



**ENLOE**  
**MEDICAL CENTER**

**ANNUAL TRAINING  
MODULE**

**STUDENTS**

**August 2011 - July 2012**

## **Annual Training: August 2011 – July 2012**

As an Enloe employee, you are to complete this annual training packet in the two months before or the month of your evaluation. Please complete the post test, and submit it to you manager, supervisor or educator for grading. You will be notified if you miss any questions at the time of your evaluation. Your manager, supervisor or evaluator will let you know the correct answers so that you may gain the information you need to work safely and efficiently.

*Take a moment to look through these materials. If you are classified as a non-patient contact employee and you are NOT required to have an annual TB test, you need only complete the test questions 1-41. For those of you who are required to have an annual TB test, you will complete test questions 1-40 and 42-58, skipping question 41 on the answer sheet. For inpatient RN's and LVN's, you will also complete test questions 59 - 62. Inpatient, patient care, RN's, Behavioral Health RN's, Rehab RN's and ESPAA RN's will also complete test questions 63 - 67.*

Circle the correct answer on your answer sheet and submit it to you your manager. Questions? Ask your manager, supervisor or educator.

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## **Our Mission**

*To improve the quality of your life through patient-centered care.*

## **Our Vision**

*To be the first choice for health care.*

## **Our Core Values**

***Focus on Patient Safety*** We value an unwavering focus on patient safety that fosters not only technical excellence, but compassionate and safe care for the whole patient that encompasses mind, body and spirit.

***A Culture of Service*** We value the ideal that everyone within the organization is a caregiver and fully engaged in creating a culture of service.

***Ownership and Empowerment*** We value a work environment where caregivers take ownership of their actions and are empowered to work to their highest potential.

***Integrity and Transparency*** We value sharing information and emphasizing behavior that is consistently honest and reliable.

***Mutual Respect*** We value a healing environment that is built upon the respect of all individuals.

## **PATIENT RIGHTS**

Enloe Medical Center is committed to supporting and protecting the fundamental human, civil, constitutional and statutory rights of each individual patient. These rights incorporate the requirements of the Joint Commission on Accreditation of Healthcare Organizations; Title 22; California Code of Regulations, Section 70707; and Medicare Conditions of Participation.

### **You have a right to:**

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for cultural, psychosocial, spiritual, and personal values, beliefs and preferences.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.
4. Receive information about your health status, 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 forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent, or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment, and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.
7. Be advised, if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment, you have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures, and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe, chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must

inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services, including notifying government agencies of neglect or abuse.
14. Be free from restraints and seclusion of any form, used as a means of coercion, discipline, convenience or retaliation by staff.
15. Reasonable continuity of care, and to know in advance the time and location of appointments, as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information.
17. Know which hospital rules and policies apply to your conduct while a patient.
18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
  - No visitors are allowed.
  - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
  - You have told the health facility staff that you no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household.
20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.
21. Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care.
22. File a grievance. If you want to file a grievance with Enloe Medical Center, you may do so by writing or calling:

**Patient Service Excellence Manager  
Patient Service Excellence Department**

Enloe Medical Center  
1531 Esplanade  
Chico, CA 95926

Telephone: (530) 332-7005 – This line is accessible 24 hours a day. Your grievance will be reviewed and you will be provided with a written response within 30 days. The written response will contain the name of a person to contact at Enloe Medical Center, 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 and/or The Joint Commission, regardless of whether you use the hospital's grievance process. The phone numbers and addresses for both agencies are listed below:

**California Department of Public Health**

Licensing and Certification Program (local office)  
126 Mission Ranch Boulevard  
Chico, CA 95926  
TOLL FREE TELEPHONE NUMBER: 1-800-554-0350

**The Joint Commission**

Division of Accreditation Operations  
Office of Quality Monitoring  
One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
TOLL FREE TELEPHONE NUMBER: 1-800-994-6610  
Fax: (630) 792-5636  
E-mail: [complaint@jointcommission.org](mailto:complaint@jointcommission.org)

## **PATIENT'S RESPONSIBILITIES**

1. Providing complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required.
2. Providing, to the best of your knowledge, complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters relating to your health, including perceived safety risks.
3. Ensure that the hospital has a copy of your Advance Directives.
4. Reporting perceived risks in your care and unexpected changes in your condition to your physician.
5. Reporting whether you clearly understand your treatment plan and what is expected of you. You are expected to ask questions when you do not understand information or instructions.
6. Following the treatment plan recommended by your physician. This may include following the instructions of nurses and other health care providers as they carry out the coordinated plan of care, implement your doctor's orders, and enforce the applicable hospital rules and regulations. If you believe you can't follow through with your treatment plan, you are responsible for telling your doctor.
7. Your actions and outcomes if you refuse treatment or do not follow your physician's orders for care and treatment.
8. You are responsible for keeping appointments, and, when you are unable to do so, for notifying your physician or the hospital (for any reason).
9. Assuring that your health care financial obligations are fulfilled as promptly as possible.
10. Following hospital rules and regulations affecting patient care and conduct and for assisting in the control of noise and the number of visitors.
11. Being considerate of the rights of others by treating hospital staff, other patients and visitors with courtesy and respect.
12. Being respectful of the property of other persons and the hospital.

### **Patient complaint/grievance process:**

It is the policy of Enloe Medical Center to provide for a systemic approach to resolving conflicts that may arise concerning the care of a patient. Patients have the right to communicate complaints regarding the care received, to have those complaints investigated and when possible, resolved. Patient complaints will in no way affect future access to health care. Any patient and/or family member that identify an issue that presents a conflict in the care the patient is receiving shall be

encouraged to address that issue with the direct patient care provider; the department manager or designee, an administrative representative or the Patient Service Excellence Department. If a patient/designated representative wishes to file a grievance, they may contact the Patient Service Excellence Department at (530) 332-7005. This line is accessible 24 hours a day.

*See the [“PATIENT COMPLAINT/GRIEVANCE PROCEDURE”](#) policy on DMS for more information.*

#### **Advance Directives:**

Complaints concerning compliance with the advance directive requirements may be filed with the state Department of Health Services by calling (800) 554-0350.

#### **Bioethics Committee:**

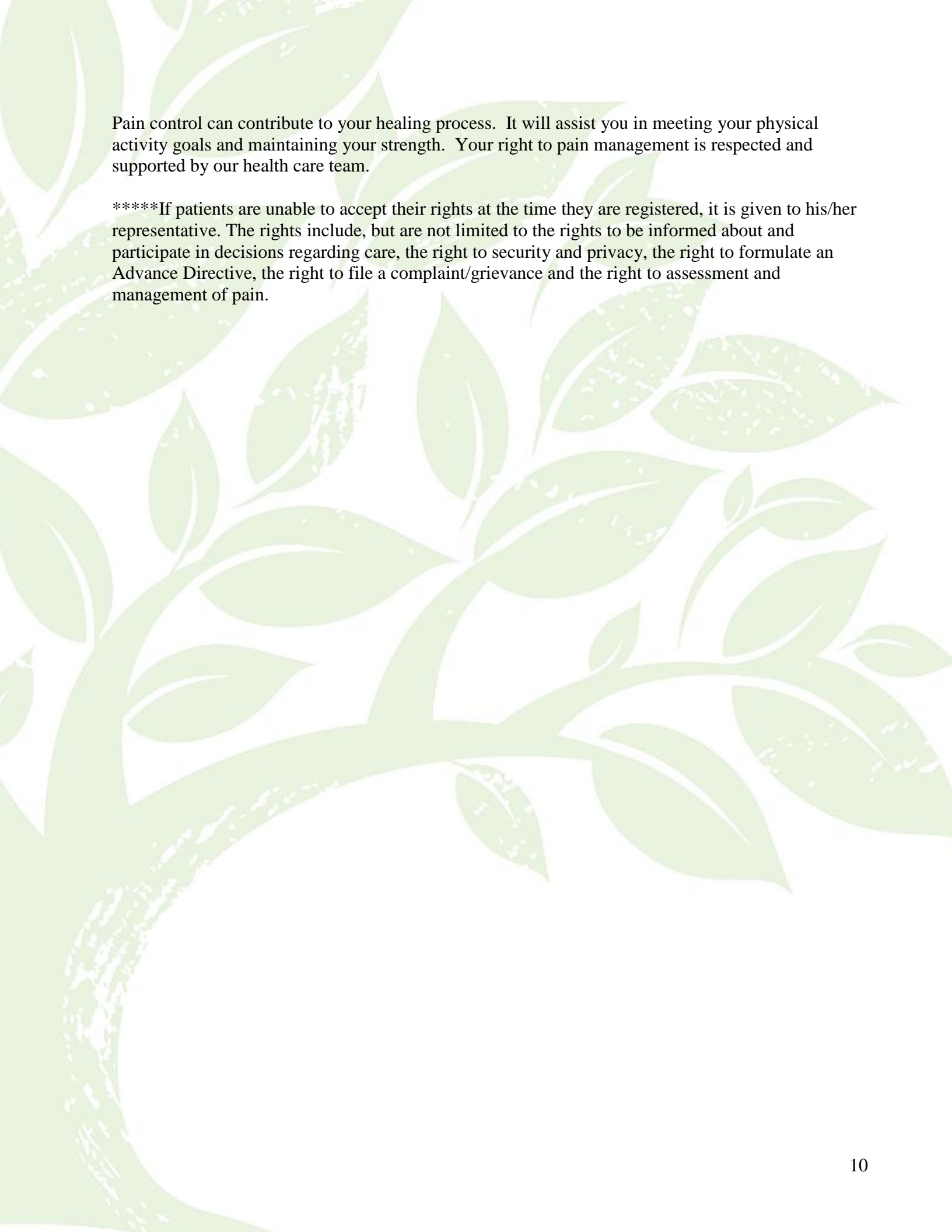
There is a Bioethics Committee which can be consulted at the request of the patient and/or his/her representative should there be any ethical concerns regarding care during hospitalization. This committee helps patients, families and health care providers better understand ethical issues and values that arise during patient care. The Bioethics Committee may be convened by a request to the attending physician, nurse or social worker. If you would like more information or have any questions about the Bioethics Committee, please call the Patient Service Excellence Department at (530) 332-7005 or (530) 332-7006.

#### **Pain Management Services:**

All patients have the right to appropriate assessment and management of pain. Pain relief is an important part of your medical care. The health professionals at Enloe Medical Center will work with you to help manage any pain that you may have during your stay. It may not be possible to keep you pain free, but as a team working with you we will try to reduce or relieve your pain. Pain management services are available to all patients including laboring women. Access to care is not dependent on financial status.

#### **What Can You Do To Help?**

- Ask the doctors or nurses what to expect--you may want to write down your questions.
- Discuss pain control options with your doctors and nurses. Let your doctor or nurse know what has worked well in the past. Let them know any concerns you have about pain medications, and side effects.
- Work with your doctor and nurse to develop a pain management plan and follow it. Understand how your plan will work and what you need to do to make it successful.
- Help your doctors and nurses “measure” your pain. Reporting your pain as a number will help the doctors and nurses know how well your treatment is working, and if changes need to be made. You will need to rate your pain on a scale from
  - 0 (no pain) – 10 (this is the worst pain you have experienced or imagined).
  - 0 = no pain 1-3 = mild pain 4-6 = moderate pain and 7-10 = severe pain
- Tell your doctors or nurses about any pain that will not go away. Your pain management plan may have to be adjusted to meet your needs. Unrelieved pain can have adverse physical and psychological effects.



Pain control can contribute to your healing process. It will assist you in meeting your physical activity goals and maintaining your strength. Your right to pain management is respected and supported by our health care team.

\*\*\*\*\*If patients are unable to accept their rights at the time they are registered, it is given to his/her representative. The rights include, but are not limited to the rights to be informed about and participate in decisions regarding care, the right to security and privacy, the right to formulate an Advance Directive, the right to file a complaint/grievance and the right to assessment and management of pain.

## 2011 HOSPITAL NATIONAL PATIENT SAFETY GOALS

**NATIONAL PATIENT SAFETY GOALS:** Each year the Joint Commission sets National Patient Safety Goals for many different patient care settings. The National Patient Safety Goals for the Hospital also apply to the Enloe Clinic's and the Prompt Care Settings.

# 2011 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

### Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

NPSG.01.03.01

Make sure that the correct patient gets the correct blood when they get a blood transfusion.

### Improve staff communication

NPSG.02.03.01

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

### Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

Take extra care with patients who take medicines to thin their blood.

### Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

NPSG.07.03.01

Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01

Use proven guidelines to prevent infection of the blood from central lines.

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

### Check patient medicines

NPSG.08.01.01

Find out what medicines each patient is taking. Make sure that it is OK for the patient to take any new medicines with their current medicines.

NPSG.08.02.01

Give a list of the patient's medicines to their next caregiver. Give the list to the patient's regular doctor before the patient goes home.

NPSG.08.03.01

Give a list of the patient's medicines to the patient and their family before they go home. Explain the list.

NPSG.08.04.01

Some patients may get medicine in small amounts or for a short time. Make sure that it is OK for those patients to take those medicines with their current medicines.

### Identify patient safety risks

NPSG.15.01.01

Find out which patients are most likely to try to commit suicide.

### Prevent mistakes in surgery

UP.01.01.01

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

UP.01.02.01

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

UP.01.03.01

Pause before the surgery to make sure that a mistake is not being made.



The Joint Commission  
Accreditation  
Hospital

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at [www.jointcommission.org](http://www.jointcommission.org).

## NATIONAL PATIENT SAFETY GOAL: HOME CARE

Enloe Home Care and Hospice follow the National Patient Safety Goals for Home Care.

# 2011 Home Care National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

### Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

### Use medicines safely

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

### Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

### Prevent patients from falling

NPSG.09.02.01

Find out which patients are most likely to fall. For example, is the patient taking any medicines that might make them weak, dizzy or sleepy? Take action to prevent falls for these patients.

### Identify patient safety risks

NPSG.15.02.01

Find out if there are any risks for patients who are getting oxygen. For example, fires in the patient's home.



This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at [www.jointcommission.org](http://www.jointcommission.org).

## **CORPORATE COMPLIANCE AND CODE OF CONDUCT**

**Compliance is part of our culture. It is the terminology we give to functioning with:**

- Honesty and Integrity
- The highest level of moral, ethical and legal standards.

**It is the process of:**

- Self monitoring
- Detection of potential errors
- Resolution of problems

**Enloe's Code of Conduct summarizes the basic principles of the Hospital's Compliance Program:**

**Standard 1** – Participation in Enloe's Compliance Program is a condition of employment and continued association with Enloe Medical Center (EMC).

**Standard 2** – Compliance with applicable laws and regulations, as well as with the Compliance Program, is a condition of employment by and continued association with EMC.

**Standard 3** – EMC employees, officers, trustees, physicians and covered contractors must be timely, truthful, accurate and complete in all of their communications.

**Standard 4** - EMC employees, physicians and covered contractors shall provide high quality health care services to all patients.

**Standard 5** - EMC must protect the privacy and security of health-related information regarding patients.

**Standard 6** – If any person or entity associated with EMC has a question concerning whether a particular practice violates applicable laws or regulations or EMC's Compliance Program, he or she should seek guidance from his or her supervisor or EMC's Chief Compliance Officer. The Compliance Officer may be reached directly at 332-6758.

**Standard 7** – If an EMC employee, officer, trustee, physician or covered contractor believes that an activity, practice or arrangement violates or may violate the law, regulations or EMC's Compliance Program, he or she must report this activity, practice or arrangement. This report may be made anonymously. EMC will not take any adverse action against any person or entity who makes such a report in good faith and who was not involved in the practice or arrangement at issue. In addition to 332-6758, anonymous and other calls can be made to the Compliance Hotline at 332-5519.

**Standard 8** – EMC will take corrective and/or disciplinary action against any person or entity who does not comply with the Compliance Program or applicable laws and regulations.

**Standard 9** – All EMC employees, officers, trustees, physicians and covered contractors must annually certify that they have read, understand, and will comply with the Compliance Program.

An essential element of EMC's compliance effort is to ensure a culture and environment where staff and others feel safe to question, speak up and report. If we don't know about it, we can't fix it. If you are in doubt or have a concern, ask someone.

### **How to Report**

Talk with your supervisor. If you cannot do that or prefer not to, then:

- Call the Compliance Hotline at 332-5519
- Call a Human Resource Representative, or
- Contact the Chief Compliance Officer at 332-6758.

### **Conflict of Interest**

EMC has a Conflict of Interest Policy. It is your responsibility to review it yearly and to watch for potential conflicts of interest that might arise for you, such as:

- Personal gain other than employment
- Intentional misuse or damage of EMC property
- Gifts or favors from patients and vendors

## **Health Insurance Portability and Accountability Act (HIPAA)**

HIPAA is the framework for the COMMITMENT Enloe makes to protect the privacy and secure the information we have on the patients we serve.

### **Goals**

- To protect all Patient Health Information (PHI)
- Control and regulate the access to and use of PHI
- Assure that PHI is used for legitimate purposes
- Ensure the integrity
- Control the disclosure of PHI
- Enhance the rights of consumers to access their PHI

### **Enloe's Privacy and Security Program**

- **Privacy/Security Officer** - Designated in the Corporate Compliance Office 332-6758
- **Notice of Privacy Practices** - To each patient on first visit after April 2003
- **Minimum Necessary** - Concept followed in internal/external communications and in response to information request
- **Complaint Process** - Privacy and Security Incident Form directed to the Compliance Officer
- **Policy and Procedures** - Detailed instructions for ensuring patient's privacy and the security of their health information

### **Reasons for Use and Disclosure of Protected Health Information**

- **Treatment** - By Enloe and to other health care providers providing treatment to the patient.
- **Payment** - To facilitate payment for services provided by Enloe.
- **Operations** - Quality improvement, regulatory requirements and internal administrative activities.
- **Facility Directory** - Patient's general condition and location in the facility.

## **Security of PHI**

### **Administration Control**

- Privacy and Security Officer 332-6758
- Employee security clearance
- Policies and procedures
- Training and review

### **Access Controls**

- Locked departments and doors
- Unique user identifications
- Password controls

### **System Controls**

- Application time-outs
- Encryption
- Audits
- Automatic Trails to Track System/User Activity
- External review for checks and balances

### **Employee's HIPAA Role**

- Employ "reasonable safeguards" to protect privacy at all times and in all types of communications related to patients.
- Follow the Terms of the Notice of Privacy Practice (NPP)
- Apply minimum necessary concept when dealing with PHI
- Be careful with conversations
- Facilitate privacy and security from others

## **HARASSMENT FREE WORKPLACE**

We are committed to maintaining an environment free from harassment. Sexual harassment is a form of discrimination based on a person's sex. It is prohibited by federal and state laws and by our Policy. In addition, federal, state or local laws and our Policy prohibit other forms of unlawful harassment or discrimination. They include, but are not limited to, discrimination on the basis of race, color, sex, sexual orientation, religion, national origin, ancestry, citizenship, age, marital status, pregnancy, mental or physical disability (including HIV or AIDS), denial of Family and Medical Care Leave, or medical condition.

We are so dedicated to keeping our workplace free from harassment that we have created this training module to teach you:

- What is sexual harassment?
- Why do I need to learn about harassment and discrimination?
- How can I help prevent harassment in the workplace?
- What do I need to know about Enloe Medical Center's harassment policy?

### **What is Sexual Harassment?**

The Fair Employment and Housing Act (FEHA) defines harassment because of sex as including sexual harassment; gender harassment; and harassment based on pregnancy, childbirth, or related medical conditions.

The definition of sexual harassment includes many forms of offensive behavior, including harassment of a person of the same sex as the harasser. The following is a partial list of types of sexual harassment:

- Unwanted sexual advances
- Offering employment benefits in exchange for sexual favors
- Actual or threatened retaliation
- Leering; making sexual gestures; or displaying sexually suggestive objects, pictures, cartoons or posters
- Making or using derogatory comments, epithets, slurs or jokes
- Sexual comments including graphic comments about an individual's body; sexually degrading words used to describe an individual; or suggestive or obscene letters, notes or invitations
- Physical touching, kissing, or assault, as well as impeding or blocking movements

**There are two forms of harassment:**

**Quid Pro Quo** (this for that) – Examples: “Sleep with me or your fired.” Sleep with me if you want a raise or promotion.” Typically, this form of harassment is by a supervisor, since he/she has the authority to grant or deny job benefits.

**Hostile Environment** – Conduct about a protected category (sex, sexual orientation, disability, race, age, etc.) that is unwelcome and unreasonably interferes with an employee's job performance or creates an intimidating, hostile, or offensive work environment. Examples: comments, jokes, pictures, touching, nicknames, offensive remarks about a person's disability and stereotypes. This form of harassment could be conducted by a supervisor OR a non-supervisory person, and the victim does not have to be the person at whom the unwelcome conduct is directed. The victim could be others who observe/hear the conduct.

**Why do I need to learn about harassment and discrimination?**

- To avoid violating the law or Enloe's policy by mistake.
- Harassers, including both supervisory and non-supervisory personnel, may be held personally liable for harassing an employee or co-worker or for aiding and abetting harassment.
- To make Enloe a more respectful workplace.

**How can I help prevent harassment and discrimination in the workplace?**

Be aware of these “danger zones.” While some of these items may not be harassment by themselves, they are risk areas, and you need to be aware of the risk you are taking if you participate in them. You may not *intend* to harass someone, but under harassment law your intent does not matter.

Jokes, sarcasm or innuendo about sex, race, color, religion, ethnicity, disability, age, national origin, sexual orientation, transsexuals, mental illness, citizenship, or any other protected category.

**Examples of inappropriate comments or actions:**

- “I'd *do* him (or her).” (sexual innuendo)
- “If you weren't married, I'd be all over that.” (sexual innuendo)
- “Your lifestyle (sexual orientation) is wrong and I would like to help you change.” (discrimination based on sexual orientation)
- Comments on personal appearance – a comment of “I like your dress” is neutral. However, if the person paying the compliment is also leering, it may cross the line.
- Comments on a person's anatomy

- Co-workers telling off-color jokes or discussing sexual experiences within hearing of other employees. (sexual innuendos or comments that could create a hostile work environment)
- Nicknames: “hey sweetie”
- “Why do they let him work here? Can’t he spread AIDS?” (disability)
- Touching/shoulder rubs/hugs/kissing (sometimes co-workers are close and may be very comfortable with a hug or a shoulder rub, but not all co-workers will be comfortable and those observing may also be uncomfortable).
- Dating/initiating personal relationships – Meeting people at work is extremely common. Just be aware of the risk involved if the relationship is not successful and remain professional at work.
- Work-related off premises conduct – be aware of your conduct at social gatherings with co-workers and when traveling for work.
- Making up and spreading a nasty rumor to get back at a person he/she believes reported a harassing action. (retaliation)
- Displaying a photo of a partially undressed model on a bulletin board for all to see. (visual harassment)
- Sending a lewd joke to a co-worker or accessing adult sites on the internet (could create an unwelcome work environment).

#### **Actions don’t have to be sexual:**

- Mocking an employee’s religious practices (religion)
- Imitating an employee’s disability (disability)
- “Why don’t they learn to speak English?” (ethnicity, national origin)
- “I can hardly understand her. I don’t know why we hire anyone who speaks English with a heavy accent.” (national origin discrimination)
- Stereotypes – There are often comments that people use and do not even realize they are offensive. Examples: “That’s so gay.” “He *jewed* her down and got a great bargain.”
- Drawings of swastikas, making anti-Semitic slurs, hanging a noose (race, ethnicity, national origin)
- Comments: *Towel Heads, Wetbacks, illegals, Japs* (race, ethnicity, national origin)
- “She should just retire” or “When do you plan on retiring?” (age discrimination)

#### **What if a customer/patient makes a request that could be discriminatory?** (“I don’t want a black, gay, Jewish, transgender person... caring for me”)

- Try to educate the customer/patient that the person caring for them is highly qualified and that if you were in their place you would feel very comfortable having that person care for you.
- Bring in a manager or charge nurse to help with the discussion.

#### **Disability & the Workplace:**

Some employees may have a disability and may have a workplace accommodation to assist in performing the essential functions of the job. If you believe you need assistance to perform the essential functions of your job, call Human Resources.

#### **Appropriate Actions to Take:**

- Tell others when their behavior “steps over the line.” We can all help educate. Point out the risk involved.

- When someone tells you “they didn’t mean anything by it,” or “it was just a joke,” remind them their intent does not matter. It could still be considered harassment.
- If you realize that you have inadvertently done something that could be considered harassment: apologize, learn from the experience, and STOP.

### **What do I need to know about Enloe Medical Center’s harassment policy?**

#### **Zero Tolerance**

Individuals who violate this policy are subject to disciplinary action.

#### **Duty to Report**

The full participation of all employees is essential to maintain a good working environment. An employee, who believes he or she or another person has been harassed, must report to a supervisor or directly to the Director or Vice President of Human Resources. Sometimes people do not realize their behavior is offensive and reporting it provides an opportunity for them to be educated. No one should ever use peer pressure to discourage harassment victims from complaining.

#### **Confidentiality**

To protect the privacy of all involved, all parties, including witnesses, will be instructed to maintain strict confidentiality throughout an investigation.

#### **Retaliation**

Retaliation against or intimidation of any individual who has reported harassment or who has cooperated in connection with the medical center’s investigation will not be tolerated. Any retaliation will be considered an independent cause for discipline, regardless of the merits of the underlying harassment allegation.

Enloe Medical Center’s Harassment Policy can be found on MCN POLICY MANAGER.

**Our goal in preventing harassment in the workplace is to create an environment of mutual respect.**

## **DOMESTIC VIOLENCE, ELDER ABUSE AND CHILD ABUSE**

### **Abuse Screening and Reporting**

All healthcare providers need to identify and report suspected child abuse, elder abuse and domestic violence pursuant to the laws of the State of California.

*Supporting Legislation: State of California Penal Code Section 11160 mandates reporting of suspicious injury.*

### **Who is a Healthcare Provider (HCP)?**

A healthcare provider is any Enloe Medical Center employee. This includes, but is not limited to: physicians, nursing staff, nurse practitioners, case managers, and laboratory and x-ray personnel. All healthcare providers at Enloe are mandated reporters of abuse. They must take action and report suspected elder or child abuse, and suspected domestic violence.

### **Key Points**

1. HCP’s are mandated reporters of abuse.

2. At each initial encounter with an Enloe agency or department (such as ED, OB, Prompt Care, upon Admission), every patient should be asked, “Do you feel safe in your home environment?” as a way to identify if further assessment and support is needed.

**If Abuse, Neglect or Violence is Suspected:**

- Report Abuse to Supervisor
- Notify your Manager or Nursing Administrative Supervisor
- Notify a Case Manager

**Abuse and Violence Includes:**

- Neglect (intentionally withholding food, water, medicine or medical care, clothing, or shelter)
- Intimidation
- Threat of injury or threat of neglect
- Physical Injury
- Abandonment
- Treatment resulting in physical or mental suffering
- Threat to withhold financial support

**Definition and Action:**

**Domestic Violence** (also called Intimate Partner Violence)

Violence toward one partner by the other. Most often, the woman is the victim.

- Violence is common during pregnancy and incidents escalate throughout her pregnancy in both frequency and severity.
- All cases of domestic violence will be reported to law enforcement.

**Elder Abuse**

Violence or neglect of a dependent, usually an elder, by a family member or other caregiver, including those in a hospital or long-term care facility.

- All cases will be reported to the County Adult Protective Services.

**Child Abuse**

Abuse or violence against a child by a parent or caregiver.

- Report abuse or violence to Children’s Services.
- Law enforcement may also be notified in severe cases or staff discretion.
- In cases where law enforcement needs to be involved, notify them immediately or as soon as practically possible.
- Written reports need to be done within two working days.

**Please refer to Organization Wide policies as needed:**

- Domestic Violence
- Elder Abuse
- Child Abuse

**SPIRITUAL, RELIGIOUS AND CULTURAL NEEDS OF OUR CLIENTS**

When patients access health care, they bring with them their spiritual and religious beliefs and cultural values. These beliefs and values can affect both acceptance of the treatment plan and recovery from illness. It is the patient’s right to have their belief and value systems considered and included, as appropriate and safe, in direct care delivered by the Health Care Team. By being sensitive to and including the patient’s beliefs:

- The Health Care Team will consider the patient’s spiritual, religious and cultural needs when planning and implementing care.
- Informed consent provided by the physician will assure the patient has the opportunity to express concerns regarding inconsistencies between belief/value systems and the treatment plan.
- The patient will be included in the care planning to assure personal beliefs and values are considered.
- The family, significant other, and/or designated decision maker will be included in treatment decisions and care planning when appropriate.

Staff will prioritize visits by clergy or other spiritual advisor into the plan of care at the patient’s request, and as is indicated by the patient’s immediate medical needs. *This means more than asking if the patient would like to see a minister.* The Nursing Administrative Supervisor and Case Management staff can assist staff in determining who is the most appropriate Spiritual Care Team Member to contact for emergency situations.

When conflict between an individual’s beliefs and values and the plan of care arises, the patient may access the Bioethics Committee, designated decision maker, or members of the Health Care Team. In order to minimize conflicts between the religious, cultural and spiritual values of the patient and care provider, the care provider should request a change in assignment if such a conflict is hindering care. *For more information, please see the “Spiritual, Religious and Cultural Needs of the Patient” policy.*

Enloe has the following resources to assist in understanding and providing care and services for our patients from cultures that may be unfamiliar to you.

1. Mosby’s Nursing Consult
2. Age Related Quick Reference Sheets – “Yellow Cards”
3. Up to Date Online
4. Drug Handbooks
5. Pediatric Textbooks
6. Culture and Nursing Care, A Pocket Guide

Please consult your manager, supervisor or educator for assistance when you have questions about providing compassionate, caring, care and services.

## **PLANETREE PATIENT – CENTERED CARE**

### **The Planetree Model of Patient-Centered Care**

The Planetree model of care is a patient-centered, holistic approach to health care, promoting mental, emotional, spiritual, social, and physical healing. It empowers patients and families through the exchange of information and encourages healing partnerships with caregivers. It seeks to maximize positive health care outcomes by integrating optimal medical therapies and incorporating art and nature into the healing environment.

Since its founding as a nonprofit organization in 1978, Planetree has pioneered methods for personalizing, humanizing and demystifying the health care experience for patients and their families. Founded by a patient, the Planetree Model is committed to enhancing health care from the patient's perspective. It empowers patients and families through information and education, and

encourages "healing partnerships" with caregivers to support active participation. Through organizational transformation, the Planetree Model creates healing environments in which patients can be active participants and caregivers are enabled to thrive.

## **Components of the Planetree Model**

**Human Interaction:** Human beings caring for other human beings, creating a healing environment for patients, families, and staff members.

**Family, Friends, & Social Support:** Contributes to the quality of the hospital experience by promoting caring connections between the patients and their support systems.

**Information & Education:** Patients, families, and community members are provided with increased access to meaningful information.

**Nutritional & Nurturing Aspects of Food:** Choice and personalized service, in combination with sound nutrition practices, add pleasure, comfort, and familiarity.

**Architectural & Interior Design:** The Planetree design considers the patients wellbeing. The hospital is welcoming and accessible, providing clearly marked signs for direction, comfortable and familiar rooms, and designs that engage the senses and break down barriers.

**Arts & Entertainment:** Music, artwork, theater, crafts, and clowns offer engagement and enjoyment to enhance the clinical environment.

**Spirituality:** Planetree recognizes the vital role of spirituality in healing the whole person. From chaplains to meditation programs, hospitals can provide opportunities for reflection and support of spiritual needs.

**Human Touch:** Touch reduces anxiety, pain, and stress, benefiting patients, families, and staff members.

**Complementary Therapies:** Expand the choices offered to patients. Aroma and pet therapy, acupuncture, and Reiki are offered in addition to clinical modalities of care.

**Healthy Communities:** Expand the boundaries of health care: Working with schools, senior centers, churches, and other community partners, organizations are redefining healthcare to include the health and wellness of the larger community.

Additional information: [www.planetree.org](http://www.planetree.org)

## HCAHPS: (HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS)

- The HCAHPS survey is the first-ever nationally standardized tool to assess patients' perspectives of their hospital care. Planetree hospitals have long been engaged in the work of identifying and responding to the full range of patient needs, many of which are explicitly measured by the HCAHPS survey, including communication with nurses and physicians, responsiveness of staff, and cleanliness and quiet in the hospital. The Planetree model of patient-centered care is structured around ten core components that represent diverse aspects of the hospital experience that patients have identified as important to them. Ranging from caring interactions with providers and the physical environment of the hospital to recognition of the role of spirituality, the arts and food in healing, these essential aspects of patient-centered care reflect that, from the patient perspective, hospitalization encompasses far more than the clinical experience.

The HCAHPS survey is a nationally standardized survey that captures patients' perspectives of their hospital care. It allows consumers, for the first time, to compare hospitals based on measures of how effectively they are satisfying patients' needs and expectations. The survey questions look beyond clinical outcomes and technical capabilities of hospitals and focus instead on aspects of the care experience that are particularly meaningful to patients.

Interested consumers, media, and fellow health care professionals are currently able to access Enloe Medical Center's HCAHPS data simply by going to the Hospital Compare website at [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov).

- Another core component of the Planetree model is access to information. This not only means that patients have access to a wide array of resources to support them in understanding and becoming actively engaged in their health and wellness, but also that patients are empowered with information about their care providers. The HCAHPS patient satisfaction data now publicly available for all U.S. hospitals can be used by patients as an additional source of information as they are making decisions about where to receive their care.
- Direct patient feedback, such as that provided by the HCAHPS survey, is essential to Enloe. Such opportunities for meaningful feedback allow Enloe to explore the patient experience in more depth, including what goes well, what could be improved, and what patients' ideas are for creating a more satisfying health care experience.
- Through Enloe's Planetree initiatives we continue to strive to improve the patient's experience. Further information regarding Planetree initiatives such as *Quiet Hospital*, can be found at [www.enloe.org/planetree](http://www.enloe.org/planetree).

## QUALITY MANAGEMENT

The Quality Management Department assures that the care of our patients is based on evidence based practice that promotes patient safety and the Best Outcome for our patients.

This is achieved by:

- Aligning our policies, procedures and care standards with regulatory standards.
- Promoting evidence based best practice
- Focusing on performance improvement
- Collaborating with Medical Staff and Employees
- Meeting Core Measures
- Adopting Quality Initiatives
- Reviewing reported data to improve our organizations performance

What is a CORE MEASURE?

- They are a set of standardized quality indicators defined by the Centers for Medicare and Medicaid Services (CMS) and Joint Commission.
- They improve the quality of care provided to hospital patients by focusing on the actual results of care.
- They benefit the hospital by making it easier and less costly to collect and report data because the same data set can be used to satisfy both CMS and Joint Commission requirements.
- They are publicly reported and our results can be viewed by anyone at [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov).

What do we report?

- **Acute Myocardial Infarction (AMI)**
- **Community-Acquired Pneumonia (CAP)**
- **Heart Failure (HF)**
- **Surgical Care Improvement Project (SCIP)**

Why are they Important?

- Improves patient outcomes
- Better reimbursement from payor sources
- Improves hospital performance

The Core Measures reflect our organizations performance in respect to the care of these patient conditions. They are not the only measurement of Quality at Enloe Medical Center. Each Department also has individual performance improvement projects and quality indicators (measurements) that reflect how your department is performing. Do you know your department's quality measures?

## Incident Error and Adverse Event Reporting Definations

An incident is an unanticipated occurrence that deviates from regular medical center operations.

An error is an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

An adverse event is an injury that is caused from a medical intervention and not from the underlying condition of the patient.

## **INCIDENT REPORTS**

1. Enloe Medical Center encourages and depends upon open and honest reporting of injuries and hazards to patients, visitors and staff. This process will be non-punitive in nature for all persons reporting incidents. The investigation of incidents will be viewed as an opportunity for education/process improvement and will focus on processes and systems, rather than human error.
2. An incident report must be reported to your supervisor and entered into the MIDAS Risk Incident Report module within 24 hours of the event. Departments that do not have access to MIDAS will complete the Incident Investigation Report Form. Please see your manager for location of these forms if you do not have access to MIDAS.
3. An incident report is initiated by the employee or individual directly involved in, responding to, or involved in the discovery of an event that is not consistent with routine medical center operations or situations that may potentially or actually result in injury, harm, or loss to any patient, visitor, student, volunteer, or employee.

## **ADVERSE EVENTS**

1. An adverse event is defined as an event that results in a serious disability – **a physical and mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at discharge, or the loss of a body part.**
2. Early identification and communication is extremely important because we have a short timeframe in which to report. The clock starts ticking from the time that **ANY Enloe Medical Staff Member** becomes aware of the event. **Reportable adverse events require immediate phone notification to Quality Management at 332-7339.**
3. All Enloe Medical Center staff and volunteers are responsible to report patient care incidents/events to their immediate supervisor in a timely manner. If your supervisor is unavailable contact Quality Management, Risk Management, or the House Supervisor.
4. When in doubt, always report your concerns to your supervisor...Quality Management will investigate. Better to be safe than sorry!!

### **Reportable Adverse Events**

Call Quality Management 332-7339, and notify your manager or supervisor.

#### **Surgical Events**

- Wrong body part
- Wrong patient
- Wrong procedure
- Unintentional retention of foreign objects
- Unexpected death during Surgery or 24 hours after anesthesia

#### **Care Management**

Death or serious disability associated with:

- Medication error (Remember to report to Pharmacy and Quality Management)

- Administration of the ABO-incompatible blood products
- Failure to identify and treat hyperbilirubinemia during first 28 days of life
- Death or serious disability from spinal manipulation at hospital
- Maternal death or serious disability associated with labor and delivery in a low risk pregnancy
- Death or serious disability related to hypoglycemia onset in the hospital
- Stage 3 or 4 ulcer acquired after admission (unless progression to Stage 3 from Stage 2 identified on admission)
  - o Nursing:
    - Notify Quality Management of any Stage 2 skin ulcer;
    - ***Visually inspect your patient's skin on admission and every shift thereafter***
    - Change your patient's position every 2 hours.

### **Patient Protection**

- Infant discharged to wrong person
- Death or serious disability associated with patient disappearance >4 hours (Refer to the "Missing Patient" policy for more information)
- Patient suicide/attempted suicide in facility resulting in death or serious disability.

### **Product/Device Events**

Death or serious disability associated with:

- Use of contaminated drug, device or biologic
  - o The device suspected of causing serious injury or death will be labeled as defective "Do Not Use" and removed from the patient care area and placed in a **secure and locked** location (i.e., Supervisor's office).
    - Keep the device plugged in to prevent loss of information.
    - If the equipment is too large to remove, room should be closed until cleared by Risk Manager.
    - It is extremely important that no adjustments or cleaning be done to the device until instructed to do so by the Risk Manager.
- Use/function in ways other than intended
- Intravascular air embolism excluding from certain neurosurgical procedures.
- Examples of such devices include, but are not limited to: ventilator, monitors, anesthesia machines, defibrillators, pacemakers, hemodialysis machines, heart valves, cardiac catheters, thermometers, patient restraints, contact lenses, hearing aids, blood glucose monitors, x-ray machines, wheelchairs, and infusion pumps.

### **Environmental**

Death or serious disability associated with:

- Electric shock (excluding planned treatments)
- Restraints/bedrails
- Burn
- Fall (This includes any fall that may have occurred while hospitalized regardless of length of time that may have lapsed)
- Any incident where line designation for O<sub>2</sub> or other gas contains wrong gas or is contaminated by toxic substance.

### **Criminal Events**

- Care ordered or provided by someone *impersonating* licensed healthcare provider (Remember, name tags are required at Enloe Medical Center, for all staff including medical staff.)
- Abduction of patient, any age
- Sexual assault of patient
- Death or significant injury or patient or staff resulting from physical assault

### **Catch All...**

*Any adverse event or series of adverse events, that causes the death or serious disability of a patient, personnel or visitor.*

### **Safety is Everyone's Responsibility!**

Any Enloe Medical Center employee who has concerns about safety or quality of care provided in the hospital is encouraged to report them.

- Speak with your manager or supervisor, or anyone on the Management Team.
- Call the Employee Comment Line at 332-5577.
- Contact the Joint Commission directly by calling the Joint Commission Complaint Line at 1-800-994-6610 or emailing concerns to [complaint@jcaho.org](mailto:complaint@jcaho.org).

Enloe Medical Center welcomes open and honest reporting of quality of care and safety issues and will take no disciplinary action because an employee reports safety or quality concerns either to their manager or the Joint Commission.

## **ENVIRONMENT OF CARE**

The goal of this program is to provide a safe, functional and effective environment for patients, associates and other individuals in the Medical Center.

### **Safety Management**

Enloe Medical Center (EMC) is committed to providing a safe work environment. Working safely in a hospital is more than a matter of watching out for back injuries, needle punctures, spread of infection and exposure to hazardous materials. It's a matter of overall *attitude*, an awareness of safe and unsafe conditions and behavior. This means watching out for accidents *about* to happen.

Each department is provided access to policies and procedures for use and reference. Included are: Safety, Infection Control, Patient Care, and Administrative policies.

### **Employee On-the-Job Injuries**

Employees/volunteers injured on the job are to immediately notify their supervisor and contact the Employee Health Nurse (or Administrative Nursing Supervisor after hours) to report the event. The Employee Health Nurse (or Administrative Nursing Supervisor) will guide the employee/volunteer through the injury reporting and medical evaluation process as indicated.

### **Reporting Unsafe Conditions**

Everyone is expected to participate in maintaining a safe environment for patients, visitors, physicians and their co-workers. This means taking an *active* role in reporting any *unsafe condition*. To report an unsafe condition, notify the Department Manager, Charge Nurse, Supervisor or the Safety Officer.

## **Examples of Unsafe Conditions**

Environmental Hazards – such as slippery or uneven floor surfaces, cluttered work areas, cabinets or furniture with sharp/protruding areas.

Fire Hazards – such as obstructed corridors and fire exits, missing fire extinguishers, accumulated trash and smoking in designated “no smoking” areas.

Electrical Hazards – such as frayed cords, exposed wires, ungrounded plugs, extension cords, or electrical appliances from the home being used in patient care areas (i.e., portable space heater).

Equipment Hazards – such as unsafe or defective equipment, overdue electrical safety inspections/preventative maintenance and damage.

Hazardous Substances – such as strong, unpleasant fumes or improper handling and disposal of toxic substances.

Unsafe Acts or Procedures – such as improper use of equipment or instruments, failure to wear appropriate protective apparel, or attempts to bypass mechanical safety switches, or other equipment safety guards.

## **Safety Officer**

The Safety Officer can be reached at 332-7585.

## **Medical Equipment Management**

The objective of the Medical Equipment Management Program is to ensure that medical equipment is safe and effective for use by patients and staff. You must be sure that equipment has been safety inspected prior to use. You will receive training in the safe operation of all equipment in your department.

## **Operating equipment inspection**

Check equipment prior to use with a visual inspection:

- Cords and plugs have no exposed wires and are not frayed.
- Tags are current.
- Functional checks, where applicable.

Equipment training is required when:

- You are new to a work area or assignment.
- New equipment is introduced to an area.
- A change or update occurs with equipment.

## **SAFE MEDICAL DEVICE ACT (SMDA)**

**Purpose:** To ensure reporting of an illness or injury that resulted from a medical device.

**Action:** Any person who knows of a medical device that may have caused illness or injury shall immediately:

- Attend to the patient’s needs;
- Report the incident to the Charge Nurse/Supervisor;
- Remove the device from service and the patient’s room;
- Not change settings or dials;
- Label the equipment as broken;
- Call Clinical Technology Services (Biomed) at 332-7627.

If you have any questions or concerns about the operation of the equipment, contact the Charge Nurse/Supervisor or Biomed 332-7627. For more information, refer to the Medical Equipment section of the Safety Manual in your department.

## **Security Management**

The Medical Center employs Security Officers to safeguard employees, patients, the Medical Center and its physical assets. Safety depends on everyone's help to make Enloe Medical Center a crime free environment.

All employees must be the "eyes and ears" of the hospital. Be aware of suspicious individuals anywhere on hospital property and report them to your Department Manager or to the person in charge immediately. The Security Department provides coverage 24-hours a day, seven days a week. Call the Security Department at 570-6407 to report an incident. If you need to report an emergency, dial "555" or "9-911" depending on your location in the organization.

Lost and found is maintained in the Security Department for 30 days. Please direct all lost and found items and inquiries to Security at 332-7947.

### **Identification Badges**

When you are in the Medical Center you are required to wear the identification badge that was issued to you by the Medical Center. The badge is to be visibly worn at all times in the lapel area or on a "break away" neck strap. This badge also serves as a "key" by allowing you to access restricted areas of the Medical Center. Anyone not wearing an Enloe identification badge will be treated as a visitor. Lost badges should be reported to Security immediately.

### **Parking**

Employees, Registry, Students and Volunteers will be expected to park in the areas listed as employee parking. Physicians may use the designated physician parking or employee parking.

### **Security Incidents**

Report ALL security incidents to a Security Officer immediately. Examples of security incidents include:

- Loss or theft of property
- Assaults
- Vandalism
- Car Accidents on Enloe property
- Threats or harassment
- Any criminal activity

### **Security Safety Tips**

Keep these safety tips in mind at work and while coming to and from the Medical Center.

- Leave valuables at home and secure your personal belongings while at work in a locked desk, office or locker.
- Try to walk with a co-worker when entering or leaving work.
- Stay aware of what is going on around you.
- Be alert and walk with confidence.
- If you drive to work, have your keys in your hand before entering the parking area so that they are ready in case of an emergency.

- Call Security if you want an escort to or from your car.
- Don't walk between cars. This will obstruct your view.
- Always lock your car and keep your valuables out of sight.

### **Emergency Response Line**

To report any type of emergency, dial "555" from any non-public telephone. If you are at the Cancer Center, Children's Center or Home Care dial "9-911." An operator answers this emergency response line immediately.

## **CODES**

Refer to your badge buddy and the Emergency Wall Guide in your Department.

Codes include

- Code Blue (Cardiac Arrest)
- Code Red (Fire Emergency)
- Code Pink or Purple (Infant or Child Abduction)
- Code Yellow (Bomb Threat)
- Code Silver (Armed Assailant/Hostage)
- Code Orange (Hazardous Materials)
- Code Zero (Evacuation)
- Code Triage (External Disaster)

### **Code Blue - Cardiac Arrest**

If you locate a person who has suffered cardiac or respiratory arrest, meaning they are unconscious and do not appear to be breathing, you should:

- Activate Code Blue immediately to summon Code Team or Emergency Response.
- Note the time.
- Summon help while remaining at the person's side. Shout or yell, if necessary.
- Send someone to call the emergency number. If you are alone, do it yourself. Call "Code Blue or Cardiac Arrest" and give your location (i.e. department, floor number, room number or the exact location.)
- Begin CPR if you know how, and continue CPR until assistance arrives and takes over.
- Important!! For persons 13 years or younger Call a "Code Blue – PALS"

### **Code Red - Fire Emergency**

Hospital Response to Fire

Code Red is paged overhead to indicate a fire within the Medical Center.

#### **Important locations to know:**

- Fire extinguisher
- Fire doors and walls
- Closest fire-alarm pull
- Evacuation route

#### **Important facility conditions to maintain**

- Keep emergency exits, fire doors, fire-fighting equipment and fire alarm pull stations clear at all times.
- Never use door wedges that prevent doors from closing.

- Keep doors closed unless they are controlled by an electromagnetic system. These are smoke and/or fire doors and they provide horizontal separation between you and the fire.
- During a "fire" evacuation, the primary type of evacuation is horizontal (to the other side of the closed fire doors).
- Elevators may not be used during a fire situation.
- Keep all corridors and exits clear of all unnecessary traffic and/or obstruction.
- Keep telephone lines clear for fire control.

**Your role during a fire:**

**Away from the point of origin:** close all doors, remove all items from hallways, calm patients, and await specific instruction.

**At point of origin:** follow RACE procedure.

**LIFE SAFETY TIPS**

In the event of a fire: **RACE**

**Rescue** anyone in danger

**Activate** the alarm (Dial "555" or "9-911", and activate a pull station)

**Contain** the fire. Close the doors and windows and **DO NOT** go through the fire doors.

**Extinguish** if safe to do so, and **Evacuate** if not possible to extinguish.

**How to use an extinguisher: PASS**

**PULL** out the safety pin.

**AIM** the nozzle at the **BASE** of the fire (stand about 10 feet away from the fire).

**SQUEEZE** the handle.

**SWEEP** the nozzle from side to side.

**Code Pink - Infant Abduction or Code Purple - Child Abduction**

The safety and security of infants and children will be protected by the collaborative efforts of all employees.

**POLICY:**

Department staff directly involved in perinatal/pediatric patient care is responsible for maintaining the integrity of the security of the units.

**All Medical Center personnel will respond** to the Code Pink/Code Purple activation in the following manner:

1. **Immediately** stop all non-critical work and cover stairs, elevators and exits in your area.
2. **Watch for suspicious behavior** (someone hurrying away from the area, carrying a large duffle bag or hiding something under a coat.)
3. **Ask anyone with an infant or child to please remain in his or her current location** until the page has been cleared. If an individual refuses or runs, **DO NOT APPREHEND**. Note the appearance, direction of travel, car information, etc. and **IMMEDIATELY contact Security**.

**Code Yellow - Bomb Threat**

**If you receive a Telephone Bomb Threat**

1. Do not hang up. Remain calm. Ask the caller if he or she is willing to talk. (Note the phone number if you have caller ID.)
2. **Initiate Bomb Threat Report on back of guidebook.**
3. Try to prolong the conversation and get as much information as possible.

- a. Ask him/her to repeat the message.
  - b. If the caller does not indicate the location of the bomb or time of possible detonation, ask for this information.
4. Pay attention to peculiar background noises.
    - a. Motor running.
    - b. Background music.
    - c. Outdoor sounds – sirens, trains, boars, whistles, road sounds
    - d. Any noise to give you a clue to the origin of the call.
  5. Does the caller seem to know about the facility? How is the bomb location described? Does the caller use a person's name? Does the caller give his/her name?
  6. After this is done, notify your supervisor and the facility operator immediately, they will decide whether overhead paging of Code Yellow will take place.
  7. Complete the Bomb Threat Report and stand by for further instructions.

#### **If you discover a bomb or a suspicious item**

1. **Leave it untouched** and secure area until Security arrives.
2. Notify emergency contacts.
3. If so directed, evacuate your area per the evacuation policy in the safety manual.

#### **All Clear**

1. When it has been determined that there is no evidence of a bomb in the healthcare facility and/or, if the local Police Department gives instructions, the Incident Commander will notify the facility operator to announce "Code Yellow, All Clear."
2. All departments will then return to normal duties.

#### **Code Silver - Armed Assailant/Hostage**

Any individual encountering a person brandishing a weapon in a suspicious or threatening manner should approach the person calmly, carefully and thoughtfully.

#### **Your Role:**

- Remain calm.
- Seek cover/protection for yourself and patients and warn others in the area of the situation.
- Dial the emergency number for your location. Provide the location, number of suspects and hostages and the type of weapon(s) involved.

#### **Your role when you are away from the site of incident:**

- Close all doors.
- Stop all patient and supply transport.
- Be alert and cautious.
- **REMAIN WHERE YOU ARE.**

#### **Code Orange - Hazardous Materials**

There are many hazardous chemicals in a hospital. To help ensure your safety, you should learn to identify hazardous materials and the precautions that need to be taken with them. Obtain information on chemical's hazards from the product label and the material safety data sheets (MSDS). **Labels** contain information, such as:

- The chemical identity
- Major hazards

- Precautions for avoiding injury
- Handling and storage instructions

MSDS are available online on the Inside Enloe page under Safety Data Sheets (MSDS). They contain more detail than is included on the label. In addition to the label information, you will also find:

- Emergency first aid procedures
- Spill or leak procedures and
- Waste disposal methods

Familiarize yourself with the MSDS list for your department and the on-line MSDS documents.

### **Personal Protective Equipment (PPE)**

PPE is available for your protection and safety. Please contact the area/shift supervisor for a detailed description of appropriate PPE available in your work area. All PPE must be removed at the site of use.

### **Internal Hazardous Spill**

- Remove anyone near the spill
- Isolate spill and deny entry
- Obtain the MSDS
- Contact your supervisor or the Administrative Nursing Supervisor
- Report the event to the Safety Officer at 332-7585

### **Material Safety Data Sheets (MSDS)**

Material Safety Data Sheets (MSDS's) are REQUIRED for ALL chemicals used in the facility. The MSDS provides safety information on chemicals used in the workplace. Each employee who uses chemicals must be familiar with the information on the MSDS and know their location in the event of an accident and if safety information is needed.

Each department maintains an inventory of hazardous chemicals and materials that employees may be exposed to within the department under normal working conditions or in a foreseeable emergency. MSDS forms are available online at [insideenloe.org](http://insideenloe.org). Some examples of items requiring an MSDS include but are not limited to hand lotion, hand soap, dish detergent, chemical reagents and cleaning products.

### **Code Zero (Evacuation)**

To safely evacuate an area within an Enloe Medical Center Facility, the surrounding grounds or the entire facility when it is unsafe to remain.

#### **Important! Evacuation may include:**

1. Horizontal – beyond smoke barrier doors or out of building.
2. Vertical – down, never up.

#### **Immediately after hearing overhead page Code Zero**

1. Assist those who have evacuated an area, as needed.
2. Assist patients and emergency responders, as needed.
3. Evacuate your area if ordered to do so by the acting Incident Commander.

Evacuation tags are located in the following areas:

**Esplanade** – Main Supervisors Office

**Cohasset** – Behavioral Health Nurses Station

## **Rehabilitation Center – Inpatient Nursing Station**

### **If ordered to evacuate by the Incident Commander**

1. Notify ALL others in the area at risk.
2. Move to your designated area of refuge, or other safe area, if directed (refer to the evacuation plan in the safety manual).
3. Account for all staff/patients/visitors and others. Report any missing or unaccounted for individuals to your Supervisor at the area of refuge or department assembly area as necessary.
4. Evacuate patients away from danger, taking critical records, as safety permits and using the following patient priority.
  - a. Ambulatory
  - b. Wheelchair
  - c. Non-ambulatory
  - d. Special equipment needed
5. Secure the area and expand the safety zone, as necessary, to prevent unauthorized exposure to hazardous conditions.
6. Prevent others from entering the area of danger (signs, post guards, etc.).

### **All Clear**

When Code Zero call is cleared, return to your normal work duties, unless otherwise directed.

## **Code Triage (External Disaster)**

A disaster or emergency situation outside of the Medical Center that results in mass casualties appearing at the hospital.

Code Triage response is dependant upon the number of victims expected to arrive at the medical center.

- Code Triage Level 1 (10 – 15 patients)
- Code Triage Level 2 (16 – 25 patients)
- Code Triage Level 3 (26+ patients)

### **WHAT IS MY ROLE IN A DISASTER:**

If you are ON-DUTY when a disaster strikes, you must contact your Department Manager or Supervisor for instructions. Keep telephone lines free for emergency communication.

### **Disaster Line:**

Access the Disaster Hotline to gain information regarding how the event is impacting the Medical Center. The Disaster Hotline number is 25511 or 332-5511.

## **Support Team**

The safety and security of patients, visitors, associates, and physicians is of vital importance. The Support Team is a designated team who responds to irate, confused or combative patients, or visitors within Enloe Medical Center.

### **ACTION:**

If you are in a situation where there is danger of physical harm or destruction of property, follow these actions:

- Stay calm

- Remove yourself from immediate danger or call attention to yourself (scream, yell or make a loud noise)
- Dial the emergency number for your location.

The Support Team is a coordinated response involving the Nursing Administrative Supervisor and Security to manage a confused or combative patient or visitor within Enloe Medical Center. This notification is made by dialing 555 and requesting the Support Team to the appropriate location. This code is not paged overhead.

## **EMERGENCY PREPAREDNESS**

### **Types of Emergencies that Enloe Must be Prepared to Manage**

Hospitals must be prepared to manage a wide variety of emergencies. Many of these emergencies result in an influx of injured or ill patients creating a stress on our resources at Enloe. These emergencies typically consist of external events (Examples: Code Triage and Code Orange) resulting from:

- Student related holiday celebrations like Halloween, Labor Day and St. Patrick's Day
- Mass casualty accidents
- Earthquake
- Acts of terrorism, etc.

Our challenge during these types of emergencies is to have the space and staff available to manage the increased number of patients we are likely to receive.

Emergencies may also consist of internal problems that disrupt our daily workflow and routines.

Examples of these are:

- Utility, computer, or telephone failures
- Bomb threat
- Armed Assailant within the hospital

### **Hospital Incident Command System (HICS) and how it helps us Manage Emergencies**

- HICS helps us to provide an organized response to any type of emergency that may disrupt our normal operations.
- HICS was derived from the "Incident Command System" (ICS), which is used throughout California by fire, law, and civil services. The HICS structure is a framework to assist in managing any type of incident.
- HICS is fully compliant with the US Department of Homeland Security's National Incident Management System (NIMS).

The HICS model consists of an organizational chart, Job Action Sheets (Job Descriptions), and standardized documentation tools. HICS organizes us under an Incident Commander (IC). Four sections report to the IC (Logistics, Planning, Finance and Operations) and each has an appointed Chief.

### **The Benefits of HICS**

- Responsibility oriented chain of command.
- Common mission and language.
- Applicability to varying types and magnitudes of emergency events.
- Grows as large as you need to manage the incident.
- Coordinates well with other emergency officials in the community and surrounding areas.

- Is compliant with NIMS, the National Incident Management System, which helps coordinate a large scale incident.

### **Other HICS Information**

- After hours and on weekends, the Incident Commander role will default to the Nursing Administrative Supervisor.
- The IC role may be handed over to a member of the Senior Administrative team once they respond.
- The Hospital Command Center (HCC) may be established to help manage the incident if necessary.
- Radios and vests may be issued to designated staff as necessary during a large event.

### **Tools and Information to Assist You during a Disaster Situation**

#### **Overhead Paging and Other Notifications**

Emergency Codes are paged overhead at the Esplanade, Cohasset and Rehab sites by the hospital operator. Additionally, the pages should be announced overhead at Homecare and EOC, where PA system capability exists.

During hours of regular business, other sites and out-buildings are notified by members of the Switchboard staff or Administration by telephone.

Other notifications occur to Department Leaders via voicemail, e-mail, pagers and cell phones.

#### **Emergency Wall Guide**

Each Department should have a posted Emergency Wall Guide, which provides immediate information on any of the Emergency Codes that may be in effect. The guide should be in a central location in your department, make sure you can find it.

#### **Disaster Hot Line x 25511**

The Disaster Hot Line is a means to communicate to staff the latest information regarding the Disaster. The message will be updated at designated intervals by the Incident Commander or the Public Information Officer.

#### **Badge Buddy**

Staff members should have a current badge buddy to attach to their ID badge. The badge buddy lists each of the Emergency Codes as well as the Disaster Hot Line.

#### **Enloe Intranet Home Page**

From any computer on the Enloe network, click on the Internet Explorer icon to get to the Inside Enloe Home Page. Navigate to the “Disaster Information” button on the right side. Ongoing disaster updates will be posted here.

#### **Department Specific Information**

Most departments must complete a Disaster Status form and submit to the Command Center. The form can be completed online from the Disaster Information section of the Inside Enloe page, hand carried or faxed to the Command Center. The fax number is located on the form.

## **Labor Pool**

The Labor Pool is where staff report if requested by the Incident Commander or your Manager. The Labor Pool Unit Leader will help coordinate and deploy staff needed to assist during the disaster. You may be deployed to perform a task that is not your normal duty, such as helping to move patients in wheel chairs, or to assist in some other capacity. You may be requested to report to the Labor Pool if you are called in off duty. The default location for the Labor Pool is the Enloe Conference Center.

## **Name Badge (Your Security Clearance)**

Your name badge identifies you as an employee and is your security clearance during a disaster. Make sure you have your badge with you if called in off duty.

When you hear an Emergency Code announced overhead or by telephone, refer to the tools outlined in this document and follow your supervisor's instruction.

## **Utility System Management**

Utility System are designed to keep our environment comfortable for physicians, employee, volunteers, contract staff, patients and visitors. However, utility systems may experience problems. When a disruption in a utility occurs, you must be familiar with procedures for maintaining a safe environment.

### **Utility Systems Include:**

- Nurse Call System
- Telephone System
- Paging System
- Beeper System
- Medical Gas System
- Vacuum System
- Domestic Water
- Steam
- Electricity with/without emergency power
- Natural Gas
- Elevators
- Air Conditioning
- Heating and Ventilation System
- Pneumatic Tube System

## **UTILITY FAILURE**

In the event of Utility Failure, immediately notify the Charge Nurse/Supervisor or Engineering.

### **Medical Gas Shut-Off**

Authorization to shut-off medical gases is as follows:

- Patient Care Areas – Charge Nurse
- Non-Patient Care Areas – Engineering

### **Emergency Power Generators**

In the event of a loss of electricity, emergency generators become operational in 10 seconds or less.

### **If Emergency Generators Should Fail:**

- Obtain a flashlight.
- Respond to the most immediate patient needs.
- Make plans to obtain medical air and vacuum.
- Patients on ventilators will require manual “bagging”.
- Communication: Hand-held radios will be delivered to patient care areas.

## **INFECTION CONTROL**

Every hospital employee is responsible for infection control. Protect yourself and others by doing the following:

### **Basic Measures**

- Wash hands often and appropriately.
- Always cover coughs and sneezes by using your sleeve as a barrier.
- Do not touch your own eyes, nose or mouth, except with freshly washed hands.
- Stay home from work if you have a contagious illness, such as the flu or the start of a cold.

### **Wash Your Hands**

- Before starting work
- When hands are soiled
- After touching a patient or anything in the patient’s environment
- After handling blood and body fluids, even if gloves were worn
- After removing gloves
- Between patients
- Before and after eating
- After performing any personal care for yourself, such as blowing your nose or using the restroom
- Before going home

### **Wash Hands With:**

- Alcohol Hand Sanitizer
- OR
- Warm water – Water that is too hot or too cold irritates your skin.
- Soap – Enough to work up a good lather.
- Friction – 15 seconds of friction is needed to remove debris.
- Free-Flowing Water – Let it flow freely enough to adequately rinse off soap and soil.
- Paper Towel – Thoroughly pat hands dry with paper towel.

### **REMEMBER:**

The single most important thing you can do to prevent the spread of infection is hand washing.

### **Infection Control Practitioner:**

The Infection Control Practitioner can be reached at 332-7338.

### **Needle Sticks:**

- Always use safety needles when available.
- Do not bend, hand-recap, shear or break contaminated needles and other sharps.
- Do not pass contaminated sharps from one person to another.
- During codes or high stress situations, communicate your actions to others.
- Dispose of contaminated sharps immediately rather than holding them in your hand or setting them on a table or bed.

- Place contaminated sharps in an appropriate puncture-resistant, leak-proof container immediately after use.
- Do not overfill sharps container. Close and seal when  $\frac{3}{4}$  full.

### **Self-protective Controls to follow:**

- When performing procedures involving blood or other potentially infectious materials, minimize splashing, spraying, splattering and generation of droplets.

#### Examples:

- Before removing a rubber stopper from specimen tube, cover it with gauze to reduce the chance of splatter.
- Before irrigating a wound or anytime the potential for an exposure occurs that is due to splatter of blood or body fluids.
- Do not eat, drink, smoke apply cosmetics or lip balms, or handle contact lenses where you may be exposed to blood or other potentially infectious materials.
- Avoid petroleum-based lubricants that may degrade latex gloves. Applying hand cream is OK if you thoroughly wash your hands first. (Use only hospital approved hand cream. Do not bring products from home to the Medical Center.)
- Never mouth pipette or suction blood or other potentially infectious materials.
- Do not keep food and drinks in refrigerators, freezers and cabinets or on shelves, countertops or bench tops where blood or other potentially infectious materials may be present.
- Do not eat or drink at nurse's station.

### **If You are Exposed:**

- If possible, wash exposed area with soap and warm water.
- Students – notify your instructor immediately.
- Employees, Volunteers and Physicians, report to Employee Health (or the Administrative Nursing Supervisor after hours).

## **Tuberculosis**

Tuberculosis (TB) is a disease caused by the bacteria *Mycobacterium tuberculosis*. TB is spread through the air from one person to another. The bacteria are carried on airborne particles when a person with TB diseases sneezes, coughs, speaks or sings. TB can also be spread during aerosoled procedures such as intubation, bronchoscopy. The nuclei are so small that normal air currents keep them airborne and can spread them throughout the building.

### **Patient Screening and Isolation**

Patients with suspected or confirmed TB are to be placed on airborne precautions in a negative pressure room.

### **Signs/Symptoms of TB**

Assess patient for any of the following:

1. Does the patient have a cough which has been present for > 2 weeks?
2. Is one of the following risk factors present?
  - Recent (2 years) exposure to TB
  - Known recent TB skin test conversion
  - Immunocompromised
  - Previous history of TB
  - Pain in chest/Coughing up blood or sputum

- Weakness or fatigue
- Recent unexplained weight loss
- No appetite
- Fever/Night sweats

If the answer to both of these questions is yes notify the patient's physician, the Nursing Supervisor, and Infection Control and place the patient in airborne precautions.

### **Airborne Precautions**

- All patients suspected or confirmed of having pulmonary TB will be placed in airborne precautions
- Negative pressure rooms are required
- Respiratory protection must be worn by all persons who enter the room
- Protection is provided by a N95 respirator or reusable powered air-purifying respirator (PAPR)
- Employees must be fit tested for the N95 respirator
- The N95 respirators can be used throughout the shift unless wet or damaged
- Discard N95 at end of shift

### **Prevention: Employees Screening**

- All EMC employees and volunteers will have tuberculin skin testing at the time of pre-employment evaluation.
- May periodically be retested based on their risk of occupation exposure, or when unprotected exposures occur.
- Job classifications will be determined as high, low or no risk annually by the Infection Control Committee with the risk classifications modified as needed according to the community TB profile, case surveillance, rate of skin test conversions, and nosocomial transmission data.

Completion of required tuberculin skin testing is a condition of employment. Employees not in compliance will be subject to disciplinary action up to and including termination of employment.

## **Bloodborne Pathogen Training**

The OSHA Bloodborne Pathogen standards are intended to protect workers from all known and, as yet, unknown diseases transmitted by blood. The viruses of greatest concern at present, however, are Hepatitis B, Hepatitis C and HIV.

### **HIV**

- The Human Immunodeficiency Virus (HIV) attacks the body's immune system and destroys the body's ability to fight infection. A person infected with HIV may simply carry the virus and remain in apparently normal health for many years. They are still infectious. Although many persons infected with HIV go on to develop Acquired Immunodeficiency Syndrome (AIDS), the rate is declining due to new drug treatments. There is still not effective vaccine to prevent HIV infection.
- The signs of HIV infection are extremely variable. Persons infected with HIV can be asymptomatic for 5-10 years. The manifestations of AIDS that may eventually develop include a decreased cellular immune response and a variety of opportunistic infections. HIV is transmitted in the blood and other body fluids such as semen and cervical secretions. Exposures to tears or saliva and other casual forms of contact have not been found to transmit the virus.

## **Hepatitis B**

- Hepatitis B virus (HBV) attacks the liver, causing hepatitis B viral infection, the major infectious bloodborne hazard you face on the job. Most persons infected with HBV clear their infection, but about ten percent of those infected go on to develop cirrhosis of the liver or liver cancer and death. Infection with HBV may present with jaundice, dark brown urine and clay-colored stools, or may go unnoticed. Completely healthy people can carry the virus, so it is important to consider all blood and body fluids as potential risks.
- Hepatitis B is far more common than HIV and is present in very high concentration in the blood of infected patients. The high blood concentrations give HBV a greater likelihood of infecting exposed persons.
- In contrast to HIV, which causes infection in only about 1 in 250 exposure victims, HBV may cause infection in up to 1 of 3 exposures. Of those who become infected, only about one-third becomes symptomatic. Flu-like symptoms and jaundice are clinical clues to hepatitis B infection. Symptomatic and asymptomatic infected individuals can become chronic carriers of the virus, unwittingly infecting others.
- You can protect yourself from hepatitis B infection simply by receiving a hepatitis B vaccine, a series of three shots in the upper arm over a period of six months. The hepatitis B vaccine is safe. It is very effective in protecting you from getting hepatitis B infection if the series is completed.

## **Hepatitis C**

- Hepatitis C virus (HCV) also attacks the liver causing hepatitis C viral infection which presents similarly to hepatitis B. Hepatitis C is more insidious than hepatitis B: about three-fourths of people infected with HCV show no outward signs or symptoms but up to 85 percent will go on to develop chronic liver disease. Currently, there is no protective vaccine for this disease.

## **Workplace Transmission of HIV, HCV and HBV**

Bloodborne pathogens may be present in blood and other materials including:

- Semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid and other body fluids visibly contaminated with blood.
- Saliva during dental procedures.
- Unfixed tissue or organs other than intact skin from living or dead humans.
- Cell or tissue cultures that contain HBV, HCV or HIV.
- Organ cultures, culture media or similar solutions.

## **Typical routes of transmission for HIV, HCV and HBV in the healthcare setting are:**

- Puncture from contaminated sharp such as scalpels, broken glass, needles or exposed ends of dental wires.
- Blood contact with a pre-existing portal of entry (such as a scratch or cut).
- Blood contact with a mucous membrane (mouth, nose or eye).

## **Standard Precautions**

People can be infected with bloodborne diseases without showing any symptoms. Some may not even know they are infected. You may not be able to tell which patients carry a bloodborne pathogen merely by taking a medical history or performing an examination. That is why you must use Standard Precautions.

- Standard Precautions combines Universal Precautions and Body Substance Isolation practice to protect you from exposure to bloodborne pathogens as well as other pathogens from moist body substances.
- Standard Precautions means treating blood, all body fluids, excretions and secretions except sweat, plus non-intact skin and mucous membranes as though infectious.
- Use personal protective equipment (PPE) to protect you from contact with blood or other potentially infectious materials.
  - o PPE may include gloves, masks, gowns, aprons, lab coats, face shields, protective eyewear, mouthpieces, resuscitation bags or other ventilation devices.
  - o PPE must be appropriate for the task you are doing. For example, wear gloves if you anticipate exposure to your hands. Wear eye protection and a mask or a face shield to protect your eyes, nose and mouth if you anticipate splatters of infectious material. Wear a gown if you anticipate exposure of your clothing or skin.
  - o You should wear only as much PPE as necessary.

### **Work Practice Control**

- Wash your hands. Washing your hands is your number one protection against infection. The sooner you wash infectious materials off your hands, the less your chance of infection. Hand washing keeps you from transferring contamination from your hands to other people or objects or to other areas of your own body.
- Handle sharps with care. Never bend, shear, break or recap contaminated needles or other sharps. Immediately after use, dispose of contaminated sharps in an appropriate puncture-resistant, leak proof container. Do not allow containers to overfill. Use sharps safety devices whenever appropriate.
- Minimize splashing, spraying, spattering or generation of droplets when performing procedures involving blood or potentially infectious materials.
- Never mouth pipette or suction blood or other potentially infectious materials.
- Do not eat, drink, smoke, apply cosmetics or lip balms or handle contact lenses in work areas where exposure may occur.
- Do not keep food or beverages in refrigerators, freezers or cabinets; on countertops or bench tops, or in any other area where they might be exposed to potentially infectious materials.

### **Decontamination**

- When cleaning up surfaces use a hospital approved cleaner.
- Do an initial wipe up.
- Spray and allow it to stand for ten minutes then wipe up.
- Dispose of all wipes in biohazard containers.
- PPE should be removed and disposed of as appropriate.

### **What to do if exposed:**

- Immediately wash the exposed skin area, needle sticks and cuts with soap and water. Flush eyes and exposed mucous membranes with large amounts of clean water. Do not use caustic agents, such as bleach.
- Report the exposure to your supervisor as soon as it happens. You will be referred by your supervisor to the Employee Health Nurse, or Nursing Administrative Supervisor, if after hours, so that the post-exposure evaluation, counseling and any necessary treatment can begin. Act quickly because treatment for some infections should start right away.

### **Conclusion:**

- Bloodborne pathogen policies are located in the Exposure Control Plan in the Infection Control Manual. Failure to follow them is a risk that does not need to be taken.

## **MRSA**

The Department of Health Services estimates that 9600 Californians die from hospital acquired infections yearly, and that these infections add \$3 billion to the state's health care budget yearly.

Responding to this statistic, Senate Bill (SB) 1058 was signed into law. SB 1058 is also known as "Nile's Law" in memory of Nile Moss, who died from a Methicillin Resistant *Staphylococcus Aureus* (MRSA) infection after a visit to the hospital where he was getting an MRI. Soon after leaving the hospital, Nile developed a high fever and an x-ray revealed that he had pneumonia. One day after being admitted to the hospital, Nile died. Following Nile's death, his mother worked to call attention to the problem of hospital infections and to work for passage of SB 1058.

This law requires hospitals to screen high risk patients for MRSA. California is the 4<sup>th</sup> state to mandate MRSA screening of certain patients.

### **What is *Staphylococcus aureus*?**

*Staphylococcus aureus*, often referred to simply as "staph," are bacteria commonly carried on the skin or in the nose of healthy people. Approximately 25% to 30% of the population is colonized (when bacteria are present, but not causing an infection) in the nose with staph bacteria. Sometimes, staph can cause an infection. Staph bacteria are one of the most common causes of skin infections in the United States. Most of these skin infections are minor (such as pimples and boils) and can be treated without antibiotics (also known as antimicrobials or antibacterials). However, staph bacteria also can cause serious infections (such as surgical wound infections, bloodstream infections, and pneumonia).

### **What is MRSA (methicillin-resistant *Staphylococcus aureus*)?**

Some staph bacteria are resistant to antibiotics. MRSA is a type of staph that is resistant to antibiotics called beta-lactams. Beta-lactam antibiotics include methicillin and other more common antibiotics such as oxacillin, penicillin and amoxicillin. While 25% to 30% of the population is colonized with staph, approximately 1% is colonized with MRSA.

### **How common are staph and MRSA infections?**

Staph infections, including MRSA, occur most frequently among persons in hospitals and healthcare facilities (such as nursing homes and dialysis centers) who have weakened immune systems. These healthcare-associated staph infections include surgical wound infections, urinary tract infections, bloodstream infections, and pneumonia.

### **What is community-associated MRSA (CA-MRSA)?**

Staph and MRSA can also cause illness in persons outside of hospitals and healthcare facilities. MRSA infections that are acquired by persons who **have not** been recently (within the past year) hospitalized nor had a medical procedure (such as dialysis, surgery, catheters) are known as CA-MRSA infections. Staph or MRSA infections in the community are usually manifested as skin infections, such as pimples and boils, and occur in otherwise healthy people.

### **Are certain people at increased risk for community-associated staph or MRSA infections?**

CDC has investigated clusters of CA-MRSA skin infections among athletes, military recruits, children, Pacific Islanders, Alaskan Natives, Native Americans, men who have sex with men, and prisoners. Factors that have been associated with the spread of MRSA skin infections include close skin-to-skin contact, openings in the skin such as cuts or abrasions, contaminated items and surfaces, crowded living conditions, and poor hygiene

### **What are the clinical features of CA-MRSA?**

CA-MRSA most often presents as skin or soft tissue infection such as a boil or abscess. Patients frequently recall a “spider bite.” The involved site is red, swollen, and painful and may have pus or other drainage. Staph infections also can cause more serious infections, such as blood stream infections or pneumonia, leading to symptoms of shortness of breath, fever, and chills, or surgical site infections.

### **What are the criteria for distinguishing community-associated MRSA (CA-MRSA) from healthcare-associated MRSA (HA-MRSA)?**

Persons with MRSA infections that meet all of the following criteria likely have CA-MRSA infections:

- Diagnosis of MRSA was made in the outpatient setting or by a culture positive for MRSA within 48 hours after admission to the hospital.
- No medical history of MRSA infection or colonization.
- No medical history in the past year of:
  - o Hospitalization
  - o Admission to a nursing home, skilled nursing facility, or hospice
  - o Dialysis
  - o Surgery
- No permanent indwelling catheters or medical devices that pass through the skin into the body.

### **What is the main way that staph or MRSA is transmitted in the community?**

The main mode of transmission of staph and/or MRSA is via hands which may become contaminated by contact with a) colonized or infected individuals, b) colonized or infected body sites of other persons, or c) devices, items, or environmental surfaces contaminated with body fluids containing staph or MRSA. Other factors contributing to transmission include skin-to-skin contact, crowded conditions, and poor hygiene.

### **How is a MRSA infection diagnosed?**

In general, a culture should be obtained from the infection site and sent to the microbiology laboratory. If *S. aureus* is isolated, the organism should be tested as follows to determine which antibiotics would be effective for treating the infection.

**Skin Infection:** Obtain either a small biopsy of skin or drainage from the infected site. A culture of a skin lesion is especially useful in recurrent or persistent cases of skin infection, in cases of antibiotic failure, and in cases that present with advanced or aggressive infections.

**Pneumonia:** Obtain a sputum culture (expectorated purulent sputum, respiratory lavage, or bronchoscopy).

**Bloodstream Infection:** Obtain blood cultures using aseptic techniques.

**Urinary Infection:** Obtain urine cultures using aseptic techniques.

### **How are CA-MRSA infections treated?**

Staph skin infections, such as boils or abscesses, may be treated by incision and drainage, depending on severity. Antibiotic treatment, if indicated, should be guided by the susceptibility profile of the organism.

### **How do CA-MRSA and HA-MRSA strains differ?**

Recently recognized outbreaks of MRSA in community settings have been associated with strains that have some unique microbiologic and genetic properties compared with the traditional hospital-based MRSA strains, suggesting some biologic properties (e.g., virulence factors) may allow the community strains to spread more easily or cause more skin disease. Additional studies are underway to characterize and compare the biologic properties of HA-MRSA and CA-MRSA strains.

There are at least three different *S. aureus* strains in the United States that can cause CA-MRSA infections. CDC continues to work with state and local health departments to gather organisms and epidemiologic data from known cases to determine why certain groups of people get these infections.

### **Are MRSA infections a reportable disease?**

MRSA is reportable in several states. The decision to make a particular disease reportable to public health authorities is made by each state, based on the needs of that individual state. To date, MRSA is not a reportable disease in California.

### **What can be done to prevent others from getting staph or MRSA infections?**

You can prevent spreading staph or MRSA skin infections to others by following these steps:

1. **Clean your hands:** Wash hands for 15 seconds with soap and warm water, or use an alcohol-based hand sanitizer.
2. **Standard Precautions:** Follow standard precautions to minimize the spread of bacteria.
3. **Contact Precautions:** Follow contact precautions when caring for a patient known or suspected of heavy MRSA.

### **Patient screening criteria:**

- All trauma activation patients.
- Patients scheduled for a Total Joint Replacement surgery.
- Diabetic patients having surgery.
- Patients who have been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission.
- Patients who will be admitted to an intensive care unit of the hospital either directly or post surgery. (ICU/CCU, NTSICU, NICU)
- Patients receiving inpatient dialysis treatment.
- Patients transferred to the hospital from a skilled nursing facility.

Patients meeting any one screening criteria are to have bilateral nares swabbed for MRSA.

**RN Screening Competency:**

The following is the specific criteria that must be completed:

- Annual completion of MRSA Screening Standardized Procedure Competency upon hire and annually.
- Passing score on MRSA Screening Standardized Procedure Competency Test.

**Additional Information:**

- MRSA testing orders can only be written by an RN who has been deemed competent to perform this standardized procedure as described above.

**Procedure:**

1. Upon admission or **within first 24 hours** of hospital stay, the patient will be assessed to see if they meet any of the indications for MRSA Testing as listed below.
  - a. All trauma activation patients.
  - b. Patients scheduled for a Total Joint Replacement surgery.
  - c. Diabetic patients having surgery.
  - d. Patients who have been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission.
  - e. Patients who will be admitted to an intensive care unit of the hospital either directly or post surgery (ICU/CCU, NTSICU, NICU).
  - f. Patients receiving inpatient dialysis treatment.
  - g. Patients transferred to the hospital from a skilled nursing facility.
2. If patient meets one of the criteria, the RN will place a MRSA Screen/Testing order on the chart and initiate the procedure.
3. The RN will provide the patient with information regarding MRSA screening and testing.
4. The RN will obtain cultures from the patient’s bilateral anterior nares using a single culturette swab set.
5. The Culture swab will be sent with the order to the Laboratory for processing.
6. If the patient’s cultures return as positive, the Laboratory will notify the RN of the positive results (if the patient remains in the hospital) or notify the Physician and Infection Control if the patient has been discharged.
7. If the patient remains in the hospital and the screening culture is positive, the physician will be notified of the positive result and isolation will be instituted.
8. The RN will provide the patient with additional education regarding MRSA prior to discharge.

Below is an example of the MRSA Screening Order Sticker to use in the patient’s chart.

<b>MRSA Screen</b>	
Date: _____	Time: _____
<b>Conduct bilateral nasal screen for MRSA and submit to laboratory.</b>	
_____ <b>RN Signature</b>	<b>RN/ per Standardized Procedure</b>
<b>S600XXXX 12/08</b>	

### Documentation:

The RN will document the following:

1. Screening criteria met.
2. Place appropriate order in the chart.
3. Document the obtaining of the cultures.
4. Document MRSA screening/testing education that has been given to patient.

### REMEMBER!

MRSA tests on bilateral nares should be swabbed using a single use RED TOP culture swab collection and transport set into both nares. The culture swab set is then submitted to the lab.

### Each patient who tests positive for MRSA:

- Shall be placed on contact precautions.
- Will be notified by the attending physician.
- Shall receive oral and written instructions regarding aftercare and precautions to prevent the spread of MRSA. (Living with MRSA pamphlet, available on DMS)

## Living with MRSA

*This is really serious.  
I need to do something  
about this now!*



Learning how to control the spread of  
Methicillin-Resistant *Staphylococcus Aureus* (MRSA)

### Special Considerations:

- Patients admitted to Enloe Rehabilitation hospital will require testing, as the **“previously discharged from a general acute care hospital within 30 days” criteria continues to apply.**
- Patients admitted to Enloe Behavioral Health will have screening and testing for MRSA performed as outlined in this standardized procedure as Behavioral Health is classified as an acute facility by Enloe Medical Center licensure.

## INDWELLING URINARY CATHETER REMOVAL

### Inpatient RN Standardized Procedure

This standardized procedure is to be used in accordance with the California Nursing Practice Act/Scope of Regulation, and Business and Professions Code.

### Purpose:

The prolonged use of indwelling urinary (Foley) catheters in the hospital setting can lead to many complications. Catheter-associated urinary tract infections (CAUTI) are the most common hospital acquired infection (HAI) and the second most common cause of hospital acquired bloodstream infections. Prompt removal indwelling urinary catheters significantly reduces the risk of these complications from occurring. Indwelling urinary catheters should be removed when determined to be no longer medically necessary. This standardized procedure will provide the registered nurse with guidelines for the discontinuation of an indwelling urinary catheter.

### Function:

The function of this standardized procedure is to establish criteria and standards for appropriate timely removal of indwelling urinary catheters.

### Contraindications (“Do Not Remove Criteria”) for Indwelling Urinary Catheters:

Patients who have indwelling urinary catheters will be evaluated **24 hours after** admission to the inpatient setting, and at least once a shift thereafter, to determine if the patient’s clinical assessment

indicates that continuation of the indwelling urinary device is medically necessary. Therefore, if the patient has any of the following conditions present, the catheter **will NOT be removed**:

- Specific physician order indicating indwelling urinary catheter is to remain in place.
- **Catheter inserted less than 24 hours earlier.**
- Relief of outlet obstruction.
- Patient condition requiring strict intake and output measurements that cannot be obtained by any other means.
- Post-operative healing of genitourinary surgery.
- Local stage 3 or 4 decubitus with presence of incontinence.
- Chronic history of indwelling or suprapubic catheter.
- Comfort care or terminal illness.
- Patient in the care of nephrologists or urologists (requires specific order for removal).

### **Indications to remove Indwelling Urinary Catheters:**

If the patient does not have any of the above conditions present, and the indwelling catheter has been present longer than 24 hours, the indwelling urinary catheter will be removed, and alternatives to assist in urinary elimination will be considered.

### **Alternatives for consideration:**

1. Assess elimination patterns, and potentials for incontinence (i.e., stress or urgency).
2. Establish a voiding schedule. For example, offer assistance in urinary elimination (BSC, bed pan, BRP or urinal) at routine intervals based on patient assessment.
3. Bladder scanning PRN.
  - a. Notify physician if bladder volume is 400 ml or greater; or
  - b. Patient is unable to effectively empty bladder; or
  - c. Patients scanned volume is less than 400 ml with symptoms of bladder distention and/or physical discomfort.
4. Obtain order for intermittent catheterization, if needed.
5. Utilize external (condom) catheters if appropriate. Replace PRN – and at least every 48 hours.
6. Adult pads/briefs for incontinence. Briefs should only be worn when ambulating.

### **Equipment:**

- 10 ml syringe
- Gloves

### **Procedure:**

1. 24 hours after admission, and at least once a shift, assess the patient (for medical necessity) for the continuation or removal of the indwelling urinary catheter.
2. If removal is indicated, the indwelling urinary catheter will be removed, according to the current procedure.
3. Assess the patient frequently. Implement alternatives to facilitate a voiding response.
4. If the patient has not voided within six hours, scan the bladder for urinary volume.
5. Notify physician if the patient has a volume of 400 ml or greater, or if the patient's scanned volume is less than 400 ml, with symptoms of bladder distention and/or physical discomfort, and continues to be unable to void.



**Documentation:**

1. Document continuation of the urinary catheter for medical necessity, urinary catheter removal, and alternatives attempted to stimulate voiding response, presence of voiding response, any scanning volumes, and any contact with the physician in the medical record.

**Requirements for RN's:**

1. **Education:** California RN
2. **Training:** Completion of the Indwelling Urinary Catheter Removal Competency and ongoing completion of the Indwelling Urinary Catheter Removal portion of the EMC Annual Training Module.
3. **Record Keeping:** Each nursing department that this standardized procedure applies is responsible to assure all RN staff have completed the initial Indwelling Urinary Catheter Removal Competency with Orientation as well as confirm that each RN has completed the EMC Annual Training Module prior to their yearly evaluation, where this competency will be reviewed.

# Indwelling Urinary Catheter Removal Flowchart

Patient has an indwelling urinary catheter in place greater than 24 hours.

Does the patient have any **one** of the following conditions?

1. Specific physician order indicating an indwelling urinary catheter is to remain in place.
2. Relief of outlet obstruction.
3. Patient condition requiring strict intake and output measurements that cannot be obtained by any other means.
4. Post-operative healing of genitourinary surgery.
5. Local stage 3 or 4 decubitus with presence of incontinence.
6. Chronic history or indwelling or suprapubic catheter.
7. Comfort care or terminal illness.
8. Patient in the care of nephrologists or urologists (requires specific order for removal).

Yes

Do not remove  
Catheter

No

Remove catheter  
and monitor voiding  
response

## THE UNIQUE NEEDS OF DYING PATIENTS, THEIR FAMILIES AND CAREGIVERS

Death is a rite of passage in which we will all participate – as family members, caregivers, or eventually patients – yet we understand little of what is important at the end of life and how to offer it. As a caregiver, you have the experience of meeting and participating in another’s life at this critical and emotional time. By being present for the patient, the devastating loneliness and fears encountered by patients and families is not experienced alone.

Your empathy and knowledge during the end of life are crucial in supporting patients and families. Keep in mind the following suggestions:

- Patients and families often want to be reassured that their pain and symptoms will be addressed consistently.
  - o Patients and families usually want to know what they could expect during this phase.
  - o Talk to the families about the signs and symptoms of dying if they ask or when appropriate.
- Communication and clear decision making with physician and caregivers empowers patients and families at a time that often feels uncontrollable.
- Families need to know that when a patient transitions to “comfort care” they will be treated and cared for. Families often express feelings or fears of abandonment at this time.
- Allow visiting as much as possible. Family members who are restricted from visiting suffer from fear, anxiety, hopelessness and helplessness. They also can display unhealthy coping strategies such as hostility and anger toward the staff.
  - o Families are unique – they may be relatives, friends, pets, spiritual care providers. Keep in mind that it’s not important how they’re related.
- Discussing end of life issues does not need to remove hope for patients and families.
- Be aware of your own emotions related to the death and dying process. Take care of your emotional needs so you can be present to your patients and families.
- Responding in an empathetic, non-judgmental way utilizing your medical knowledge can give patients and families an anchor of stability during this time of grief and loss.

Grief is unique to every individual. No two of us experience grief in exactly the same way; nor should we expect ourselves to. We need to allow individuals to express their own grief, as long as it is in a way that does not harm themselves or others. Keep in mind the many varied ethnic and cultural beliefs/traditions that may be expressed by the grieving.

“People will forget what you said... People will forget what you did... But people will never forget how you made them feel.”

### **Supporting tools and policies:**

“Comfort Care Order Set”

“White Rose Policy”

“Care of the Patient at the End of Life Policy”

“Spiritual, Religious and Cultural Needs of the Patient Policy”

“Cultural and Nursing Care, A Pocket Guide”

# RESTRAINTS

## Restraints – Patient Care Providers Only

Enloe Medical Center recognizes the need to ensure patients their human and civil rights, and supports the concept **that restraining devices and methods are used only as a last resort** when less restrictive interventions have proven ineffective at providing safe care and a safe environment. Because of their restrictive nature, restraints will be used with due caution and consideration throughout the organization. The prevention of the need for restraint or seclusion is the first priority.

### Suggested Restraint Alternatives

The following list is only meant to be suggestive; other alternatives may be tried.

#### 1. Provide Companionship and Supervision

- Ask family, friends, or volunteers to stay with the patient.
- Frequent observation/reorientation to surroundings.
- Determine when the patient requires one-to-one attention (typically at night) and intervene accordingly.
- Always respect the patient's need for personal space, but be physically available if needed.

#### 2. Care and Treatments

- Set consistent limits on type and degree of aggressive behavior to be tolerated.
- Initiate oral (as opposed to IV or NG) feedings.
- Offer nourishments and check patient's nutrition/hydration needs.
- Schedule treatments/tests based on patient needs.
- Offer pain medications and inquire more frequently about need for pain medication.
- Offer non-pharmacological pain relief measures (backrub, etc.)
- Other comfort measures – frequent position changes, etc.
- Keep bed in low position when possible. (Use partial bedrails for increased mobility and assistance with positioning.)
- Relaxation techniques.

#### 3. Modify the Environment

- Increase or decrease the amount of light in the room, depending on glare or the patient's preferences/needs.
- Position the bedside commode so the patient can easily use it.
- Arrange for the patient to be in a room near the nursing station, unless the stimulation triggers agitation or worsens confusion.
- Reduce environmental noise.
- Keep the call button accessible to the patient.
- Use special furniture (a lower bed, reclining chair, etc.)
- Change the temperature of the room (e.g., cooler, warmer).
- Undisturbed "quiet time."

#### 4. Reality Orientation and Psychosocial Interventions

- Involve the patient in conversation. Do not "talk over" him/her. Encourage patient to verbalize inner feelings/validate patient's feelings.

- Acknowledge patient's tension/stress.
- Use active listening to elicit the patient's feelings.
- Explain procedures to reduce fear and convey a sense of calm. Elicit patient understanding of procedures.
- Provide reality links when appropriate (TV, radio, calendar, clock, etc.).
- Place personal items within reach.
- Use relaxation techniques (therapeutic touch, massage, and warm baths).
- Encourage the patient to participate in his or her own care.

#### 5. Offer Diversionary and Physical Activities

- Use TV, radio, or music for diversion (depending on the patient's cognitive capacity and individual preferences).
- Provide exercise and ambulation whenever possible.
- Initiate training in activities of daily living.
- Use physical therapists to help the patient increase strength, endurance, and a sense of accomplishment.

#### 6. Design Creative Alternatives

- Use specifically designed music to reduce agitation/provide diversion.
- **Develop toileting routines to reduce fall risks.**
- Consult with other disciplines or family members about appropriate interventions.
- Consult nursing/rehabilitation/therapeutic recreation literature sources.
- Place mattress on floor/protective floor mats.
- Comfortable furniture (e.g., recliner) in room.
- Labels/pictures to assist with orientation to environment.
- Familiar belongings from home.
- Motion detectors (e.g., bed or chair alarms).

#### Definitions:

The term restraint includes either a physical device or drug that is being used as a restraint. The intent or purpose of the medication or device determines whether it meets criteria as a restraint, not the medication or device itself.

1. **Physical restraint** is any manual method (means of subduing a patient by safely grasping or holding, using reasonable force, without causing harm) or physical/mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove. The restraint restricts freedom of movement or normal access to one's body.
2. **Chemical restraint** is a medication used to control intentionally dangerous behavior or to restrict the patient freedom of movement and is not a standard therapy or treatment for the patient's medical or psychiatric condition. The use of a drug to control behavior as part of the medical regimen is not considered chemical restraint.
3. **Non-behavioral** (acute medical/surgical restraint) is a form of immobilization that utilizes physical or mechanical devices to assist with the treatment of the patient. These devices are used to prevent the patient from interfering with necessary medical treatment (e.g., pulling out IVs, NG tubes), after alternatives were unsuccessful. Or to protect him/her from injury if less restrictive methods are unsuccessful.

4. **Behavior Management/Seclusion restraint** is the use of chemical, physical/mechanical restraints to manage behavior in an emergency situation that should be reserved for those occasions when unanticipated, severely aggressive or destructive behavior places the patient or others in imminent danger. Restraints for behavior management will only be used outside of the emergency department or behavioral health following a review by clinical leaders (manager, director and/or nursing supervisor) in order to ensure that the nursing unit that will receive the patient has adequate resources and training to safely provide care to the patient.

Seclusion is the involuntary confinement of a person in a room or an area where the patient is physically prevented from leaving. California Code Title specifically defines the term “time out” as seclusion. Seclusion does not include confinement on a locked unit or ward where the patient is with others. Seclusion may only be used for the management of violent or self destructive behavior.

### **Restraint Standard Do Not Apply to the Following Situations/Devices**

1. **Limitation of Mobility** – Mechanisms customarily employed during medical, diagnostic or surgical procedures/tests that are considered a regular part of such procedures/tests. These mechanisms include, but are not limited to:
  - a. Surgical positioning
  - b. Arm board during intravenous administration
  - c. Papoose boards for the insertion of pediatric intravenous devices
  - d. Radiotherapy procedures
  - e. Protection of surgical and treatment sites in pediatric patients
2. **Adaptive Support** – Mechanisms intended to a permit a patient to achieve normative bodily functioning. These mechanisms include, but are not limited to:
  - a. Orthopedic appliances
  - b. Braces
  - c. Tabletop chairs
  - d. Other appliances or devices used to give postural support to the patient

*However, devices which serve multiple purposes, such as a Geri Chair or side rails, when they have the effect of restricting a patient’s movement and cannot be easily removed by the patient, constitute a restraint (CMS COP Patient Rights).*

3. **Protective Devices**, such as helmets.
4. **Forensic and Correction Restrictions**
  - a. The use of restrictive devices, such as handcuffs, applied and monitored by law enforcement officials are not governed by restraint guidelines.
  - b. However, restraint use related to clinical care for individuals under forensic or correction restrictions will follow these restrain guidelines.

### **Restraints – Inpatient RNs and LVNs Only**

(In addition to this module, review the policy and procedure on the MCN.)

#### **Acute Medical/Surgical Restraints (Non-Behavioral)**

1. On Initiation of Restraint, the RN on the team documents:
  - a. Observed restraint reason.
  - b. The alternatives attempted.

- c. A clinical assessment (including an O<sub>2</sub> saturation and vital signs) – based on their own assessment and/or review of LVN data.
  - d. Physician notification to obtain an order is done prior to placing restraints, unless it is an emergency. In the event of an emergency, the physician will be contacted immediately after placement of restraints.
  - e. Education of the patient/family (can be delegated to the LVN).
  - f. The plan of care.
2. Every 8 hours, the **RN** on the team documents:
    - a. The restraint rationale.
    - b. The reassessment of the patient (can be based on the LVN data).
    - c. The continued need of restraints (or as needed in the shift if DC occurs).
    - d. The review of the plan of care.
  3. Every 2 hours, **RN or LVN** documents:
    - a. The patient's neuro and respiratory status.
    - b. Observations of the patient.
    - c. The care given to the patient (the **CNA** will be able to chart some of this).
    - d. The outcome of the observations and care given.
  4. A team member will document this, as needed:
    - a. The restraint type.
    - b. When and why the restraint was removed.
    - c. When and why the restraint was applied.
    - d. The RN, LVN or CNA will perform care and will document *within current scope of practice*.

**Early Release Criteria: (All restraint types)**

1. The patient's medical condition has changed so that restraints should no longer be used.
2. Loosening restraints for tests or therapy under close observation is not considered early release.
3. A new order for restraint will be required if the restraint is discontinued.

**An early release of restraints should be performed as soon as the patient's condition allows.**

**Behavior Management Restraint/Seclusion**

ALL behavior management restraint documentation occurs in the Restraint/Seclusion Section in Meditech or on the **Behavioral Restraint Record/Plan of Care** form. The patient in Behavior Management Restraints needs continuous in-person observation. Leather restraints are always considered to be for behavior management.

1. Clinical leadership is immediately notified of any instance in which a patient remains in restraint or seclusion for more than 12 hours, or experiences two or more separate episodes of restraint and/or seclusion within 12 hours. Leadership is notified every 24 hours if either of the above circumstances continues.
2. Upon **Initiation**, the **RN** on the team documents:

- a. Observed restraint reason.
  - b. The alternatives attempted.
  - c. A clinical assessment (including an O2 saturation and vital signs) – based on their own assessment and/or review of LVN data.
  - d. Physician notification to obtain an order is done prior to placing restraints, unless it is an emergency. In the event of an emergency, the physician will be contacted immediately after placement of restraints.
  - e. Education of the patient/family (can be delegated to the LVN).
  - f. The plan of care.
3. Every 4 hours the RN on the team documents:
    - a. The restraint rationale.
    - b. The reassessment of the patient and the continued need of restraints and obtains a new order. (A new order is required every 4 hours.)
  4. Every 2 hours the RN or LVN documents:
    - a. The patient's Neuro and Respiratory status.
    - b. Observations of the patient.
    - c. The care given to the patient (the CNA/MHW will be able to chart some of this).
    - d. The outcome of the observations and care given.
  5. Every 15 minutes a team member documents:
    - a. Observations (behavior/safety etc.).
    - b. Outcomes.
  6. The RN, LVN, CNA/MHW will perform care and document *within current scope of practice*.
  7. Physician Responsibilities
    - a. Conduct a face to face evaluation of the patient and document within 1 hour and ever 8 hours the patient is in behavioral management restraints.
    - b. A new order for behavioral management restraints/seclusion must be obtained every 4 hours.

#### **Early Release Process:**

1. Release the restraints one limb at a time over several minutes to evaluate for re-escalation of behavior. The best method is to release the dominant leg first, non-dominant hand, non-dominant leg, and finally the dominant hand.
2. Early release criteria:
  - a. During the previous 15-minute observation period, the patient has not exhibited the behavior for which the restraints were applied or the behavior is markedly reduced.
  - b. The patient agrees to modify his/her behavior/ Continued problematic behavior despite the patient's verbalization is justification for continuing the restraint/seclusion.
  - c. Patients who are asleep automatically meet early release criteria, but may not safely be release from all devices rapidly.

- d. Release the devices as above and observe the patient's behavior. Re-escalation may still occur.
  1. When all of the restraining devices are discontinued, reapplication of restraints is based on new behavior (new order and physician assessment are required).
  2. It is acceptable to awaken the patient to observe behavior or obtain verbal agreement to modify behavior.

### **Key Points – All RN's**

- Physician order is required prior to the application of restraints.
- In an **emergency**, an **RN** (and only an RN) may initiate restraints, and then must obtain a physician order immediately thereafter.
- A PRN or standing order is not acceptable as a restraint order.
- Restraints must be discontinued at the earliest possible time. **Don't forget to document when the restraint was discontinued!!!!**
- Behavioral management/seclusion restraints require a physician to conduct a face to face interview with a patient within 1 hour of application and every 8 hours thereafter. New orders are required every 4 hours.

### **Key Points – Non-Behavioral (Med-Surg) Restraints:**

- An RN must document an assessment of the need for restraints initially and reassess for continuing need every 8 hours.
- A patient in restraints must be monitored **at least** every two hours, the restraints released periodically for the patient's comfort, and care provided consistently. This must be documented completely in the patient's medical record.
- A physician order is **required** every calendar day. **Nursing must obtain a verbal order if there isn't a written physician order.** Calendar day begins at midnight.

### **Consider these Aspects:**

- Would you give a medication without a physician's order?
- **No order, no restraints!** Don't put your patient, yourself, or your license, at risk!
- Have you really considered all of the options and alternatives to avoid using restraints?
- Restraints can only be initiated/continued for **observed** behaviors, such as pulling on ET tubes or IV lines.
- The rationale that a patient should be restrained because he "might" fall is an inadequate basis for using a restraint.
- One of the least frequently used alternatives is to call in the family to help. How would you feel if this was your family member? Would you still restrain them in the manner that you were planning?

## **POLST**

### **Physician Orders for Life Sustaining Treatment/POLST Forms**

#### **What is it?**

The Physician Orders for Life Sustaining Treatment (POLST) is an active physician order form that captures an individual's wishes regarding life sustaining treatment and/or resuscitation. The patient

may present the document upon registration or at any time during the hospital stay. We are required by law to acknowledge the patients wishes.

#### POLST Forms:

- Are recognized throughout the state of California;
- Are brightly colored and clearly identifiable (Pulsar Pink);
- Are valid physician orders that follow the patient from one facility to another (portable);
- Can be revised or revoked by an individual with decision making capacity at any time;
- Provide statutory immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction or any other sanction to a healthcare provider who relies in good faith on the request and honors a POLST;
- Are an alternative to the Pre-Hospital Do Not Resuscitate form, although POLST is more comprehensive in that it addresses other life-sustaining treatment in addition to resuscitative measures;

#### **What do I do with it if a patient has one?**

- Make a copy of the original. It is two-sided.
- Place the original Pink POLST in a protective sleeve, and the copy in the patient's medical record. (In front of the chart.)
- Notify the physician of record and obtain Life Sustaining Treatment Orders/Do Not Resuscitate Orders (6303218) if indicated per the POLST.
  - o If the physician who signed the POLST document is a member of the Enloe Medical Staff, the POLST document will be followed until the orders are obtained.
  - o If the physician who signed the POLST document is NOT a member of the Enloe Medical Staff, the POLST document is a guideline to the staff until orders are obtained.
- Return the original Pink POLST to the patient upon discharge.

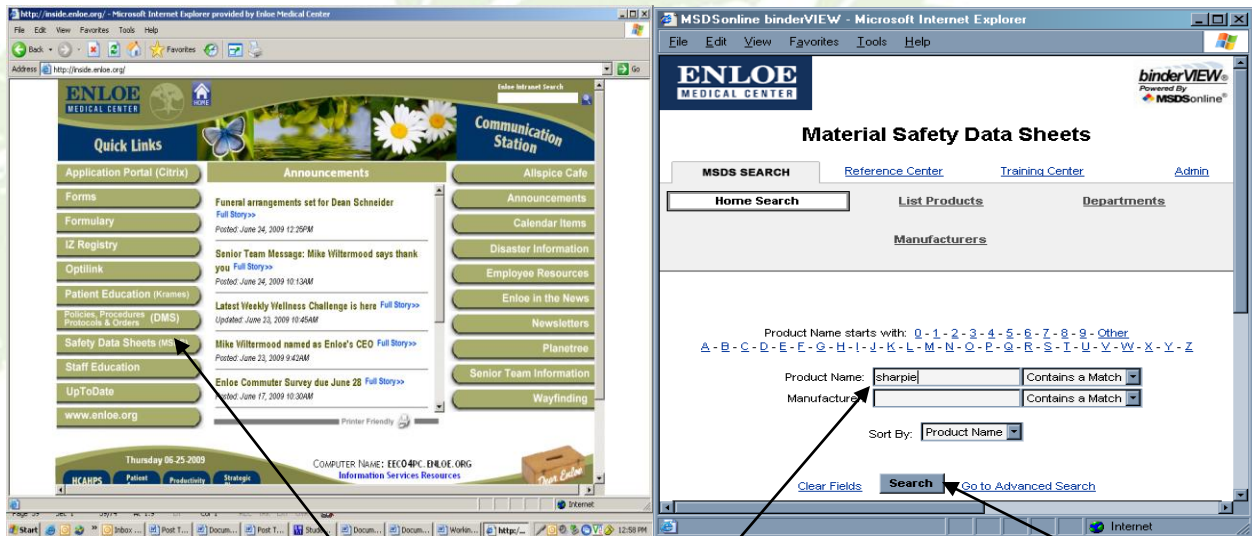
### **MATERIAL SAFETY DATA SHEETS**

Enloe Medical Center's written Hazard Communication Program directs that Material Safety Data Sheets (MSDSs) are REQUIRED for ALL chemicals used in the facility. In addition, OSHA mandates that MSDSs be readily accessible and there must be no barriers to employee access during the work shift. The Material Safety Data Sheet (MSDS) provides safety information on chemicals used in the workplace. Each employee who uses chemicals must be familiar with the information on the MSDS and know their location in the event of an accident and if safety information is needed.

The purpose of the MSDS is to provide detailed safety information on each hazardous chemical used in the workplace, including, but not limited to, potential hazardous recommendations for appropriate protective measures. An MSDS must be available for each hazardous chemical in the workplace. MSDSs are not required for biological/infectious agents or physical hazards encountered in the workplace. In addition, the MSDS is NOT directions for product use, directions on quantity to be used or intended product use.

Each department maintains an inventory of hazardous chemicals and materials that employees may be exposed to within the department under normal working conditions or in a foreseeable emergency. MSDS forms are **available online** at [inside.enloe.org](http://inside.enloe.org). Some examples of items

requiring an MSDS include but are not limited to hand lotion, hand soap, dish detergent, chemical reagents and cleaning products.

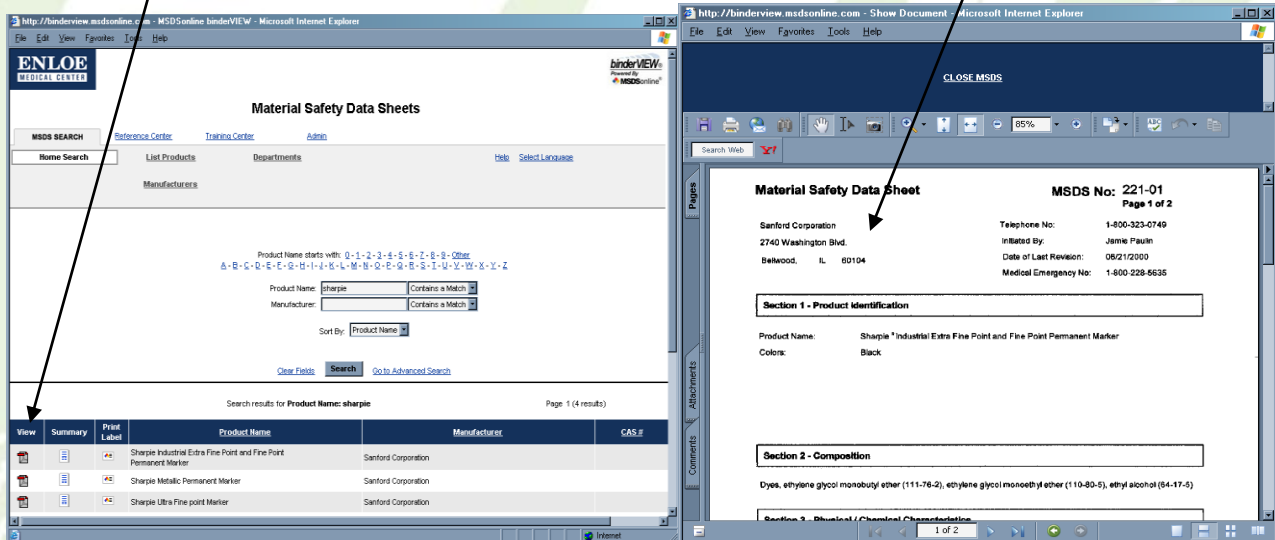


1. Click on Safety Data Sheets (MSDS).

2. Type in product name. 3. Click Search.

4. Select your product by clicking the icon under "View".

5. View the MSDS.



Please note, in the event of a power or system failure, there is a back-up CD-ROM version of the master MSDS file in the Nursing Administrative Supervisor's office and the Hazardous Materials Coordinator's office.

## **PERSONAL SAFETY TO PREVENT INJURY**

### **PATIENT AND NON PATIENT CARE PROVIDERS**

#### **Risk Factors**

Occupational risk factors are conditions that can cause stress to the muscles, tendons, ligaments, bones or discs in your back. Generally, the more risk factors present the greater the likelihood of injury (e.g., sprains/strain, bulging/herniated disc, osteoarthritis).

#### **Poor/Awkward Posture**

Poor/awkward posture means that the spine's normal curves are increased or decreased. This can create stresses and strains to the tissues of your back, result in pain and set you up for an injury.

*Examples of poor/awkward posture include: bending, twisting, overreaching and working overhead.*

#### **Repetitive Movement**

Repetitive movement is performing the same motion over and over again.

*Examples of repetitive motions: stocking supplies, gardening, filing, keying, chopping vegetables, hammering.*

#### **Forceful Exertion**

Forceful exertion is the amount of physical or muscular effort needed to perform a task.

The amount of force exerted depends on a combination of factors that include:

- Load shape, weight, dimensions
- Grip type, position and friction characteristics
- Length of time the forceful exertion is applied.

#### **Environment**

The environment we work in can affect how our body can cope with the stresses we place on it.

*Examples of environmental risk factors are: extreme temperatures, wet or slippery surfaces, vibration.*

#### **Personal Condition can be a risk factor**

Lack of rest  
Poor nutrition  
Inflexibility  
Poor strength

## **Prevention of Injuries**

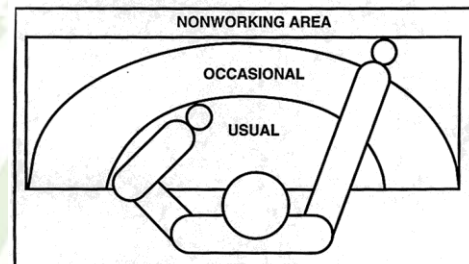
To prevent back injuries, it is important to reduce or eliminate as many risk factors as possible.

- Maintain a neutral posture during activities.
- Neutral posture/spine allows the back to maintain its natural three curves
- Keep your ears, shoulders and hips inline to maintain neutral posture
- Avoid twisting by turning your whole body to face your work or pivoting your feet as you turn.
- Bend at your hips and knees to avoid forward bending in the back, and to allow using legs to help lift.

- Avoid overhead work (use a stepstool, lower the work area) to reduce backward bending. Try to work at about waist level whenever possible.
- Strengthen your stomach muscles to support your lower back.
- Ensure that you have proper rest, nutrition, flexibility and strength.
- Try to vary your posture to use different muscles throughout your shift.

When sitting, adjust your chair to keep your spine neutral, feet supported and hips, knees and ankles bent at about 90 degrees.

- Make sure your computer workstation is arranged to keep your arms relaxed at your side, your wrists straight, and neck neutral.
- Keep frequently used items in front of and close to you.



When standing, try to place feet at about shoulder width apart (shoulder width can be side to side or front to back) for a good base and slightly bend the knees. If standing for prolonged periods, try to vary your stance (e.g., one foot in front of other, elevate one foot on a box or stool).

Use good body mechanics when lifting, carrying, reaching, pushing or pulling.

- Test the weight before attempting the move. Reduce the weight, if possible.
- Hold items close to your body using both hands/arms.
- Awkward or misshaped objects may need more than one person to move.
- Use assistive devices to move materials (e.g., cart, hand truck, dolly, patient moving equipment etc.)
- Use your legs, (bend your knees)
- Tighten your abs to give your back support/protection
- When possible, push rather than pull.
- Pivot feet, do not twist.
- Ask for help if needed. (e.g. Team Lift, 2<sup>nd</sup> person)
- Remember to include stretching, rest breaks, plenty of fluid and proper nutrition.

### **Prevent Patient Care Related Injuries**

In addition to the above, practicing the following, will help prevent injuries to yourself or co-workers:

- Gathering information/assess the situation (e.g., look on Green sheets, previous documentation, ask co-workers)
- Set up for safe mobility: have the equipment you need close and ready, know the mobility status of your patient before you begin mobilizing them; have a second person ready etc.
- Ask for help if needed (e.g., Team Lift, assistance from co-workers)
- Ask the patient to do for themselves, what they can, to help you (i.e. lift their head or push with their legs when moving up in bed, scoot forward and push through their legs when transferring, etc.)
- Test the weight before attempting the move. Reduce the weight if possible.
- Difficult patients may need more than one person to move.
- When possible, push rather than pull.

- Remember to include stretching, rest breaks, plenty of fluid and proper nutrition in your daily routine.
- Use the appropriate patient movement device which include:
  - **Slipp or AirPal** – lateral transfers or repositioning a patient in bed.
  - **Opera** – transfer dependent or maximum assist patient between surfaces. (e.g., chair, bed, gurney and from the floor.)
  - **Vander Lift (similar to the Opera)** – should be used on patients weighing 440-1000 pounds.
  - **Hover Jack** – Gets patients off the floor, after a fall (up to 1100 pounds).
  - **Encore** – to transfer a moderate assist patient from a seated position.
  - **Stedy** – to transfer a minimal assist patient from a seated position (e.g., for toileting or showering).
  - **Slide Boards and Gait Belts** - as appropriate.

