental support systems
- Equipment support systems
- Communication system

Back-up water supply options

The Materials Management Storeroom maintains an inventory of one and five gallon bottles of drinking water.

Two hot water heaters located in the engineering mechanical room contain about 200 gallons each and Softener tanks contain about 800 gallons. These tanks must be manually drained.

Back-up systems for loss of external power

- An emergency power generator (automatically implemented within 10 seconds of power failure) supply power to the emergency branch circuits equipment.
- Uninterrupted power source (battery) for computers (limited time capacity)

Back-up for internal telephone systems

- In the event of a power failure, the telephone system is supported by the emergency generator
- Modem and FAX lines are typically off the PBX system. Single line analog phones may be attached and used for external communication
- In the event of complete outside telephone failure, two-way radios and/or messengers will be utilized for communication with emergency services and medical staff in the community. INITIATE A CODE TRIAGE.

Equipment Management Plan

The objectives of the Equipment Management Plan are to develop, implement and maintain a Medical Equipment Management Program that assures the operational reliability of all patient-related medical equipment and to assess special risks and/or failures in a rapid and effective manner.

Equipment Management Plan Implementation

- Assessing and minimizing clinical and physical risks of equipment use through inspection, testing and maintenance
- Reporting and investigating equipment management problems, failures and user errors
- Establishing criteria for identifying, evaluating, and taking inventory of medical equipment to be included in the management program before the equipment is used

Defective Biomedical Equipment

All staff shall immediately report equipment malfunctions, user errors, and damaged equipment to the Bio-med Department. Defective equipment shall be immediately tagged by the user as “defective – do not use”. Equipment involved in a negative patient outcome shall be tagged and secured pending a third party review. All staff shall complete an incident report to describe the incident.

Preventive Maintenance

All biomedical equipment is placed on a cyclical Preventive Maintenance (P.M.) schedule. Each piece of equipment is labeled with a P.M. sticker, which denotes the date the next P.M. is to be performed. If equipment is found with an out-dated P.M. sticker, the Biomedical department should be notified.

Security Management Plan

The objective of the Security Management Plan is to establish and maintain a security program designed to protect staff, patients and visitors from harm. The primary purpose of the plan is to maintain a social order within prescribed ethical and constitutional limits. The Security Management Rules and Regulations comply with all applicable law with recognition of both the statutory and judicial limitations of hospital security authority and the constitutional rights of all people.

Security Implementation

- Employee must, by law, report all security issues such as theft, vehicle damage, or assault/battery concerning patients, visitors, personnel and property
- Annual risk assessments are conducted
- Access/Egress control is implemented to sensitive areas as determined by the hospital
- Infant/pediatric security procedures are identified and implemented
- Identification, as appropriate, is provided for all patients, visitors and staff

Security Sensitive Areas

Appropriate access control shall be established in security sensitive areas. Areas that have been identified as security sensitive include:

Medical Records	Rooftop Access	ER
Selected Perimeter Doors	Pharmacy	
Mechanical/Equipment Rooms	OR	

Controls used for these areas include magnetic door locks, high security locks and regulated key distribution.

Identification

- Hospital staff are identified with picture ID badges issued by the Human Resources Department; per the Joint Commission, ID badges must be visible at or above waist height.
- Contract staff are required to wear picture badges issued through their employer.
- Patients are identified by means of wrist bands issued at time of admission. The band must be used as a “patient identifier” denoting the patient name and medical record number prior to any procedure, diagnostic test or administration of medication or blood products
- Vendors and contractors must wear temporary identification badges issued in Materials Management
- Visitors must check in at the front lobby or ER lobby and wear a visitor badge.

Code Pink/Purple

Upon hearing a Code Pink/Purple announcement, all healthcare facility personnel are to immediately stop all non-critical work. Staff will cover all doors and exits from the facility, stopping anyone who is carrying anything that possibly could conceal an infant, such as a duffle bag, backpack (could carry a small infant), etc. Once all exits are covered, the staff are to search staff locker rooms, examination and equipment rooms, staff and public restrooms, waiting rooms, empty rooms and other areas within the hospital. If a child is reported missing it is important to call a Code Pink/Purple immediately. This increases the chance of locating the child and decreases the chance of them leaving the property either on their own or due to another person.

Code Gray

When a combative situation is identified where there is a potential risk of physical harm to staff, visitors or patient, dial “2020” and request a Code Gray to the location.

- Staff and managers who have received HI/MAB training will respond to the scene
- Safely protect yourself, patients and visitors from the person(s) involved

Hazardous Materials & Waste Management Plan

The Hazardous Materials & Waste Management Plan describes how the organization will establish and maintain a program to safely control hazardous materials and waste. An effective and comprehensive Hazardous Materials & Waste Management Program is essential in reducing work-related injuries and illnesses, maintaining a safe, healthful work environment and complying with all laws and regulations.

Implementation

- Selecting, handling, storing, using and disposing of hazardous materials and waste from receipt or generation through use or final disposal
- Emergency procedures that describe specific precautions, procedures and protective equipment used during hazardous material and waste spills or exposures
- Management of MSDS sheets

MSDS Sheets

Material Safety Data Sheets (MSDS) are located on-line or contact MSDSONline at 1-888-362-7416 and obtain by fax.

MSDS Information

- Product name on label, chemical and common name(s) of ingredients which have been determined to be health hazards, and which comprise 1% or greater of the composition, except carcinogens which are listed if the concentrations are 0.1% or greater
- Chemical and common name(s) of all ingredients which have been determined to present a physical hazard when present in the mixture
- Relevant physical and chemical characteristics of the hazardous chemical (such as vapor pressure, flash point)
- Relevant physical hazards, including the potential for fire, explosion, and reactivity
- Relevant health hazards, including signs and symptoms of exposure, and any medical conditions generally recognized as being aggravated by exposure to the chemical
- Primary route(s) of entry into the body
- OSHA permissible exposure limit and ACGIH Threshold Limit Value. Additional applicable exposure limits may be listed
- Statement of listing of hazardous chemical in the National Toxicology Program (NTP) Annual Report on Carcinogens (latest edition) or International Agency for Research on Cancer (IARC) Monographs (latest edition) or by OSHA
- Precautions for safe handling/use, including appropriate hygienic practices, protective measures during repair and maintenance of contaminated equipment, and procedures for clean-up of spills/leaks
- Appropriate control measures, such as engineering controls, work practices, or personal protective equipment
- Emergency and first aid procedures
- Date of preparation of the MSDS or the last revision
- Name, address and telephone number of the chemical manufacturer, importer, employer, or other responsible party preparing or distributing the MSDS, who can provide additional information on the hazardous chemical and appropriate emergency procedures, when necessary.

Code Orange

2020 should be dialed to report a CODE ORANGE when a spill occurs that disrupts the affected area.

Disruption to the area could occur if the spill:

- Cannot be easily contained
- Produces large amounts of harmful vapors
- Requires advanced protective personal equipment
- Is extremely harmful even in small quantities

Emergency Operations Plan

An Emergency Management is developed, implemented and maintained to assure the readiness and preparedness of staff, equipment, supplies and facilities in the event of an unexpected emergency. The Emergency Management will contain elements of education, training, and staff knowledge associated with specific requirements and applications.

Emergency Operations Implementation

- Implementation of specific procedures utilizing the HICS model, in response to a variety of disasters – internal and external
- Conduction of emergency preparedness drills including response to mass casualties, medical surge, and acts of terrorism
- Management of patients during emergencies including scheduling, modification, or discontinuation of services, control of patient information and patient transportation
- Provision of facilities for radioactive, biological or chemical isolation and decontamination as could occur with Bio-terrorism attacks
- Assignment of available personnel during emergencies to cover all necessary staff positions
- Evacuation of facility when the environment cannot support adequate patient care and treatment
- Notification of external authorities when emergency response measures are initiated
- Provision for back-up communication system
- Provision of supplies, food and water for rapid and extended care of mass casualties
- Provide plan for sheltering staff and families with appropriate provisions and space

Code Triage

Emergency Preparedness Plan is activated by an overhead page by any of the following persons when circumstances warrant activation: CEO, CNO, COO, Nursing House Supervisor, Administrator-on-call, Emergency Preparedness Coordinator. Local fire authority or EMS who are responding to an on-site emergency will notify our ED and they will notify the appropriate administrative staff to implement the Emergency Management procedures.

- Internal disaster such as major fire, partial building collapse, or large chemical spill
- External disaster such as earthquake, transportation system event, or a community-wide disaster

“CODE TRIAGE” Employee Response

Once the overhead page for “Triage Code Internal or External” is announced, the following guidelines are in effect:

- All breaks/meals are immediately cancelled unless approved by the Incident Commander
- Personnel completing their shifts are not to leave until the alert is over or until given permission by their supervisor
- ALL PERSONNEL shall immediately report to their department for assignment. Department authority or representative is to report to the Incident Command Center located in Meeting Room 3 or other location if area not safe
- All personnel should refrain from using the telephone and paging system except for disaster related communications and emergencies
- ALL DEPARTMENTS shall determine how many staff can be spared. Each department shall complete the “Department Disaster Status Sheet” to include list of staff on duty. One person from the department shall hand deliver this “Status Sheet” to the Incident Command Center **within 15 minutes**
- Extra personnel shall then report to the Labor Pool area located in the cafeteria until released by the pool coordinator
- The Labor Pool will contact each department if additional staffing for the pool becomes necessary

ADVANCE DIRECTIVES FOR HEALTHCARE

Placentia-Linda Hospital supports a patient's right to participate in healthcare decision making. Through education and inquiry about advance directive, Placentia-Linda Hospital will encourage patients to communicate their healthcare preferences and values to others. Such communication will guide others in healthcare decision making for the patient if the patient is incapacitated. A DNR (Do Not Resuscitate) requires a physician order. The current method is that the physician will enter a computer order and nursing will transcribe order onto pink form.

As part of the admission process, the patient or significant other is provided with information regarding the patient's rights to make decisions concerning health care. The information given to the patient or significant other includes the statement that Placentia-Linda Hospital has formal policies in place to ensure that his/her wishes regarding treatment will be followed and that these policies are available to them upon request.

The person who documents a patient's admission will ask the patient, or significant other, whether he/she has completed an advance directive. If an advance directive has been completed, the person who documents the patient's admission will ask for a copy of the advance directive so that it may be placed in the patient's medical record. If a copy of the advance directive is not immediately available, the patient will be informed that it is his or her responsibility to provide a valid copy of the advance directive to Placentia-Linda Hospital as soon as possible. When a copy is received, it is placed in the patient's medical record. An Advance Directive sticker is placed on the front of the patient's chart to communicate its presence to all health care providers, and a stamp is placed in the physician progress notes to communicate the directive to the physician.

A patient, who needs more information regarding advance directive decision making, shall be referred to Social Services.

Patient Self-Determination Act (1990) - P.S.D.A.

Federal Law that requires that hospitals participating in the Medicare or Medi-cal Programs provide information regarding the right, under state law, to formulate advanced directives concerning healthcare decisions to all adult (and emancipated minor) inpatients.

The hospital is required to ask all adult inpatients about the potential presence of an advance directive. If the advance directive is present it is required that a copy be placed in the patients medical record. If the document is not present, attempts must be made to obtain the document.

All patients receive a booklet entitled "Your Right To Make Decisions About Medical Treatment"

Some Definitions

Advance health care directive- Documents that state your choices about medical treatment or name someone to make decisions about you medical treatment, if you are unable to make these decisions or choices yourself.

Agent- Individual designated in a power of attorney for health care to make a health care decision for the patient.

Conservator- A court appointed conservator having authority to make a health care decision for a patient.

Two Types of Advance Directive recognized in California State Law

Power of Attorney for Health Care - Written instrument designating an agent to make health care decisions for the principal (the patient).

Living Wills – Document that usually provides specific directives about the course of treatment that is to be followed by health care providers and caregivers.

PATIENT RIGHTS

All hospital staff, medical staff members and contracted agency staff performing patient care activities shall observe these patients' rights.

These rights are a combination of Title 22 and other California laws, the Joint Commission and Medicare Conditions of Participation requirements and are:

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 licensed health care practitioner acting within the scope of his or her professional licensure, who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and non-physicians who will see you.
4. Receive information about your health status, diagnosis, prognosis, 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 foregoing 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 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 members of the medical staff, to the extent permitted by law.
7. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure proposed 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 response 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 medications, but if so, must inform you that there are physicians who specialize in the treatment of 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 you 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 you 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. 41

16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of you discharge plan. Upon you request, a friend or family member may be provided this information also.
17. Know which hospital rules and policies apply to your conduct while a patient.
18. Designate a support person as well as visitors of your choosing, if you have decision-making capacity, including but not limited to: a spouse, domestic partner (including same sex domestic partner), another family member, or a friend, unless:
 - The facility reasonable determines that the presence of a particular visitor would endanger the health or safety of a patients, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
 - You have told the health facility staff that you no longer want a particular person to visit.

However, a health facility may establish reasonable restriction upon visitation, including restriction upon the hours of visitation and number of visitors. The health facility must inform you (r your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis or race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

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 comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.
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, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression, or the source of payment for care.
22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or calling: Placentia Linda Hospital, 1301 N. Rose Dr. Placentia, CA 92870. The grievance committee will review each grievance and provide you with a written response within 30 days. The written response will contain the name of a person to contact at the hospital. The steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).
23. File a complaint with the California Department of Public Health regardless of whether you use the hospital's grievance process. The California Department of Public Health's phone number and address is: 681 S. Parker St. Suite 200, Orange, CA 92868. Phone number: 714-567-2906.
24. Placentia Linda Hospital supports the right of a patient to request and have a chaperone present during certain sensitive physical examinations and treatments. Sensitive physical examinations and treatments are typically those that involve the reproductive and sexual organs, those that may be perceived as potentially threatening to a patient's sense of privacy or modesty, or those that may induce feelings of vulnerability or embarrassment. Healthcare providers should be aware that a patient's cultural and religious beliefs might necessitate the presence of a chaperone or same gender providers. As part of an individual's plan of care, the decision to use a chaperone during a sensitive physical examination or treatment should be made by the patient following discussion with the health care provider performing the exam. The chaperone may be another healthcare provide of the same gender as the patient or a friend or family member, depending on the patient's preference.

These Patient's Rights incorporates the requirements of The Joint Commission; Title 22, California Code of Regulations, Section 70707; Health and Safety Code Sections 1262.6, 1288.4, and 124960; and 42 C.F.R. Section 482.13 (Medicare Conditions of Participation) as of April 2012.

PAIN MANAGEMENT

All in-patients, ER and Day Surgery patients will be evaluated on admission for the presence of pain. Should the patient express the presence of pain, then a comprehensive pain assessment will be completed.

The pain assessment should be based on the patient's self report, using the appropriate pain scale. PLH uses different pain assessment tools depending on the patients being served. They are:

1. Numeric scale – 0 to 10
2. Wong Baker face scale
3. FLACC scale (Infant to school age)
4. Behavioral pain indicators

All employees have the responsibility of reporting to a licensed caregiver any experiences they may have of a patient reporting pain

Pain reassessment will be done:

1. Routinely at regular intervals postoperatively/post procedure as determined by the operation/procedure and severity of pain.
2. Thirty to sixty minutes after pain relieving interventions
3. As the 5th vital sign
4. As determined by the patient's condition, diagnosis, medication regimen and interventions planned to determine effectiveness of pain relief.

** Before giving any medications, the patient's identity **MUST** be confirmed by checking the MAR with the patient's arm band for: the patient's name and Medical Record number. Scan patient and scan medication except in ER.

Pain management computerized documentation includes:

1. Initial assessment/reassessment
2. Care plan
3. Graphic & ADL flowsheet
4. Pt/family education record

Pt. education should include:

1. Pt's right/responsibility regarding pain management
2. Hospitals commitment to pain management
3. Importance of pain reporting and early intervention
4. Pain scale
5. Work together to develop pain management options
6. ***Name, reason, side effect of medications they are receiving on hard copy
7. Discharge instructions and information

We have implemented a policy of hourly rounding to address the "4-P's" – Checking for pain management, potty (in fluid levels, oral fluids and offering toileting), positioning and attention to personal needs.

RESTRAINTS

Patients have the right to be free from restraints. Placentia-Linda Hospital strives to maintain a "restraint-free" environment for our patients.

At times it may be necessary to restrain a patient to protect them from harming themselves or others. Restraints used may be non-behavioral or behavioral. The use of behavioral restraints is limited to the Emergency Department or the Intensive Care Unit.

Only staff who have received education and have documented evidence of competency are authorized to apply and/or remove restraints. If you need to provide care or service to a patient in restraints, inform and request assistance from the licensed nurse assigned to the patient.

Placing a patient in restraints requires a specific order. PRN orders are **not** to be accepted. The order must contain specific information and is allowed for a limited period of time, which varies, depending on the type of restraint. A "Physician's Order for Restraint" Form is to be used and all appropriate areas completed as indicated based on type of restraint to be used.

While restraints are being utilized, patients require additional care and monitoring to ensure that their safety and comfort is maintained, and that their basic needs are met. A "Restraint Flowsheet" has been developed to document compliance in providing this care and monitoring. The form must be filled out correctly, completely, and in a timely manner.

We have implemented a policy of hourly rounding to address the "4-P's" – Checking for pain management, potty (in fluid levels, oral fluids and offering toileting), positioning and attention to personal needs. We hope this will lessen the need for restraints.

Placentia-Linda Hospital

ABUSE/NEGLECT SCREENING CRITERIA Elder/Child/Spousal

Every clinical discipline and support staff has the opportunity to notice signs and symptoms of abuse. Whether you are assigned in the kitchen, or radiology, housekeeping or engineering, there may be an opportunity to observe symptoms of abuse.

SOME OF THE SIGNS MAY BE, BUT ARE NOT LIMITED, TO:

1. Red blotches or bruises on the body, especially on the trunk where they may be hidden by clothes. Attempts to hide injuries.
2. Malnourished – Thin and Emaciated.
3. Poor personal hygiene.
4. Unexplained injuries.
5. Multiple bruises in different stages of healing.
6. Human Bite Marks.
7. Burns – Particularly on back or buttocks.
8. Spiral Fractures.
9. Unexplained fractured or multiple fractures in various stages of healing.
10. Head injuries – Fractured skull.
11. Internal Bleeding – Internal Injuries – liver, spleen, pancreas, kidneys, and/or other vital organ damage.

QUESTIONS TO CONSIDER ASKING THE PATIENT ARE:

1. Do you feel “*unsafe*” in your own home?
2. Are you afraid of anyone?
3. Have you been emotionally, physically or sexually abused?
4. Have you been struck, slapped, kicked, or otherwise physically hurt, within the last year?
5. Have you ever been touched in a manner that made you feel uncomfortable?
6. Is there evidence of neglect by self?
7. Is there evidence of neglect by caretaker? (*Evidence may include: chronic poor hygiene, malnutrition, sores, etc.*)

If there is a YES answer to any of the above questions, collaborate with a clinical discipline (immediate licensed supervisor, case management/social worker, or risk management) for reporting abuse to the appropriate regulatory body immediately or as soon as possible. Reporting on abuse is mandatory, and if not performed is punishable by fines and imprisonment for up to a year.

EMTALA

- If a patient comes to the hospital and requests an examination or treatment, the patient must receive an appropriate medical screening examination by qualified medical personnel to determine whether the person is suffering from an emergency medical condition.
 - ◆ Any person can present themselves anywhere in the hospital or on hospital grounds. Any person requesting an examination or treatment must be accompanied to the Emergency Room.
- If an emergency medical condition exists, the person must be provided with stabilizing treatment within the capabilities of the hospital, including routine ancillary services and services of on call specialists.
 - ◆ The patient with an emergency medical condition must receive stabilizing treatment before he is asked about his financial or insurance status.
- An initial examination must be offered and provided regardless of the person's ability to pay, and provided without a delay to inquire about the person's financial status.
 - ◆ No one can ask about the patient's insurance or ability to pay prior to a medical screening examination by the Emergency Department Physician.
- After the examination has been provided, a patient with an emergency medical condition cannot be transferred to another facility unless such a transfer is an "appropriate transfer."
 - ◆ If the patient has an emergency medical condition requiring hospitalization, the hospital is obligated to admit the patient for stabilization.



What Is HIPAA?

Health Insurance Portability and Accountability Act

HIPAA is a 2,000 page document that addresses many aspects of health insurance portability. The primary section that concerns us as health care workers is the administrative portion of HIPAA, which protects the security and privacy of protected health information (PHI). PHI include but are not limited to *social security numbers, names, addresses, health information, billing information, quality of care documents*, etc. The privacy portion and security portion of the law was necessary because of the ease in transmitting information due to technological advances i.e. transmitting information via a computer. The privacy regulation protects all protected health information including but not limited to electronic, oral, written etc. The security portion of the law pertains only to electronic health information and the access to that information. Placentia-Linda Hospital has policies and procedures protecting the privacy and security of patient information. These documents and the pertinent forms can be found on the shared drive or on the Placentia-Linda site on e-Tenet.

What are Patient's Rights under HIPAA?

Patients privacy rights under HIPAA are outlined in the brochure called the Notice of Privacy Practices (NPP) that we hand out to patients when they come to the hospital as required by law. These rights include the following:

- Right to access their information. They may review or obtain a copy of their protected health information.
- Right to restrict their PHI. They must be given an opportunity to consent or object to who may or may not receive their health information.
- Right to revoke the above authorization.
- Right to confidential communications i.e. have their protected health information sent somewhere other than their home of record or by other means such as via fax.
- Right to amend their PHI if they feel the information is incomplete or in error.
- Right to an accounting of disclosures i.e. a listing of where we sent their health information and to whom.

The NPP tells the patient how the hospital may use and disclose their protected health information (PHI). The law also requires us to make sure the patient signs an acknowledgement statement that they have received their copy of the NPP.

What is "Opting Out"?

When a patient wants to "opt out" of a directory, he/she does NOT want anyone to know they're in the hospital. For this reason, they are not listed in the directory. Patients who want to "opt out" must fill out a form in admitting, and this form is kept in their medical record.

Privacy and Minimum Necessary

Minimum necessary refers to just the right amount of information necessary to do your job. For example, you can have access to the medical record as a nurse because you're taking care of the patient or you can access the medical record because you're a coder coding the chart. Minimum necessary also means that you cannot have access to the information of a G.I. patient if you're in the Medical Surgical floor because you are not taking care of the patient. You may not access your own chart or a chart of a relative or friend.

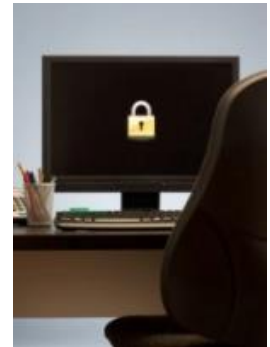
Training

All Placentia-Linda employees, contractors, volunteers, and anyone working at Placentia-Linda Hospital either permanently or temporarily must be trained in privacy and security. Training is conducted at live initial orientation, and/or a video online or on eTenet.

Safeguards

Safeguards refer to the precautions we take for protecting the privacy and security of PHI. Examples of safeguards are listed below:

- Not talking about patients in public areas.
- Drawing the curtains between beds in a patient room and speaking in a low voice so the other patient cannot hear.
- **DOUBLE-CHECK:** fax numbers, patient armband, each piece of paper before releasing, patient consent or object before discussing information with visitors.
- Verifying the correct fax number of the recipient.
- Faxing information using a coversheet with a confidentiality statement informing the recipient what to do in the event of receiving a fax in error.
- Verifying whether or not the caller requesting information is allowed to receive the information and that the person is really who he/she claims to be.
- Keeping medical records and computer screens out of public view.
- Keeping computer screens locked when leaving the computer.
- Not sharing passwords or ID access with anyone.
- Encrypt all e-mails by typing "SECURE" at the beginning of the Subject line.
- Discarding documents containing protected health information in the shred box.
- Access only patient charts necessary for you to perform your job duties.



What do you do in the event of a suspected violation, a privacy/security complaint, or if you have any questions related to privacy or security?

Violations or breeches in privacy or security come in many forms from the simple error which includes sending a fax to a wrong number to the serious violation of downloading patient information for personal gain. Other privacy/security breaches may include but are not limited to the following:

- Disclosing patient information to a physician who is NOT involved in the care of a patient or has NO need to know, and/or witnessing a physician inappropriately accessing a patient chart.
- Discarding PHI in the regular trash can instead of in a shred bin.
- Disclosing PHI on a patient who opted out to a non-employee or physician and has NO need to know.
- E-mailing or faxing PHI to the wrong recipient.
- Any intentional or accidental disclosures or release of information require tracking, investigation, mitigation or fixing of the problem, and/or, if necessary, discipline.

Under State law, the hospital must report privacy violations within FIVE DAYS of discovery.

Please report errors, suspected violations or address any privacy/security questions to the Hospital Compliance/Privacy Officer at ext.4236.

All Placentia-Linda Hospital staff are responsible for maintaining the privacy and security of protected health information (PHI).



ONE LEGACY ORGAN & TISSUE REFERRALS

- The Medicare “Conditions of Participation” specifies that hospitals must report all deaths through the *One Legacy* Communications Center. Calls regarding patients who have suffered cardiac death and are not organ donor candidates are immediately linked to the tissue bank serving Placentia-Linda Hospital. These calls are listed on the monthly reports under the 4th column under *T/B* for Tissue Bank and under the 5th column as T for a tissue call. This system requires that only one phone call be placed by the hospital staff to report a death or potential organ donor.
- Calls to *One Legacy* regarding patients who meet the definition for “imminent death”* or are brain dead, are evaluated by *One Legacy* coordinators as possible organ donors. These calls are listed under the 5th column as an “O” for organ donor referral.
- *Imminent Death is defined as a severely brain injured, ventilator dependent patient with a Glasgow Coma Scale of less than or equal to 5 and/or there is a plan to discontinue mechanical/pharmacological support.*
- The *One Legacy* report is reconciled against a report generated by the hospital Tissue Bank and all calls are included in the monthly report to the hospital.
- At Placentia-Linda Hospital, the House Supervisor or clinical coordinator makes the telephone call to the *One Legacy* Communications Center and records the date and time of the call on the “Death/Mortality Log” located in the House Supervisor Office, located on the north side of the main hallway, just past the Facility Management Hall.

PERFORMANCE IMPROVEMENT & PATIENT SAFETY

Performance Improvement Plan

Purpose

This Performance Improvement Plan describes the systematic organization-wide approach to quality that is used to plan, design, measure, assess and improve organizational performance. Under this plan, our organization:

- Provides high-quality, clinical services and demonstrates the outcomes of services through various means (i.e. awards, recognition, surveys)
- Achieves performance improvement goals in a systematic manner through collaboration with our physicians and other external/internal entities;
- Provides a mechanism to assure that all patients receive the same level of care;
- Provides a culture where care is delivered in a safe environment and quality care is measured, monitored, and continuously improved;
- Utilizes performance improvement information and aggregate data (*non-patient identifiable*) in formulating and achieving objectives of the strategic plan.

Mission, Vision, & Values

- **Mission Statement:**
“Quality HealthCare with a Personal Touch”
- **Vision Statement:**
“Placentia-Linda Hospital will be recognized as the Community Leader in Healthcare”
- **Values:**
“As a Service Organization, the Goal of Service is:
 - *Every Effort Shall Be Made to Provide the Best Possible Care to the Sick or Injured*
 - *The Needs of the Patient Are Paramount and Shall Be Met*
 - *The Patient is an Individual and Shall Be Assured Every Reasonable Protection of Personal Safety and Property*

Governing Board

The Governing Board is responsible for establishing and maintaining the organization's Performance Improvement Program. The Governing Board has delegated to, the Medical Staff and Chief Executive Officer, the responsibility for implementation of the program. It is the Board's duty to assure patient care is safely delivered within the guidelines established by the medical staff and hospital leadership while meeting all national, state and community standards and regulations. The Chief of Staff and the Chief Executive Officer, in collaboration with the Director of Clinical Quality Improvement, have delegated oversight of performance improvement functions to Quality Council.

The Governing Board requires the medical and organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the performance improvement activities will be evaluated and reported to the Governing Board.

Medical Executive Committee

The Medical Executive Committee and Quality Council, receives, analyzes and acts on performance improvement findings from hospital and medical staff committees and is accountable to the Governing Board for the overall quality of medical care.

The Medical Executive Committee and the Medical Staff are responsible for the following:

1. Maintaining a consistent high level of care;
2. Evaluating the clinical performance of all individuals with delineated clinical privileges;
3. Development of policies and procedures which provide for provision of one level of care throughout the facility;
4. Measuring and acting upon peer review information.

Organizational Leadership

The leaders have the responsibility to create an environment that promotes performance improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders perform the following functions:

1. Adopt an approach to performance improvement, set exceptions and priorities for organization-wide performance improvement, that are designed to improve safe patient care delivery, outcomes, and customer satisfaction.
2. Ensure that important processes and activities are measured, assessed, and improved systematically throughout the organization.
3. Participate in interdisciplinary and interdepartmental performance improvement activities in collaboration with the medical staff.
4. Allocate adequate resources including personnel, time, and data collection systems for assessment and improvement of the organization's governance, managerial, clinical and support processes.
5. Assure all staff is trained in the basic approaches and methods of performance improvement, including the tools utilized in evaluating processes and systems that contribute to improved patient outcomes.
6. Analyze and evaluate the effectiveness of the performance improvement activities.

Measuring and Monitoring Performance

At a minimum the organization collects data on measures as outlined by The Joint Commission, CMS, and QIO that include but are not limited to:

- National Patient Safety Goals;
- Safe Medication Practices;
- Operative and other procedures that place patients at risk;
- Blood and blood components usage;
- Restraint and seclusion;
- Care or services provided to high-risk populations (i.e. ICU patients, Behavioral health patients);
- Outcomes related to resuscitation;
- Accountability Measures and/or Evidence Based Measures;
- Moderate and deep sedation;
- Risk Management;
- Utilization Management;
- Quality Control;
- Environment of Care;
- Medical Records/Health Information Management;
- Medical staff, patients, families, employees opinions including perceptions of risk to patients and suggestions to improve patient safety
- Culture of patient safety and reporting medical/healthcare errors;
- Mortality;
- Infection Control Surveillance and Reporting; and
- Research data when applicable.

Process Improvement Team Methodology

“F – O – C – U – S P – D – C – A”

F = Find a Process to Improve

O= Organize the Team to know and understand the Process

C= Clarify current knowledge of the Process

U= Understand causes of the Process Variation

S= Select the Process Improvement

The **PDCA**, is a theory (Walter A Shewhart – Western Electric) modified by Dr. Edward Deming, and is called the **“Plan, Do, Check, Act”** cycle.

Patient Safety Plan

Purpose

To improve the health, safety, and quality of care of patients through the promotion of evidence-based best practices that insure patient safety and reduce preventable patient safety events consequent to the course of medical treatment. In the event of an occurrence, adverse or unexpected outcome, variance from everyday normal activities; the occurrence must be reported to your director, manager, or supervisor. This report must be made within 24 hours from the event. If the variance is a major or catastrophic event, the Risk manager must be notified immediately.

Objectives

To improve patient safety and reduce risk to patients through a culture that not only encourages a safe environment; but utilizes regulatory mandates, National Patient Safety Goals, and hospital based safety data to measure and quantify success. Consequently, the plan strives to:

- Prioritization of Patient Safety through Leadership and Management
- Unequivocal organizational commitment to patient safety
- Recognition and acknowledgement of risk to patient safety
- Initiation of actions to reduce these risks to patient safety
- Internal reporting of identified risks and the corrective action taken
- Implementation of recognized safe practices that have been shown to prevent errors
- Ongoing focus on processes and systems, while maintaining a blame free environment
- Creating a culture of safety, through the implementation of Hospital-wide Patient Safety Champions, which will promote the open communication of healthcare errors and near misses.
- Development of internal programs, which effect necessary behavioral and cultural changes
- Enhancement of knowledge base through on-going continual organization-wide education related to events and potential events.
- Support of hospital staff involved in managing critical safety events or occurrences
- Recognition and management of professional misconduct or unsafe/negligent behavior
- Accountability for patient safety, including informing patients if errors occur (disclosure of unanticipated outcomes).
- Maintenance of confidentiality of patient information and the privileges status of information protected pursuant to the Rules of Evidence in the State of California.

eSRM (electronic Safety and Risk Management) System or Occurrence Reports

- After implementing any necessary immediate action to ensure patient, staff, medical staff and bystander safety, staff shall report all **Adverse Events, Sentinel Events and Near Misses** into eSRM or an Occurrence Report. Staff shall limit their reports to the pertinent clinical facts and shall avoid assigning blame or responsibility
- Staff shall also report any **Hazardous Condition** even though the conditions have not yet resulted in an Adverse Event, Sentinel Event or Near Miss.
- Occurrence reports shall be submitted to and reviewed by the Patient Safety Officer/Risk Manager.

Complaint & Grievance Process

- Every hospital must have a process for Prompt resolution of patient grievances. A patient grievance is a written or verbal complaint (**when the verbal complaint about patient care is not resolved at the time of the complaint by staff present**) by a patient, or a patient's representative, regarding patient's care, abuse, or neglect, issues related to the hospital's compliance with Centers for Medicare Service – Conditions of Participation or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489. The Grievance is resolved if hospital staff present at the time of the complaint or who can quickly be at the patient's location (nursing administration, nursing supervisors, patient advocates) to resolve the patient's complaint.
 1. If issue (complaint) resolved promptly then it is NOT a grievance
 2. Hospital conducts in-services on the importance of customer service
 3. Staff must manage patient requests in timely manner
 4. Patient complete satisfaction surveys and are reviewed for opportunities for improvement
 5. Patients may contact CDPH or The Joint Commission if they have a complaint regarding quality and safety
- Verbal Complaints and Grievances may be entered on a Complaint–Grievance Form and forwarded to the Risk Manager.
- Written Grievances are forwarded to Administration and Risk Manager within 24 hours.
- Complaints/Grievances must be investigated and responded to in a timely manner.

Bioethical Issues / Dilemmas



Definition of Bioethics

A field of study concerned with the ethics and philosophical implications of certain biological and medical procedures, technologies, and treatments, as organ transplants, genetic engineering, and care of the terminally ill.

Random House Unabridged Dictionary, © Random House, Inc. 2006.

From the encyclopedia

Bioethics, in philosophy, a branch of ethics concerned with issues surrounding health care and the biological sciences. These issues include the morality of abortion, euthanasia, in vitro fertilization, and organ transplants (see transplantation, medical).

The Columbia Electronic Encyclopedia Copyright © 2004, Columbia University Press.

Examples of areas subject to bioethical analysis include:

Abortion	Feeding tube
Assisted suicide	Life extension
Blood/blood plasma (trade)	Life support
Circumcision	Lobotomy
Confidentiality (medical records)	Organ donation (fair allocation, class/race bias)
Consent	Pain management
Euthanasia	Patients' Bill of Rights



If you feel there is an issue that may be a bioethical concern, please notify the following people as quickly as possible:

Primary Contact

Your Director

If your director is not available, then contact the House Supervisor.



Others who will be contacted by either your director or the house supervisor:

Peggie Alonzo, Director of Case Management

Fred Valtairo, Associate Administrator and Director of Risk and Quality Management

Linda Weaver, Director of Medical Staff Services

She will organize the Bioethical Committee meeting if one is needed. The Bioethical Committee is comprised of the medical chair, the physician involved in the issue, a representative from nursing, case management, and clergy (if appropriate).

UTILIZATION MANAGEMENT

Placentia-Linda Hospital has a Utilization Management Plan to maintain high quality, medically necessary and efficient treatment for all patients, regardless of payment source, by ensuring that patients receive the right care at the right time in the right place. The plan provides for review of services provided by the hospital and by members of the medical staff to patients.

Case Managers review all admissions, extended stays, professional services, and appropriateness of level of care.

- Daily Bed Meetings are held Monday through Friday by an interdisciplinary team including Unit Charge Nurses/Managers of Nursing units, ER, and Outpatient Surgery Service; Case Manager; Administration; Nurse Supervisor; Laboratory, Radiology and Environmental Services representatives.
- Bed Meeting goals include:
 - ✓ Patient Discharge coordination of services
 - ✓ Bed Control and identification of admitting strategies for the day
 - ✓ Review of CORE measures to assure patient treatment plans are in compliance
 - ✓ Identification of potential patients for readmissions
 - ✓ Identification of Infection Control issues
 - ✓ Identification of specific patient issues
- Multi disciplinary rounds M-F @ dept. level. (ICU,DOU and Medical/Surgical.)
- Weekly Case Management meetings are conducted with Case Managers, Physician Advisor, and nursing representation to review:
 - ✓ Extended patient stays
 - ✓ Patients with potential extended stay issues
- The Utilization Management Physician Advisor conducts Utilization Management Meetings (not to be less than 4 times per year)

The Physician Advisor provides clinical consultation to case managers and will consult with attending physician regarding mitigating circumstances regarding inappropriate admissions and conducts concurrent stays utilization review.

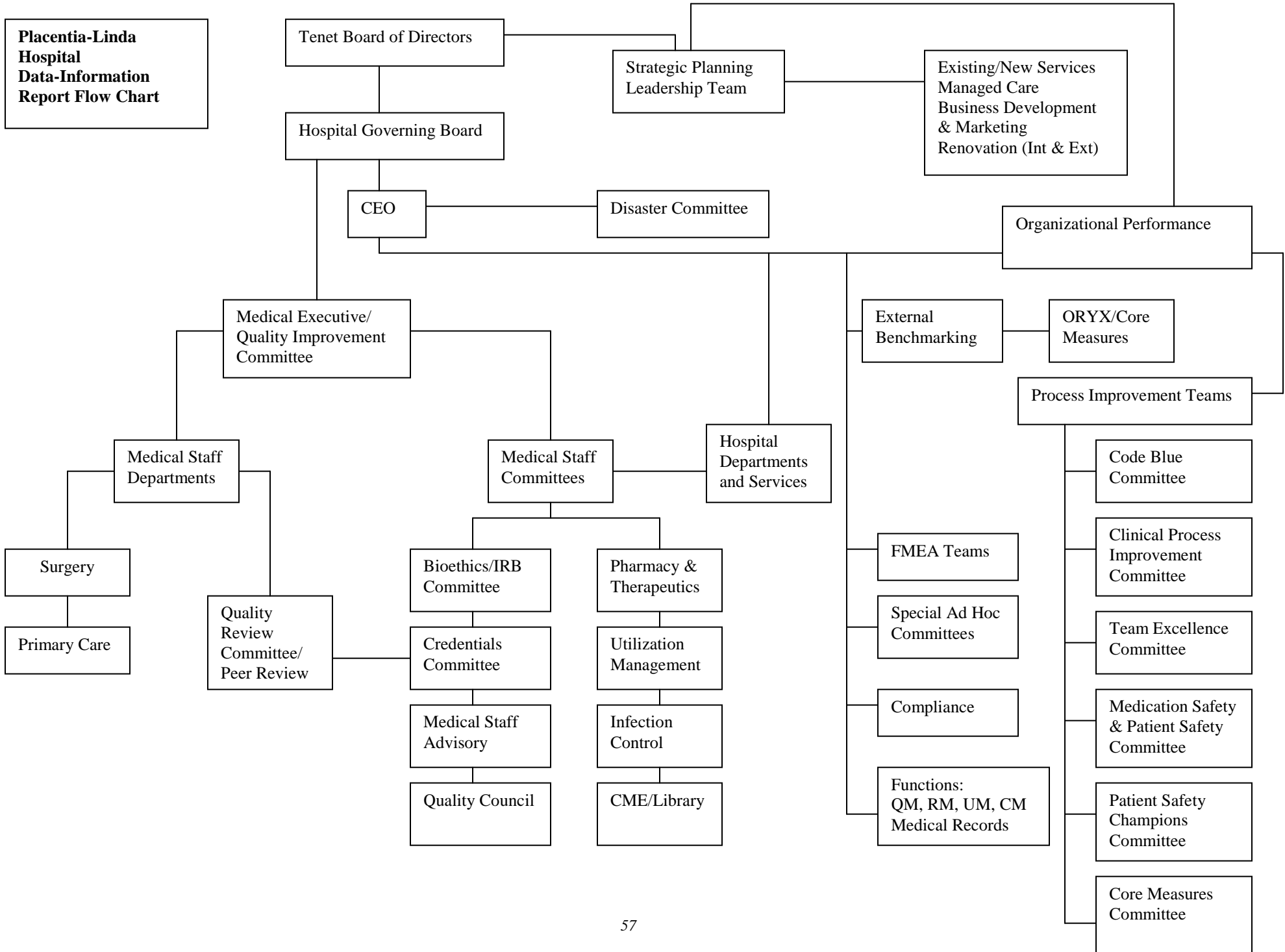
Case Managers assist the medical and nursing staff in discharge planning.

SOCIAL WORK SERVICES

The Licensed Clinical Social Worker (LCSW) works with patients and their families to help manage the complexities of the hospital stay. With years of experience, our social worker is committed to educating family members, serving as an advocate, and facilitating communication during and after the hospital stay. The Social Worker performs psychosocial assessments, provides counseling and support to help patients and families cope with the emotional stresses of illness and hospitalization, assists with discharge planning to ensure continuity of care, and provides referrals to community services and resources

- Crisis Intervention
- Loss and Grief Resources/Support
- Care Giver Issues
- Alcohol and Substance Abuse Resources
- Mental Health Support
- Homelessness

**Placentia-Linda
Hospital
Data-Information
Report Flow Chart**



PHYSICIAN IMPAIRMENT

The Impaired Practitioner is by definition one whose behavior or performance has been affected by alcohol, chemicals, and/or mental or physical illness that interferes with his or her ability to function competently.

Signs and symptoms may include: difficulty meeting schedules or deadlines, slurred speech, poor coordination, failure to respond to pages, dramatic mood swings, poor hygiene, and inappropriate anger.

Your response if you suspect practitioner impairment includes:

- 1) Reporting incidents to your supervisor-report up the hospital chain of command
- 2) File an incident / occurrence report
- 3) Call the Ethics Hotline (1-800-8-ETHICS or 1-800-838-4427)

You should never argue with the physician or practitioner, tolerate physical abuse or threats of violence, allow patient safety to be jeopardized, take it personally, or ignore it and not report your concerns.

The organization has a written policy and procedure including Last Chance Agreements, which clearly define unacceptable behavior in hospital and medical staff policy.

DISRUPTIVE PHYSICIAN BEHAVIOR

Your response if you encounter disruptive physician behavior:

- 1) Reporting incidents to your supervisor-report up the hospital chain of command
- 2) Fill out an ESRM from Medical Staff
- 3) Call the Ethics Hotline (1-800-8-ETHICS or 1-800-838-4427)

Regulatory Agencies & National Quality Organizations

- **California Department of Public Health** provides hospital licensure and is the administrative agency of the state that enforces CA healthcare regulations such as Title XXII and the Health & Safety Code.
- **Institute of Medical Quality (IMQ)** participates in The Joint Commission surveys through a physician surveyor.
- **The Joint Commission** is an accrediting body that is a CMS-recognized deemed status hospital accreditation program.
 - **Unannounced Surveys** require no advance notification and occur every three years for the hospital and every two years for the lab
 - **Intracycle Monitoring** are interim surveys that occur annually and are announced for those years where there is no unannounced survey
 - **Tracer Methodology** - surveyors are directly out to the Patient Care Units, where “Tracer Methodology” is performed. Surveyors will directly observe caregivers at their respective tasks, and, often solicit information from staff by asking pertinent questions related to The Joint Commission Standards of Care and National Patient Safety Goals.
- **The Center for Medicare and Medicaid Services (CMS)** develops **Conditions of Participation** that health care organizations must meet in order to participate in the Medicare and Medicaid Programs and are health and safety standards for improving quality and protecting the health and safety of beneficiaries
- **The Leapfrog Group** is a voluntary program aimed at mobilizing employer purchasing power to promote health care safety, quality and customer value. Leapfrog encourages transparency through the Leapfrog Hospital Survey by comparing hospital’s performance on the national standards of safety, quality, and efficiency that are most relevant to customers and purchasers of care.
- **National Quality Forum** is an organization that builds and endorses consensus on national priorities and goals for performance improvement through the **Safe Practices for Better Health Care**

CORE Measures & Value Based Purchasing

CORE Measure is a term that was originally implemented by the Joint Commission and Centers for Medicare Service to identify those highly frequented and treated diagnoses, throughout the Nation's Hospitals and Healthcare Delivery Systems. It is mandated by these Regulatory Agencies that all Healthcare Delivery Systems participate in this reporting, otherwise "run the risk" of Licensure and Accreditation Status. The results of these measures are also public reported via WebSites such as "Hospital Compare".

Placentia-Linda Hospital reports abstracted data on the following CORE Measures:

- Acute Myocardial Infarction – AMI
- Congestive Heart Failure – CHF
- Community Acquired Pneumonia – PN
- Surgical Care Improved Project – SCIP

Over time, additional quality data sets were developed and are also required to be abstracted in order to be eligible for the annual payment update under the Inpatient Quality Reporting Program and the Outpatient Quality Reporting Program. These additional quality data sets include:

- Stroke
- VTE (venous thromboembolism)
- Immunization (pneumococcal and influenza)
- Throughput in the ER

Certain measures are incorporated into Value Based Purchasing where hospital reimbursement is dependent on performance. Value Based Purchasing includes performance with patient satisfaction and outcomes such as mortality. 30 day readmissions is also tied into hospital reimbursement for the AMI, CHF, and PN populations.

Placentia-Linda Hospital is licensed by the State of California and accredited by The Joint Commission. If you have any concerns or issues regarding quality, safety-of-care or safety of environment, please contact Joint Commission at:

**Division of Accreditation Operations
Office of Quality Monitoring
The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Or by fax at (630) 792-5005
Or by email at complaint@jointcommission.org**