# Orientation Supplement Guide

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Understanding the Accreditation Survey Process

The objective of the accreditation survey is to improve the quality and safety of health care provided to the public through establishment of standards, evaluating healthcare organizations, rendering accreditation decisions, and providing education and consultative support to healthcare professionals. Our hospital’s ability to participate in Medicare and Medi-Cal programs (and be reimbursed for care) is closely linked to accreditation.

The on-site visit will last approximately four days. There will be at least 4-5 Joint Commission surveyors, including one Institute for Medical Quality (IMQ) surveyor.

During the visit, survey teams will:
■ Visit patient care units and observe our care process.
■ Trace patients through our organization from admission to discharge.
■ Interview staff members and patients.
■ Provide feedback.
■ Review staff files.
■ Review our Performance Improvement and Patient Safety programs.
■ Review policies and procedures, meeting minutes.
■ Interview department and hospital leaders.
■ Provide a preliminary report.

Surveyors are most interested in speaking with frontline staff and will spend the majority of their time visiting patient care units and departments.

Tips for Talking with Surveyors

■ Smile.
■ Continue to breathe.
■ Think about the question. If you do not understand the question, ask them to rephrase it until you understand what they are asking.
■ Show your pride in our hospital by answering positively and with enthusiasm.
■ Surveyors are our guests. DO NOT be argumentative or aggressive.
■ Project an “I want to learn” attitude.
■ EXPLAIN – Do not argue the standard or intent with the surveyor.
■ Know your policies and your role in the organization.
■ When asked questions, if you are not sure of the answer, it is OK to refer to your name badge cards, this Continuous Education Staff Reference Guide, and the Resource Guide for the answers (except for Fire Response – this is a significant safety issue that we must all be prepared to respond to immediately). Avoid saying “I don't know.” An alternative response would be, “Let me locate that information for you.”
■ Remember that hospital policies, the Safety Manual, and the Infection Control Manual can be accessed through InTouch in DocuShare.

Steps to accessing policies on DocuShare.
(Name badge cards are available for this process.)
1. Go to “InTouch” and select “Applications and Documents.”
2. Select “DocuShare” under Applications.
3. Scroll down to “Patient Care Services” (or any other department) listed in this Department Documents section, and choose it. Be patient at this point. It takes about 30 seconds to load all the policies.
4. Scroll down to find the policy you want and choose it. Policies are listed alphabetically.
   You can also use the search function in DocuShare. For practice, find the policies “Advance Health Care Directive” and “Restraints.”

5. Print or view.

6. Access your unit-specific policies at step 3 or 4.

Note:
The search function searches only current department folders. If you are unable to find what you’re looking for, try searching in another folder.

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Mission and Vision Statements/Core Values/ Guiding Behaviors

Mission Statement
We, Saint Agnes Medical Center and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Vision Statement
Saint Agnes Medical Center will be THE trusted health partner in Central California through its unrelenting pursuit of excellence.

Core Values
- Reverence – We honor the sacredness and dignity of every person.
- Commitment to those who are poor – We stand with and serve those who are poor, especially those most vulnerable.
- Justice – We foster right relationships to promote the common good, including sustainability of Earth.
- Stewardship – We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.
- Integrity – We are faithful to who we say we are.
- Compassion – We give love, care and comfort to heal the body, mind and spirit, even when there is no cure.
- Excellence – We promise not to settle for good enough, personally or professionally, and we hold one another accountable for keeping our promise.

Guiding Behaviors
- We support each other in serving our patients and communities.
- We communicate openly, honestly, respectfully and directly.
- We are fully present.
- We are all accountable.
- We trust and assume goodness in intentions.
- We are continuous learners.

Questions you may be asked
1. What is the Saint Agnes mission?
2. Name three things that you do every day to support our mission.
2015 National Patient Safety Goals

Patient Safety is a significant issue since the Institute of Medicine’s report suggesting that 44,000 to 98,000 patients die each year in the United States related to medical errors. Saint Agnes Medical Center has a patient safety program integrated with the Performance Improvement and Risk Management program. In 2002, The Joint Commission established its National Patient Safety Goals (NPSGs) program; the first set of NPSGs was effective January 1, 2003. The NPSGs were established to help accredited organizations address specific areas of concern in regard to patient safety.

A panel of widely recognized patient safety experts advise The Joint Commission on the development and updating of NPSGs. This panel, called the Patient Safety Advisory Group, comprises nurses, physicians, pharmacists, risk managers, clinical engineers and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of healthcare settings. Listed below is The Joint Commission’s 2015 National Patient Safety Goals for Hospitals.

All staff and physicians are expected to know and follow the Safety Goals that apply to them.

NPSG.01.01.01
Use at least two patient identifiers when providing care, treatment and services.

Elements of Performance
1. Use at least two patient identifiers when administering medications, blood or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient’s room number or physical location is not used as an identifier.
2. Label containers used for blood and other specimens in the presence of the patient.

NPSG.01.03.01
Eliminate transfusion errors related to patient misidentification.

Elements of Performance
1. Before initiating a blood or blood component transfusion:
   • Match blood or blood component to the order.
   • Match patient to blood or blood component.
   • Use a two-person verification process.
2. When using a two-person verification process, one individual conducting identification verification is the qualified transfusionist who will administer the blood or blood component to patient.
3. When using a two-person verification process, the second individual conducting identification verification is qualified to participate in the process, as determined by the hospital.

NPSG.02.03.01
Report critical results of tests and diagnostic procedures on a timely basis.

Elements of Performance
1. Develop written procedures for managing critical results of tests and diagnostic procedures that address the following:
   • Definition of critical results of tests and diagnostic procedures.
   • By whom and to whom critical results of tests and diagnostic procedures are reported.
   • Acceptable length of time between availability and reporting of critical results of tests and diagnostic procedures.
2. Implement procedures for managing critical results of tests and diagnostic procedures.
3. Evaluate timeliness of reporting critical results of tests and diagnostic procedures.
NPSG.03.04.01
Label all medications, medication containers and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups and basins.

Elements of Performance

1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include:
   - Medication name
   - Strength
   - Quantity
   - Diluent and volume (if not apparent from the container)
   - Preparation date
   - Expiration date when not used within 24 hours
   - Expiration time when expiration occurs in less than 24 hours

4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.

   Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

6. Immediately discard any medication or solution found unlabeled.

7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.

8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for management of medications.

NPSG.03.05.01
Reduce likelihood of patient harm associated with use of anticoagulant therapy.

Elements of Performance

1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.

2. Use approved protocols for the initiation and maintenance of anticoagulant therapy.

3. Before starting a patient on warfarin, assess patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. Baseline status and current INR are documented in the medical record.

4. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.

5. When heparin is administered intravenously and continuously, use programmable pumps to provide consistent and accurate dosing.

6. A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants.

7. Provide education regarding anticoagulant therapy to prescribes, staff, patients and families. Patient/family education includes:
   - Importance of follow-up monitoring
   - Compliance
   - Drug-food interactions
   - Potential for adverse drug reactions and interactions
8. Evaluate anticoagulation safety practices, take action to improve practices, and measure effectiveness of those actions in a time frame determined by the organization.

**NPSG.03.06.01**
*Maintain and communicate accurate patient medication information.*

**Elements of Performance**
1. Obtain information on the medication the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.
2. Define the types of medication information to be collected in non-24-hour settings and different patient circumstances.
3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.
4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, does, route, frequency, purpose).
5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

**NSPG.06.01.01 – Clinical Alarm Safety**

*Elements of Performance*
1. Alarms and the identification of the most important alarms is an organizational priority.
2. Evaluation of current alarms.
3. Eliminate “nuisance” alarms.

**NPSG.07.01.01**
*Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.*

**Element of Performance**
1. Clean hands before and after patient care for at least 15 seconds.
2. Measure and monitor compliance.
3. Improve compliance with hand hygiene guidelines based on established goals.

**NPSG.07.03.01**
*Implement evidence-based practices to prevent healthcare-associated infections due to multidrug-resistant organisms in acute care hospitals.*

**Element of Performance**
1. Measure and monitor.
2. Annual staff education about multiresistant organisms and prevention strategies that aligns with CDC and evidence based standards.
3. Educate patients and families.

**NPSG.07.04.01**
*Implement evidence-based practices to prevent central line-associated bloodstream infections (CLABSI).*

**Elements of Performance**
1. Educate staff about CLABSI prevention.
2. Educate patient about CLABSI bundle.
4. Use catheter checklist and a standardized protocol for central venous catheter insertion.
5. Perform hand hygiene prior to catheter insertion or manipulation.
6. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.
7. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.
8. Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.
9. Use chlorhexidine for skin preparation during central venous catheter insertion.
10. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.
11. Evaluate all central venous catheters routinely and remove nonessential catheters.

NPSG.07.05.01
Implement evidence-based practices for preventing surgical site infections (SSI).

Elements of Performance
1. Staff education on SSI prevention and policies to reduce the risk of SSI.
2. Education of patient and family on hygiene pre- and postop.
3. Appropriate hand hygiene.
4. Administration of prophylaxis antibiotics prior to incision and right antibiotic prophylaxis.
5. Clipping hair, no shaving.

NPSG.07.06.01
Implement evidence-based practices to prevent indwelling catheter associated urinary tract infections (CAUTI).

Elements of Performance
1. Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:
   - Limiting use and duration to situations necessary for patient care.
   - Using aseptic techniques for site preparation, equipment, and supplies.
2. Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:
   - Securing catheters for unobstructed urine flow and drainage.
   - Maintaining the sterility of the urine collection system.
   - Replacing the urine collection system when required.
   - Collecting urine samples.
3. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
   - Selecting measures using evidence-based guidelines or best practices.
   - Monitoring compliance with evidence-based guidelines or best practices.
   - Evaluating the effectiveness of prevention efforts.

NPSG.15.01.01
Identify patients at risk for suicide.

Elements of Performance
1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address patient’s immediate safety needs and most appropriate setting for treatment.
3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to patient and his or her family.
UNIVERSAL PROTOCOL

UP.01.01.01
Conduct a preprocedure verification process.

Elements of Performance
1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.
   \textit{Note:} Patient is involved in verification process when possible.
2. Identify items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include:
   \begin{itemize}
   \item Relevant documentation (\textit{i.e.,} history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment).
   \item Labeled diagnostic and radiology test results (\textit{i.e.,} radiology images and scans, or pathology and biopsy reports) that are properly displayed.
   \item Any required blood products, implants, devices and/or special equipment for procedure.
   \end{itemize}
3. Match items that are to be available in procedure area to the patient.

UP.01.02.01
Mark procedure site.

Elements of Performance
1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
2. Mark procedure site before procedure is performed and, if possible, with patient involved.
3. Procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure qualifications.
4. Method of marking the site and type of mark are unambiguous and used consistently throughout the hospital.

UP.01.03.01
A time-out is performed before the procedure.

Elements of Performance
1. Conduct a time-out immediately before starting the invasive procedure or making the incision.
2. Time-out has these characteristics:
   \begin{itemize}
   \item It is standardized, as defined by the hospital.
   \item It is initiated by a designated team member.
   \item It involves immediate members of the procedure team, including individual performing the procedure, anesthesia providers, circulating nurse, operating room technician, and other active participants who will be participating in the procedure from the beginning.
   \end{itemize}
3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.
4. During time-out, team members agree, at a minimum, on:
   \begin{itemize}
   \item Correct patient identity
   \item Correct site
   \item Procedure to be done
   \end{itemize}
5. Document completion of the time-out.
Questions you may be asked

1. Are you familiar with the National Patient Safety Goals?
2. What two identifiers do you use to ensure that you have the right patient before giving medications, obtaining specimens or performing any treatment or procedure?
3. What two identifiers do you use to identify a patient who is not wearing an armband?
4. What two identifiers do you use to identify a patient who is wearing an armband?
5. Can you explain the Critical Values Reporting Process?
6. What type of education is provided to a patient and family regarding anticoagulant therapy?
7. How many seconds do you wash your hands with soap and water?
8. If a patient screens positive for being a suicide risk, what is your next step?

Patient Rights/Organizational Ethics

Patient Rights

■ Patient Bill of Rights is posted throughout the facility. Patients are given a copy of their rights upon admission.
■ Patients have the right to make complaints without jeopardizing future care.
■ Patients are informed of their right to receive information about Advance Directives when admitted to the hospital. An Advance Directive is a document that allows patients to name someone else to make healthcare decisions for them if they become unable to do so for themselves. Contact the Center for Spiritual Care or Clinical Social Work Services if a patient would like information.
■ Patients have a right to receive a Notice of Privacy Practices. This notice describes how individually identifiable information about the patient will be used and disclosed and how the patient can get access to this information.

Confidentiality/Privacy

■ Individually Identifiable Patient Health Information or Protected Health Information (PHI) is confidential.
■ Saint Agnes Medical Center is required by law to maintain the privacy of individually identifiable patient health information.
■ PHI comes in many forms, including electronic, paper and oral.
■ The Privacy regulations cover all forms of PHI.
■ Only the minimum amount necessary to perform a specific task or job should be accessed by authorized staff in the medical record.
■ Conversations containing PHI should be avoided in public places such as hallways, elevators, lounges and cafeterias. If you’re on a cell phone, remember to move away from the public.
■ Only the minimum amount necessary to perform a job should be shared with other personnel on a need-to-know basis.
A written authorization from the patient or patient representative is required for use of photographic equipment including cell phone cameras.

If you observe or suspect a privacy- or security-related incident, report it immediately through VOICE, 24-Hour Integrity Alertline at 1-866-477-4661 or call the Compliance Department at ext. 3510.

A written authorization from the patient shall be obtained before a patient's medical record can be made available to anyone not directly involved with his or her care.

Any breach of confidentiality will be subject to corrective action up to and including termination of employment.

Annual Confidentiality Agreement
Every year when signing your performance evaluation, you agree to this statement:

“I also acknowledge the Saint Agnes Medical Center confidentiality policy and HIPAA policies and procedures, and agree to abide by them in the performance of my duties.”

Reporting Quality or Safety Issues
We encourage you to report quality and safety issues to respective departments right away. Quality or safety issues that have not been appropriately addressed by Leadership within the organization may be reported directly to The Joint Commission. Staff members are encouraged to follow a process similar to the Organizational Integrity Program's Four-Step Process. Individuals who report quality or safety issues to The Joint Commission will not be reprimanded or punished in any way.

Research Human Subject Protection
Institutional Review Board (IRB) is an administrative body established by federal law to protect the rights and welfare of human research subjects. All research studies involving human subjects require prior IRB review and approval. IRB is administered through the Saint Agnes Clinical Research Center and is responsible for continuous oversight of all research activities.

Only IRB-approved research can be conducted at Saint Agnes.

Participation in research is voluntary and confidential.

Participants must be consented to participate using a valid, date-stamped, IRB-approved informed consent for the study.

All participants must receive a copy of the signed and dated informed consent document and the “California Experimental Subject's Bill of Rights.”

Principal Investigator (physician) is responsible for conducting the study in compliance with federal law and according to protocol.

Participants may contact the IRB Chairperson if they believe their rights have been violated.

Information concerning clinical research at Saint Agnes Medical Center can be found on the intranet under Department Resources, Clinical Research.

Abuse Reporting
All staff members receive information about abuse reporting during general orientation. Abuse identification and reporting requirements are reviewed annually with age competencies. This information is reviewed, signed and placed in the staff personnel file. In addition, Clinical Social Work Services staff provides in-services, upon request, and for high-risk areas.

Screening questions are asked at time of admission. Patient should be interviewed alone. Clinical Social Work Services is notified if there are any “yes” answers to screening questions.

All staff members are required to report suspected abuse (child abuse, elder abuse or domestic violence). You should notify your supervisor, Clinical Social Work Services, and patient's physician when abuse is suspected or reported.
You play an important role in protecting patients from continued abuse, of which there are several different types. Abuse occurring may be one type or a combination of two or more.

- Physical neglect
- Physical abuse
- Emotional abuse
- Psychological abuse
- Financial abuse
- Sexual abuse

**Mandated Reporters**

Certain individuals working with the public are identified as “mandated reporters.” These individuals have a legal responsibility to report to the appropriate agency any signs or symptoms of abuse or neglect. Healthcare professionals are mandated reporters. They would include, but are not limited to, physicians, nurses, emergency clinical technicians, paramedics, clinical social workers, pharmacists, physical therapists, and other allied health professionals.

- It is critical to identify suspected victims of abuse.
- Patients should be assessed for signs of abuse on admission and throughout the continuum of care.

**Indicators of physical neglect**

1) Evidence of poor health care such as untreated infections, pressure ulcers or contractures, overmedication or undermedication, dehydration or malnutrition.

2) Poor personal hygiene, especially teeth; presence of lice or fleas.

3) Missing or broken assistive devices such as glasses, dentures, hearing aids.

**Indicators of physical abuse**

1) Multiple injuries at various stages of healing.

2) Patient seen repeatedly in Emergency Department.

3) Fractures that require significant force, or that occur only rarely by accident.

4) Significant delay between time of injury and seeking help.

**Indicators of emotional abuse**

1) Depression, low self-esteem, unusual fearfulness, hunger for attention and socialization.

2) Suicide attempts.

3) Being quiet when caregiver is in room.

4) In children: slow emotional and intellectual development, especially language.

5) In older children: drug or alcohol addiction, vandalism, school absenteeism.

**Indicators of psychological abuse**

1) Psychological abuse happens by instilling fear.

2) Feeling that self or children are threatened, blackmail, destruction of pets or property, harassment.

**Indicators of financial abuse**

1) Nonpayment of utilities, unexplained loss of income.

2) Pressure to endorse checks.

3) Unanswered mail and bills and uncashed checks.

4) Money or access to job withheld.

**Indicators of sexual abuse**

1) In children and elders: sexually transmitted disease, recurrent UTI.
2) In adolescents: pregnancy.

**Behavioral indicators of abuse in children and/or adolescents**

1) Excessive daydreaming.
2) Regressive behavior such as bedwetting.
3) Running away from home.
4) Profound and rapid personality changes.
5) Rapidly declining school performance.

**What to do**

- Anytime any indicators of abuse are present, notify Saint Agnes Clinical Social Work Services, who will coordinate an investigation and determine if evidence suggesting abuse exists.
- Assist physician with any necessary assessments.
- Provide a safe and supportive environment.
  1) With patient permission, limit visitors and/or telephone calls.
  2) Identify if any legal restraining orders are in effect.
     a. Notify Saint Agnes Security, if appropriate.
  3) Separate victim from suspected abuser.
  4) Provide one consistent caregiver whenever possible.
  5) Remain with victim as much as possible.
  6) Reassure victim of his or her safety.
- Reporting
  1) In all cases of suspected abuse, Clinical Social Work Services will make an immediate telephone report to police or sheriff’s department and/or appropriate county protective services agency.
  2) Refer to Patient Care Policy A-30 “Suspected/Abused Child or Adult” for guidance.
  3) Whenever a telephone or verbal report is made, a written report must be sent to appropriate agency/agencies within 36 hours.
  4) If Clinical Social Work Services has not documented in Professional Progress Record that a report has been completed, contact them to do so.
- Provide community resources.
  1) Social Services will provide appropriate community resources.
  2) Safe placement may be offered by law enforcement and/or protective agency.

*For additional information about abuse, refer to Patient Care Policy A-30.*

**Ethics Team**

If an ethical issue in patient care arises, you should notify your supervisor or House Supervisor immediately. The issue may be referred to the Ethics Team for resolution. House Supervisor can be reached on cell phone 779-6074.

Ethics Team is responsible for:

- Consultation with concerned parties when ethical conflicts occur to facilitate communication and provide a process for conflict resolution.
- Development, education and implementation of criteria, procedures and guidelines for consideration of cases having ethical implications.

**Organizational Integrity**

All staff members receive training about the Organizational Integrity Program, Standards of Conduct, and Four-Step Process for obtaining help in reporting concerns or seeking answers.
Four-Step Process

1. Look at Saint Agnes Medical Center policy and read the Trinity Health Standards of Conduct. Talk with your manager.
2. If you are not comfortable asking your supervisor or are not satisfied with advice received through existing policies or procedures, contact a higher-level manager.
3. If you still are not satisfied, call your Local Integrity Officer at ext. 3510.
4. If none of the above steps resolves your question or concern, call the 24-Hour Integrity Alertline (1-866-477-4661).

For more information regarding ethics and patient rights, call the House Supervisor, ext. 6074. For more information regarding confidentiality, call the Compliance Department at ext. 3510.

Questions you may be asked

1. Whom should you contact if an ethical issue in care arises?
2. What should a staff member do if he or she feels there has been a violation of laws, regulations, policies, procedures or the standards of conduct?
3. How are patients informed of their rights?
4. How are you reminded every year about patient confidentiality?
5. How do you support patient rights?
6. How would you determine whether a patient was participating in an approved Clinical Research Study?
7. When requested, how would you provide a patient with information concerning clinical research at Saint Agnes?
8. What organization might you report unresolved issues related to quality or safety of care?
9. What do you do if you suspect a privacy or security incident has occurred?

Emergency Codes

These very important codes should be familiar to you. Report any code-related information directly to Hospital Operator (dial ext. 3300). Information will be routed to appropriate authority.

CODE RED = Fire

“Code Red” announced by Hospital Operator means there is a possible fire in the building. A chiming alarm is also heard throughout the Medical Center. Staff members are to respond by reporting to their departments immediately. Building evacuation from nearest fire exit should only be done if announced overhead. Do not use elevators and keep all doors and windows closed.

Acronym R.A.C.E. outlines steps for fire response:
- **Rescue** – Remove people if safe to do so.
- **Alarm** – Pull alarm box and call ext. 3300 (9-911 must also be notified in some outside buildings).
- **Contain** – Contain fire, close doors and windows.
- **Extinguish** – Use nearest extinguisher if appropriate.

Acronym P.A.S.S. outlines steps for fire extinguisher operation:
- **Pull** – Pull the pin.
- **Aim** – Aim at base of fire from approximately 8-10 feet away and work toward fire.
- **Squeeze** – Squeeze handles together.
- **Sweep** – Sweep from side to side.

Medical gases may also need to be turned off in the fire area. THIS IS THE RESPONSIBILITY OF MAINTENANCE OR RESPIRATORY THERAPY. If they cannot reach the area, they may instruct you to do so. Instructions are posted inside the medical gas valve box in the hallway.
CODE PINK = Infant/Pediatric Abduction

1. Call ext. 3300 if an infant is discovered missing.
2. All hospital personnel will stop, look and be aware. Any suspicious person carrying an infant, large package, basket, etc., should be reported to Security and exits will be monitored.
3. Detain all suspicious persons and notify Security.
4. If a pediatric person is missing, a description of the child will also be announced.

***See policy for specific departmental responsibilities.

CODE YELLOW = Bomb Threat

All staff members are asked to search their own area for unusual items and report them to Security. Calls or messages with threats of a bombing should never be disregarded, no matter how casually made. You should notify Security (dial ext. 3300) immediately if you receive or suspect any type of bomb threat. Do not use cell phones or two-way radios until the area is clear.

UTILITY TRIAGE = Loss of major utility

The type of impacted utility will be announced (telephone, water, sewer, power, steam, etc.).

Information regarding loss of power, water or medical gases can be found quickly in the Safety Manual under Emergency Response/ER009 – Loss of Utilities and “Utility Triage” (On page 6 of the policy there is a reference grid for “Systems Failure & Basic Staff Response”) and/or in department-specific Safety Plans.

- **Loss of Power**: Generator starts within 10 seconds, feeding power to red outlets and switches.
  If no power to red outlets, call ext. 4040 or 3300.

- **Loss of Medical Gas or Water**: Call Duty Pager, ext. 6120.

For more information, refer to Emergency Management Plan in your department’s Safety Manual.

CODE ORANGE = Hazardous Material Spill (Internal or External)

If a significant hazardous materials release has occurred, either within the hospital or in the community, a Code Orange will be called overhead. This will signal our decontamination team to report to an announced location. Staff not assigned to decontamination team should avoid the area if at all possible.

Hazardous Spills

Two types of hazardous spills:

1. **Incidental spill** is a small spill presenting NO hazard to trained staff or the environment.
   - **Response**: A trained user cleans up this spill utilizing appropriate Personal Protective Equipment.

2. **Emergency spill** is any spill that may present a hazard to people OR the effects are unknown.
   - **Response**: Isolate area (evacuate), deny entry to others, call ext. 3300.

All hazardou*s waste* spills are to be reported to Risk Management & Accreditation Department on an Online Incident Report. A Hazardous Material Spill Report also needs to be completed and can be found in your Safety Manual under Hazardous Materials.

Every department has an inventory list of all hazardous materials contained within the department. Products containing Prop. 65 chemicals (carcinogens and reproductive toxins) are identified with an asterisk (*).

CODE SILVER = Hostage/Weapon/Active Shooter

If there is a weapon or hostage situation, Code Silver will be announced with a location. Depending on the situation, you should run, hide or fight. However you choose to respond, know that you will be supported. Staff in immediate area will attempt to get patients, visitors and themselves to safety behind closed doors, if possible. Law enforcement will be called to address the situation.
**CODE BLUE = Cardiac/Respiratory Arrest**

“Code Blue” announced by Hospital Operator indicates that a patient needs resuscitation. A designated team and an available physician will respond. If you suspect that anyone is suffering cardiac or respiratory distress, call Hospital Operator (dial ext. 3300). Most staff members will not have to interrupt what they are doing if a Code Blue is called, because only a designated team is to respond. Please keep hallways clear if Code Blue is called in your area.

**SHELTER IN PLACE = Facility Lockdown**

If a significant airborne contaminant, such as chlorine gas, is released into the air, a **Shelter in Place** is announced overhead. All air intakes are shut down; only emergency elevator use is allowed and the medical center goes into lockdown – no entering or exiting is allowed.

**CODE GRAY = Aggressive/Hostile/Combative Person**

CODE GRAY establishes a protocol when patients, visitors and/or staff are confronted by an aggressive, hostile combative or potentially combative person.

- An employee hearing the request to initiate a CODE GRAY will request an overhead page by dialing 3300 and giving the location.
  1. Staff in the area will clear hallways and escort patients and visitors from the immediate area.
  2. Staff outside the area should avoid the area.
- Only trained personnel will respond to or minimize potential acts of aggressive behavior or violence including verbal abuse or physical battery.
- The CODE GRAY team's action plan objectives may include:
  1. Identify potentially violent person.
  2. Separate potential violent persons to protect visitors, staff and patients.
  3. De-escalate potentially violent behavior.
  4. Coordinate response with law enforcement, if appropriate.
- When the CODE GRAY has been resolved, the Team Leader will request and overhead page to announce “CODE GRAY, ALL CLEAR”.
- Refer to Safety Manual policy ER016 for more information.

**CODE White = Computer downtime**

Staff should check in with Supervisor or Practice Coordinator for additional direction or information.

*Please refer to your particular department’s Policies and Procedures for more details regarding each code.*

**Questions you may be asked**

1. What does Code Blue mean?
2. What does Code Red mean and what do you do?
3. What is Code Yellow and what is your role?
4. What is Code Pink and what is your role?
5. What does Code Silver mean and what is your role?
6. What is Code Orange and what is your role?
7. What is Shelter in Place?
8. What is Code Gray and what do you do?
9. What is Utility Triage?
10. What is Code White and what do you do?
11. How would you report a hazardous material spill?
Emergency/Disaster Management

Emergency/Disaster Management Plan

- Disaster Plan is located on Docushare, Safety Manual/Emergency Response/#ER001 – Emergency Response Plan (HICS).
- The Medical Center uses the HICS for emergency management. HICS stands for Hospital Incident Command System. It is a “system” or a “structure” or a “framework” for our Medical Center’s Disaster Plan. HICS is based on the premise that every disaster is different, thus requiring different resources (both human and material). It is also based on the fact that the Medical Center cannot come to a grinding halt while taking care of disaster victims. We must continue to give quality care to our existing patients.

Procedure

In the event of a disaster, Medical Center personnel will be alerted by any of these means:

- Telephone
- Radio
- Television
- Messenger
- Police officer
- Other staff members
- Text message

Staff entry into the hospital during a disaster will only be permitted through the back door by the Lab and with a hospital identification badge.

General Principles of HICS Disaster Management System

Each response will be different. Emphasis is to maintain “business as usual.” Hospital Command Center is announced overhead.

Code Triage

- Maintain business as usual unless instructed otherwise.
- Department person “In Charge” completes the Department Status Report and delivers it to the Hospital Command Center within 10 minutes.

Questions you may be asked

1. What are the two stages of an external disaster and what do they mean?
2. What is your role in a disaster?
3. What is HICS?
4. What is Code Surge and what is expected?
Infection Prevention and Control

Infection Prevention and Control will be a major focus of The Joint Commission. National Patient Safety Goal #7 stresses the need to reduce the risk of Healthcare-Acquired Infections (HAI).

Infection Control Officers for Saint Agnes are Dr. Robert Libke, Hospital Epidemiologist, and Christi Paradise, Infection Prevention and Control Coordinator.

The hospital must identify infection risks, set goals and a prevention plan. You should know the risks, rates of infection and plans for infection prevention that your unit has identified. Focus on:

- Pathogens/organisms – “bugs” or “germs”
- Procedures/devices (i.e., Foley, central line)
- Cleaning and disinfection of medical equipment, devices, supplies and their storage
- Sharps and infectious waste disposal
- Environmental cleaning
- Hand hygiene, cough etiquette and respiratory hygiene

We communicate responsibilities for preventing infection to our employees and physicians through Scene, Safety Scene, DocTalk, posters, CAT and training. For visitors, patients and families, we provide information about infection prevention, hand hygiene, cough etiquette and respiratory hygiene with Healthy TV videos, posters, brochures and Respiratory Hygiene Stations that provide masks, tissues and hand gel.

Patient Education: Be sure that patients with MRSA, C. diff or VRE receive handouts and oral education about infection prevention. Be sure patients who have surgery or a central line receive handouts and oral education about infection prevention. Then document on InTouch in PowerChart, Adhoc, Patient Education Form.

Hand Hygiene

All employees must comply with World Health Organization (WHO) and Centers for Disease Control (CDC) hand hygiene guidelines.

The WHO “5 Moments for Hand Hygiene” include:
1. Before touching a patient
2. After touching a patient
3. Before an aseptic procedure
4. After blood/body fluid exposure risk
5. After touching the surroundings

Other important times to perform hand hygiene: before putting on and after removing gloves, before eating or preparing food, and after using the bathroom.

Perform hand hygiene for at least 15 seconds (20 seconds for dietary employees). Both alcohol hand gel and soap and water are acceptable methods. Exception: if hands are visibly soiled or after caring for a patient with C. diff, wash with soap and water only.

Patient care providers (anyone who touches patients), environmental services, dietary, sterile processing and sterile supplies employees are not allowed to wear artificial nails, and natural nails may not extend beyond fingertips. Nail polish must be fresh and in good repair.

The Joint Commission will be watching to see if employees wash hands at the right times.

Standard Precautions

Use personal protective equipment (PPE), which may include gloves, mask, eye protection (shield, goggles, or glasses with side shields), cover gowns/aprons, shoes to prevent exposure to blood or body fluid.

You are responsible for knowing where to find PPE and using the proper PPE. ALWAYS wash your hands after removing PPE.

Transmission-based Precautions

Based on the “bug” and how it is spread. Includes:

- Contact: MRSA, VRE, C. diff and other multidrug-resistant organism (MDRO) – wear gown and gloves for contact with patient or environment.
■ **Droplet:** Flu, Meningitis – wear mask *(surgical or N95)*, eyeshield

■ **Airborne:** TB, Shingles, Novel Flu – N95 mask *(PAPR hood for High Hazard procedures)* and NEGATIVE Airflow room. Be sure the monitor is turned on. Check airflow daily.

### Steps for Transmission-based Precautions

1. Explain to patient and family the need for isolation. If diagnosed with MRSA, VRE or C. diff, or other MDRO, provide handout and document education.

2. Notify Bed Control at the start and stop of isolation – enter order for Isolation *(contact, droplet, airborne)* or dc isolation in PowerChart *(Alerts or Adhoc: Precautions Isolation)*.

3. Place patient in private room or cohort with matching organism. Place sign on door.

4. Document date/time of isolation in PowerChart *(Alerts or Adhoc: Precautions Isolation)*.

5. Assist family/visitors with proper precautions and provide handout. If a suspect/known active TB patient is ready for discharge, contact Infection Control or Discharge Planning to obtain approval from the County Health Department before discharging patient.

Notify both the receiving and referring organization *(hospital/EMT)* for any reportable disease or infection requiring isolation identified at Saint Agnes. All Reportable Communicable diseases MUST be reported to the County Health Department in a timely manner *(see Infection Control Policy)*.

### Cleaning

It is everyone’s job to keep the environment clean. Focus on frequently touched objects. Use gloves when using hospital-approved cleaning products and know how long the item needs to stay wet *(contact time)*. The contact time for the cleaning wipes is at the top of the front label. PDI purple top is 2 minutes. PDI Bleach wipes, orange top is 4 minutes. Air dry.

### Employee Health and Infection Prevention

■ Use Standard and Transmission-based precautions.

■ Get your vaccines: Flu, Hepatitis B *(free)*.

■ Annual TB testing and Mask Fit testing.

■ Follow up with Employee Health *(ED after hours)* for exposure to blood/body fluids *(within 2 hours of exposure)*, TB or other infectious/communicable disease. The Bloodborne Pathogen *(BBP)* and Aerosol Transmissible Disease *(ATD – formerly known as the TB control plan)* Control Plans are located in the Infection Control Manual in Docushare on InTouch.

■ Spills of blood/body fluids: If small, put on gloves, wipe with paper towel, then disinfect with germicidal wipe. For larger spills, contact Environmental Services.

### Questions you may be asked

1. What do you *(or your department)* do to prevent infections? What are your unit infection rates?

2. What are Standard and Transmission-based precautions?

3. Where is your PPE located and when do you wear it? *(surveyors will watch)*

4. How do you clean up a blood/body fluid spill?

5. How do you clean __________ *(piece of equipment or environment)*?

6. How are patients and visitors educated about infection prevention?

7. What training have you received about infection prevention?

8. Be prepared to tell if you had a flu vaccine.
Hazardous Materials/Waste Management

Safety Data Sheets
- S.D.S. = Safety Data Sheets
- S.D.S. ARE NO LONGER KEPT IN EACH DEPARTMENT.
- S.D.S. can be obtained by calling 3E at 1-800-451-8346. They will fax the S.D.S. to you at nearest fax. You can also access S.D.S. icon on Zenworks.
- In 2014, M.S.D.S. was changed to S.D.S. (Safety Data Sheets) in compliance with new Global Harmonization System (G.H.S.).
- A master S.D.S. Manual is in Environmental Services Department.
- S.D.S. tells you everything you need to know about a product: storage requirements, personal protective equipment requirements, spill/leak procedures, and so forth, through the use of pictograms.

Laboratory, SPD, Radiology, Pharmacy, Oncology, Engineering, Environmental Services, and, at times, some of the nursing departments are examples of some departments where hazardous materials can be found. Personal protective equipment for each type of potential spill is kept within each department.

If you are exposed to a hazardous material, you must inform your supervisor, complete an online TH Incident Report, and, if needed, report to the Emergency Department immediately.

Mock hazardous material spill drills are conducted routinely. Remember, all secondary containers used for chemicals must be labeled correctly (name of chemical, name and address of manufacturer, hazard warning – i.e., flammable, toxic, etc.). What is a secondary container? Whenever a chemical is removed from its original container and placed into another container, such as a spray bottle, it is called a secondary container.

Waste
1. Medical Waste consists of:
   A. Sharps waste – must be disposed of in rigid containers with lids that seal securely and then disposed of in a red-lined container.
   B. Chemo sharps waste – must be disposed of in special yellow chemo containers.
   C. Biohazardous waste (any item that drips with blood/body fluids freely or when compressed) – must be placed in RED bags.
2. Recyclable Waste (includes all colors of paper) – must be disposed of in designated recycle containers to maintain confidentiality.
3. Regular Waste (any waste that does not fall into the above categories) – may be disposed of in regular trash cans. Any item containing patient-specific information MAY NOT be placed in regular trash unless shredded.
4. Pharmaceutical Waste

Pharmaceutical Waste Program is designed to prevent medications from harming the environment. To accomplish this, federal, state, and local regulations state that pharmaceutical waste must be managed according to their toxicity classification.

Five categories of waste
A. Pharmaceutical waste – Place in white and purple containers.
B. RCRA hazardous – Place in black containers.
C. Fentanyl patches – Folded in half and disposed of in white and purple containers.
D. Chemotherapy waste – Place in yellow containers.
E. Inhalers and compressed anesthesia gases – Bag and return to pharmacy or dispose of in black container labeled for this purpose.

For more information, refer to Pharmaceutical Waste Grid or Safety Manual Policy HM005 – Medical Waste Management Plan.

Refer to Pharmaceutical Waste Disposal Grid to determine if it is classified as RCRA, chemo or regular pharmaceutical waste. Sharps are not to be placed in pharmaceutical waste containers.

PHARMACEUTICAL WASTE shall be defined as any prescription or over-the-counter medication that may be partially used, opened and unused. These items include capsules, tablets, powders, liquids,
injectables, topicals, suppositories, ophthalmics and otics, and IV solutions with medications. These items must be differentiated from items previously designated as hazardous cytotoxic waste and those items listed under the Federal Resource Conservation and Recovery Act (RCRA).

All pharmaceutical waste shall be handled, stored and disposed of within the Medical Center in accordance with waste management law and compliance with Senate Bill 1966, chapter 536 (SB 1966) as regulated by California Department of Public Health Services (CDPH) and local waste water management (Public Owned Treatment Works – POTW).

1) Hazardous cytotoxic (chemotherapy agents) waste shall be disposed of in accordance with Saint Agnes policy regarding proper handling and disposition of cytotoxic agents (currently in place). (Oncology Unit Policy A-3, Pharmacy Policy 7170-IV-110)

2) Pharmaceutical hazardous waste listed under the RCRA shall be logged and disposed of in accordance to waste management law. RCRA pharmaceutical hazardous waste must be returned to Pharmacy for disposal. Items shall be logged in regard to product name, NDC number, strength and amount disposed of in Pharmacy if a black container is not in the area.

Waste shall be disposed of in pharmaceutical hazardous waste containers labeled for incineration only. Items identified under RCRA shall include cough syrups with alcohol content greater than 24%, all inhalers*, compressed anesthesia gases*, >60% barium, chromium, selenium containing products, lindane, nicotine, acetone, mitomycin c, chlorambucil, cyclophosphamide, diethylstilbestrol, hexachlorophene, melphalan, phenol, uracil mustard, Silvadene, and warfarin.

RCRA items have been identified as having characteristics of ignitability, corrosivity, reactivity or toxicity. RCRA waste shall also include items identified.

* Must go into designated Black container.

For more information, refer to Hazardous Materials/Waste Management Program outlined in your department Safety Manual, or call Environmental Services, ext. 3128.

Questions you may be asked
1. What is an S.D.S. and how do I obtain one?
2. What do you do if you are exposed to a hazardous material?
3. What type of waste goes in RED bags?
4. Where do you dispose of pharmaceutical waste?
5. Where do you dispose of RCRA pharmaceutical waste?
6. What is G.H.S?
Workplace Safety

Workplace Safety

The Safety Manual, located on InTouch, includes an area-specific safety policy, which addresses on-the-job safety precautions relevant to that department.

Workplace safety concerns can be reported by contacting a supervisor or by completing an Employee Safety Suggestion Form. These forms can be obtained from the Employee Safety section and the Forms section of the Safety Manual or the Safety Web page or calling the Safety Officer at ext. 3721.

Workplace Violence Security Plan (SC005)


■ All staff members are required to inform their immediate supervisor of an act or threat of violence from a visitor, patient, medical or hospital staff, or contractor.

■ Staff members are encouraged to report threats from family and/or acquaintances outside of work if they feel that there is a possibility the threat may be carried out in or around the workplace.

■ All staff members will immediately contact Security through the switchboard at ext. 3300 if an act of violence is in progress. Staff members in buildings not on the Medical Center main campus will also dial 9-911.

Accident Procedures for Staff Members/Volunteers

If a staff member or volunteer is injured on the job, follow these steps:

1. Fill out an online Trinity Health Unified Incident Report and have your supervisor sign it before reporting to Employee Health Services.

2. If you need medical attention, report to Employee Health Services or Emergency Department (if appropriate) with Incident number.

3. If you do not need medical treatment, file an online Trinity Health Incident Report within 24 hours.

Accident Procedures for Visitors/Physicians/Students

■ If you witness a visitor, physician or student accident, you should report it to Security immediately by dialing ext. 3300.

■ Security will take a report, regardless of whether the person requires medical attention or not. If person requires medical treatment, Security will assist him or her to the Emergency Department.

■ Contact Security to take pictures of all slips and falls, including employees.

Questions you may be asked

1. Can you locate Safety Manual policies?
2. How would you report a safety concern?
3. Where is the Workplace Violence Security Plan located?
4. What do you do if you receive a threat from a visitor, patient, physician or staff member?
5. What do you do if you are injured on the job?
6. What do you do if you witness a student, visitor or physician injury?
Patient Safety/Incident Reporting

- When a patient safety issue is identified, all staff have the responsibility to “speak up” and communicate the concern without fear of retaliation.
- Any errors or “near-miss events” should be reported via VOICE, the electronic incident reporting system.

Ongoing education about patient safety occurs in a variety of ways:
2. All staff members complete the Continuous Education Training (CAT) test annually. This includes safety principles, environmental and equipment safety, incident reporting, prevention of infection and handling hazardous materials.
3. ISMP Medication Error Prevention posters and newsletters, and Sentinel Event Alerts.
4. Housewide and unit-specific competencies and training.
5. Crisis Prevention Intervention Classes.
7. Discussion in daily huddles.
8. Safety ambassadors program
9. System- and organizationwide training through webinars and outside speakers.

Just Culture/Safe Choices

Just Culture is what we strive to achieve at Trinity Health.
- Provides a simple and powerful approach to change our way of thinking about safety, both for patients and associates.
- Helps us learn from undesirable outcomes and how the errors and behavioral choices that we make can impact our patients, each other and the organization.
- Focuses on finding opportunities to reduce risk in our actions, environment, policies, and procedures and systems.

- Helps us create a continuous learning environment where we seek to learn from each other’s experiences to make a safer organization.
- Helps us be mindful of the opportunity to be finders and fixers of defects within our work environment.

Reporting Errors, Injuries and “Near-Miss” Events

Saint Agnes has a Nonpunitive Incident Reporting Policy (Admin 0-36). This means that staff/physicians who report errors will not be treated in a punitive manner. Reporting is expected and appreciated.

This policy also includes reporting of “near-miss” events. This means that any process, procedure or activity that may have or did result in an error or harm to a patient should be reported on an Online Incident Report. This includes events that didn’t actually occur and whether or not there was an injury. Follow-up on events will be focused on improving the process that allowed event to occur, NOT on the individual reporter.

When an incident occurs that is outside the prescribed treatment, research protocol or standard of patient care (medication errors, falls, etc.), you should:

1. Attend to patient, remain calm and reassure those involved.
2. Report incident to your supervisor and attending physician.
3. Initiate an Online Incident Report and keep your documentation accurate and honest.

If you have further questions, contact your department supervisor, or Risk Management at ext. 7545, or Environmental Safety Officer at ext. 3723.
Questions you may be asked

1. What do you do if an incident occurs that is outside the prescribed treatment of a patient?
2. What should you do if you recognize a serious error almost occurred?
3. What does it mean to have a Nonpunitive Medical Error Reporting Policy?
4. When was the last time you received education/training on patient safety?

Electrical and Equipment Safety

Equipment Safety Tags

All electrical equipment used in the hospital for patient care must be approved by Clinical Engineering (BioMed) or Maintenance departments. All equipment verified as safe is tagged. Nonpatient care equipment will be initially checked by Clinical Engineering (BioMed) and will receive an approval tag, but will not require annual reinspection.

Equipment Safety Rules

- It is the responsibility of each person to make sure that every patient care device is in good physical condition and has a current inspection sticker before use.
- Any type of equipment that may come in direct contact with a patient, although it may not be medical equipment, must have an inspection sticker.
- Any medical device found without an inspection sticker or is 30 days or more past the inspection due date must be removed from service and reported immediately to Clinical Engineering (BioMed).

Patient Care Equipment Malfunctions

If a piece of equipment malfunctions, you should:

1. Check to see if anyone was injured and immediately inform a supervisor.
2. Pull equipment from service and place an “out of order” tag on it.
3. Not touch any controls or settings.
4. Call Clinical Engineering (BioMed) Department (ext. 3121) or Risk Management (ext. 7545).
5. Complete an Online Incident Report (VOICE).
6. Save all equipment accessories and packaging.

For more information, refer to the Safety Manual.
Questions you may be asked

1. What kind of equipment needs to be inspected by Clinical Engineering (BioMed) or Maintenance?
2. What kind of equipment needs to be inspected at least annually by Clinical Engineering (BioMed) or Maintenance?
3. What do you do if you find a piece of equipment without an inspection sticker?
4. What do you do if a medical device tag indicates that the equipment should have been inspected 30 days ago or longer?
5. What do you do when a piece of equipment malfunctions?

Quality and Performance Improvement

Saint Agnes Medical Center performance improvement initiatives are aligned with key organizational objectives

- Service
- Safety
- Financial Stewardship
- Employee Engagement
- Strategic Growth

Performance Improvement Methodology

- Establish a clear aim or goal for the process improvement project.
- Determine what changes can be put in place to make an improvement.
- Determine if the changes are making a difference by measurement/data collection and using PDSA.

The Plan-Do-Study-Act (PDSA) cycle is used to implement small tests of change for performance improvement. This allows changes to be piloted on a small scale before implementation across a whole department or service line.

Performance Improvement Education

Education on Performance Improvement occurs in many formal and informal settings throughout the Medical Center. All staff members receive an orientation to Performance Improvement at Saint Agnes during General Orientation, which includes our methodology for improvement. Other types of training you may receive:

- Orientation to Annual Quality/Strategic Initiatives and Prioritized Projects
- Departmental orientation, in-services or staff meetings
- Performance Improvement Structure Committees or Teams
Questions you may be asked
1. What is our Performance Improvement methodology/process?
2. How are you involved in Performance Improvement activities?
3. What type of training have you received about performance improvement?
4. Whose job is it to improve organizational performance and patient safety?
5. Can you name some examples of organizationwide Performance Improvement projects?
6. How do you ensure quality measures are met for your patient(s)?
7. What things have been done to make care safer in this department than it was a couple of years ago?

Teams/PI Initiatives at Saint Agnes Medical Center
- Readmissions Reductions
- Sepsis Management
- CAUTI (Catheter-Associated Urinary Tract Infections)
- CLABSI (Central-Line Associated Blood Stream Infections)
- HAPU (Hospital-Acquired Pressure Ulcers) Prevention
- Falls Prevention
- Use of Two Identifiers
- Operative & Procedural Safety
- Universal Protocol
- Sedation Practices
- Quality measures for stroke, venous thromboembolism, ED throughput, perinatal care and surgical patients.

For more information, contact your manager or call the Quality Resources Department, ext. 2928.
Patient Care Areas

Important Information for Care Providers

1. Crash cart checking and restocking

Crash carts must be checked daily in all areas. Crash cart check includes: check that O₂ tank is present, full and not expired, discharge the defibrillator UNPLUGGED, check that bathroom key is on cart, drug expiration date is current and that both SPD and Pharmacy locks are secure. Then complete documentation and re-plug crash cart into RED outlet.

*Note:* For defibrillators with a multifunction cable, discharge into the test load daily. Clinical Engineering performs paddle discharges monthly.

**Pediatric Patients** – All units that care for pediatric patients routinely will have pediatric emergency supplies located in a pink drawer in the crash cart. 4-Main is the inpatient unit designated for pediatric patients.

Whenever the crash cart has been opened, staff will immediately call SPD to obtain a replacement cart. Carts will be restocked in SPD. All medications are sent to Pharmacy. Pharmacy will restock the crash cart medication drawer and lock crash cart. A complete list of medications contained in the crash cart is located on cart.

Once a month, Pharmacy checks medications in the crash cart for expiration dates. Semi-annually, SPD checks all crash cart supplies and equipment for expiration dates.

2. Planning care

Be prepared to discuss how you prioritize care and what your patients’ high-priority needs are for the day. Priorities are determined on an individual basis; however, examples may include safety, prevention of infection, patient/family education, etc.

*Be sure that these priorities are addressed in the Interdisciplinary Plan of Care (IPOC) and/or Clinical Pathway.*

3. Medications

*Be prepared to discuss specific Patient/Family educational needs (i.e., medications, disease process, planning for home care, etc.).*

**National Patient Safety Goals** require care providers to always use two identifiers when giving a medication. At Saint Agnes, patients who have an armband will be identified using their name and medical record number. Patients without an arm band will be identified by their name and birth date.

Appropriate use of CareAdmin (bar code scanner) with name verification in inpatient areas meets this requirement. Scan the patient’s armband, then scan the drug barcode PRIOR to giving the medication.

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All other areas must consistently use two identifiers. Name and medical record number if patient has an armband. Name and date of birth if NO armband.

Remember the five rights: Right Patient, Right Drug, Right Dose, Right Route, and Right Time before administering medication and documentation.

Medications must always remain in control of a licensed care provider or stored in a secure location.

Always double-check high-alert/high-risk drugs with another licensed care provider and document the double-check in CareAdmin (bar code scanner) or on your area specific form. Examples include infusions of insulin, heparin, chemotherapy, sedatives, neuromuscular blockers, and narcotics including PCAs (complete list is on InTouch > Department Resources > Pharmacy Web page).

Look-alike/sound-alike drugs: Safety measures in place to reduce the chance of medication errors include bar coding and scanning, Tallman lettering, and storage in Pyxis with access only to the specific pocket (complete list is on the InTouch > Department Resources > Pharmacy Web page).
- All telephone medication orders will be entered into the computer and the entire order will be repeated back to the physician while the physician remains on the phone.
- Never carry medications in your pockets, not even saline flushes.

4. Disposal of fentanyl patches
   A. Remove patch from patient and fold the patch in half.
   B. Place the folded patch into the Pharmaceutical Waste container.

5. Adverse Drug Reaction (ADR)
   - An Adverse Drug Reaction is an unintentional, unexpected or significantly poor patient response to administered medications in dosages accepted in current medical practice.
   - ADR examples include: anaphylaxis, rash, seizures, renal failure, respiratory arrest, acute dystonic reactions, hemorrhage secondary to anticoagulants, elevated drug levels that require treatment or require that medications be discontinued.
   - Adverse drug reactions are tracked by and reported to Pharmacy & Therapeutics Committee.
   - To report an ADR, complete an online Voice Report or contact the Pharmacy.

6. Serious Reportable Events (SRE)
   An SRE is a serious event that is largely preventable and may cause serious harm or death. Saint Agnes Medical Center is required to report all SREs to CDPH (California Department of Public Health) and Trinity Health:
   A. Surgical or Invasive Procedure Events
      1. Surgery or other invasive procedure performed on the wrong site.
      2. Surgery or other invasive procedure performed on the wrong patient.
   3. Wrong surgical or other invasive procedure performed on a patient.
   4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
   5. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient.
   B. Product or Device Events
      1. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
      2. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
      3. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
   C. Patient Protection Events
      1. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
      2. Patient death or serious injury associated with patient elopement (disappearance).
      3. Patient suicide, attempted suicide or self-harm that results in serious injury, while being cared for in a healthcare setting.
      4. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
      5. Patient death or serious injury associated with unsafe administration of blood products.
6. Material death or serious injury associated with labor or delivery in a low-risk pregnancy while cared for in a healthcare setting.

7. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.

8. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.

9. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to healthcare setting.

10. Artificial insemination with the wrong donor sperm or wrong egg.

11. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.

12. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology or radiology test results.

D. Environment Events

1. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.

2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, or are contaminated by toxic substances.

3. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient process in a healthcare setting.

4. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

E. Radiologic Events

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

F. Potential Criminal Events

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed healthcare provider.

2. Abduction of a patient/resident of any age.

3. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.

4. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

Any incident that may be considered a Serious Reportable Event (SRE) should be reported to your supervisor immediately. Risk Management and Patient Safety will determine whether an occurrence meets our definition of an SRE. If event does meet the criteria, a team will be formed to conduct a root cause analysis to determine the root causes of the event. Actions will then be implemented to prevent a future occurrence.

The Joint Commission publishes Sentinel Event Alerts that identify significant safety issues identified by hospitals across the nation and suggested strategies for preventing such events in other facilities.

To date, alerts have been published relating to prevention of medication errors, fatal falls, and surgical errors, radiation safety and use of alarms. Sentinel Event Alerts are distributed to appropriate individuals by Risk Management. Copies are available in Risk Management & Accreditation Department and on Patient Safety & Accreditation Web page on InTouch.
7. **Restraints**

A restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move arms, legs, body or head freely.

- Patients have the right to remain free of inappropriate use of restraint and to be protected when the use of restraint is necessary.
- Restraint may only be imposed to ensure the immediate physical safety of the patient, and after all other alternatives have proven ineffective.
- The Practice Coordinator of the unit will be notified of each impending episode of restraint in all areas. Patient will be moved to a room directly across from the nurses station when possible.
- When considering restraints, patient will be assessed to identify any physiological problems that may be causing changes in patient's behavior.
- Alternative interventions will be considered prior to application of restraints.
- MD order will be obtained just prior to or concurrently with application.
- Restraints will be removed as soon as the patient's condition makes it safe to do so.
- Restraint orders must be reviewed every 24 hours by the MD.
- Documentation will be in Restraint Plan of Care/IPOC.
- Patients will be monitored every two hours and PRN.
- Patient observed every 15 minutes and PRN.

Saint Agnes Medical Center goals with regard to restraints:

A. Maintain patient comfort, safety and dignity whenever restraints are utilized.
B. Limit use of restraints to clinically justified situations.
C. Promote use of alternatives to physical restraints whenever possible.
D. Ensure appropriate documentation in medical record whenever restraints are used.
E. Never write a PRN order for restraints.

*For additional information on use of restraints, please review Patient Care Policy C-9 Restraints & Seclusion.*

8. **Process for critical lab values**

- Lab calls the value to the nurse caring for the patient.
- The lab is reviewed, is it:
  - A known deviation?
  - Abnormal but improved?
  - Abnormal that is expected due to the disease process? *(Example: elevated BUN, Cr in a Hemodialysis patient)*

If it is any of the above, the physician should be notified the next time he does rounds.
- If the lab is an unexpected or worsening abnormal, the process is:
  - Call the physician with the abnormal lab.
  - Use the read back/confirm method with the physician.
  - Take any orders the physician may give and use the read back/confirm method with the physician.

9. **Language Line/Interpreter Services**

How do you communicate with patients whose primary language is not English?

- The use of family members as the translator is discouraged.
- Saint Agnes has a contract with Language Line.
■ Call the Operator to connect you, or call direct, 1-844-724-8216.
■ Phones available in PC office or Central Distribution.
■ Tell the person the language that is needed.
■ You will be connected to a translator for that language.
■ All questions related to interpreter/language services should be directed to Service Excellence.

Access Language Line phone or laptop from Practice Coordinator or House Supervisor. Refer to Patient Care Policy E-3.

10. Moderate Sedation for Procedures (formerly Conscious Sedation)

Only staff members who have completed sedation competency can monitor a patient receiving or recovering from Moderate Sedation.

Procedure Record and Plan of Care include all required elements of documentation for sedation.

All physicians responsible for ordering, administering and/or monitoring patients receiving Moderate Sedation must also have defined Medical Staff privileges.

Staff can contact House Supervisor if there is a question regarding whether or not a physician has privileges for procedures or sedation, or staff can access information on InTouch.

11. Accessing Physician Privileges

Physician privileges are now located on InTouch. Go to Department Resources: look for “Physician Privileges” in third column on right. In addition, all Allied Health Professional Staff privileges are included in Physician Privilege document. Privilege information is updated quarterly following approval by Board of Trustees.

Please remember that privilege information should be accessed on an as-needed basis and is not intended for publication outside Saint Agnes. If you have questions or need help accessing information, please call Medical Staff office, ext. 3631, or House Supervisor, ext. 6074.

12. Pediatric Patients

Pediatric patients at Saint Agnes are most often seen in the Emergency Department and 4-Main Surgery, and are placed on 4-Main when an inpatient. Staff members caring for children have completed appropriate age-specific competencies. For more information, refer to your Pediatric Patient Care Policies available on InTouch.

13. Waived Testing

Waived testing is any kind of bedside testing that is performed by nonlab personnel, such as test used to check fingerstick blood glucose. To use these kinds of tests, there must be demonstrated competency for all staff performing the test. Be sure to check which types of tests are performed on your unit.

■ Information about ordering and collecting laboratory tests can be found in DocuShare under Laboratory Department. Specimen Collection Manual provides an alphabetical listing of tests with preparation and collection requirements, while the General Laboratory Information document provides general information on specimen collection, ordering priorities, and so forth.

■ Whenever specimens are collected, two patient identifiers must be used (i.e., name and birthdate or name and medical record number).

14. Pain Management

Effective pain management generally involves an interdisciplinary therapeutic approach with a combination of pharmacologic, cognitive-behavioral, psychological and physical treatments.

A comprehensive pain assessment must be completed:

■ on admission or transfer
■ at regular intervals appropriate for specific patient
■ with each new report of pain
■ after a known pain-producing procedure
Pain will be assessed using an appropriate assessment tool for the patient, and will include these elements:

- presence of pain, onset
- location
- intensity
- duration
- description
- frequency

Pain will be reassessed following pain management interventions, once sufficient time has elapsed for treatment to be effective, and prior to discharge.

Prior to administering a new opioid, attention should be given as to whether patient is opiate naïve (does not receive opioid analgesics on a daily basis), or whether patient has an existing narcotic patch or implanted drug delivery system or infusion pump. In these cases, the narcotic effect may be significantly greater, and monitoring patient for quality and adequacy of respiration and depth of sedation is critical. Report signs of over-sedation and respiratory depression immediately to physician.

Please consult your Docushare/Patient Care or contact your supervisor if you have questions.

Questions you may be asked

1. How often is crash cart checked?
2. What are the high priority needs for this patient today?
3. What two patient identifiers do you use when patient has an armband?
4. What two patient identifiers do you use when patient does not have an armband?
5. If you do report an error, do you feel you will be punished?
6. What is an Adverse Drug Reaction?
7. What is a Serious Reportable Event?
8. How would you find out if a physician has privileges to perform a procedure?
9. How do you maintain patient confidentiality?
10. What pain score requires intervention?
11. How often do you assess for pain?
12. How do you know you are doing a good job of managing pain?
13. When do you need to use two identifiers to ensure that you have the right patient?
14. What two identifiers do you use if the patient doesn’t have an armband?
15. If the lab is an unexpected abnormal, what is the process?