Student Clinical Mandatory Education
NPSG.01.01.01 ~ Use at least two (2) ways to identify patients.

- Two patient identifiers are used when administering medications, blood or blood products, collecting specimens, providing treatment or performing procedures.
- Label containers used for blood and other specimens in the presence of the patient.
Knock and wait for permission before entering the patient’s room
Acknowledge everyone in the room
Assure privacy
Make the patient priority #1
Be courteous and respectful
Introduce yourself
Ask patient how they’d like to be addressed.
Refer to patient as Mr., Mrs., Miss- instead of slang
Why use SBAR?

Why:

- Promotes patient safety during urgent patient care situations
- Benefits clinicians by communicating readily and more efficiently
- Applies to most forms of communication among healthcare professions
- Standard framework to transfer important information
- Helps nursing students and recent graduates organize thoughts prior to calling physician, during handoff and transferring patient to other levels of care.
• Reduce errors related to miscommunication
• Script to follow when communicating crucial patient information
• Sharing of information in an easy-to-follow and logical sequence
• Makes communicating more efficient
• Reduces confusion resulting in differences in clinician communication patterns
• Standardizes communication in accordance with TJC and IHI standards
Bedside Rounding

- Shift to shift reporting done at patient’s bedside
- Include patient, when applicable, in report
  - Fosters patient/caregiver trust
  - Address patient’s concerns and/or questions
  - Integrates patient into the care team
  - Gives patient knowledge of “plan of care”
- Update whiteboards
- Set goals for shift
- Assess baseline, observe wounds, dressings, lines etc...
- Celebrate patient’s milestones (i.e.; no pain, walking to bathroom....)
- Promotes accountability
- Completed by all Clinicians that are part of the patient’s healthcare team
Communicate Patient Changes

Report to RN....

• If patient refuses treatment
• Any changes in the mental or physical status
• Any changes in vital signs
• Change in diet
• Change in mobility
• Alteration in skin integrity
• Changes in patient input and/or output
Structured Hourly Rounding

Intentional hourly rounding to include the “4 P’s”

• Pain – ask patient if he/she needs pain medication
• Potty – encourage the patient to void
• Positioning – assist the patient to a comfortable position
• Possessions – be sure the patient can reach all necessary items before leaving the room
Critical Lab/Test Result Process...

- Patient’s primary nurse receives critical test result from the diagnostic testing dept. (i.e., lab work, X-Ray report).
- Primary nurse reads the results back to the person reporting the results.
- Primary nurse notifies the appropriate physician of the critical lab or test result as soon as possible or within one hour, which ever comes first and documents the physician notified, date and time in EPIC.
- Primary nurse requests the physician read-back the results to verify that he/she received the information correctly. The read-back is documented verifying the accuracy of the information communicated.
Preventing Infections

We can all make a difference in infection prevention by.....

• Washing hands before patient contact (NPSG.07.01.01)
  ▪ Before touching a patient
  ▪ Before clean/aseptic procedure
  ▪ After body fluid exposure risk
  ▪ After touching a patient
  ▪ After touching a patient’s surroundings

Save Lives, Clean Your Hands!

• Removing gloves before leaving a patient’s room

• Labeling patient supplies and leaving them in the patient’s room

• Using standard precautions for all patients, unless on specific isolation precaution

• Using linen hamper, do not place dirty linens on the floor

• Cleaning computer keyboard before using
MDRO Prevention...

- Preventing infections will reduce the burden of MDROs in healthcare settings. Prevention of antimicrobial resistance depends on appropriate clinical practices that should be incorporated into all routine patient care – including:
  - optimal management of vascular and urinary catheters
  - prevention of lower respiratory tract infection in intubated patients
  - accurate diagnosis of infectious etiologies
  - judicious antimicrobial selection and utilization.
Multi-Drug Resistant Organisms

• Successful control of MDROs have been documented in the United States and abroad using a variety of combined interventions.

• Some of these interventions include;
  • improvements in hand hygiene
  • use of Isolation Precautions until patients are culture-negative for a target MDRO
  • active surveillance cultures (ASC)
  • education
  • enhanced environmental cleaning
  • improvements in communication about patients with MDROs within and between healthcare facilities.
Central Line Associated Bloodstream Infection (CLABSI)
National Patient Safety Goal (NPSG.07.04.01)

Safety Initiatives...
• Promptly remove unnecessary central lines
• Follow proper insertion practices
  ▪ Perform hand hygiene before insertion
  ▪ Adhere to aseptic technique
  ▪ Use maximal sterile barrier precautions (i.e., mask, cap, gown, sterile gloves, and sterile full body drape)
  ▪ Perform skin antisepsis with appropriate disinfectant – Chlorhexidine swab
  ▪ Choose the best site to minimize infections and mechanical complications
  ▪ Avoid femoral site in adult patients
  ▪ Cover the site with sterile gauze or sterile, transparent, semipermeable dressings
Central Line Associated Bloodstream Infection (CLABSI)
National Patient Safety Goal (NPSG.07.04.01)

• Handle and maintain central lines appropriately
  ▪ Comply with hand hygiene requirements
  ▪ Scrub the access port or hub immediately prior to each use with an appropriate antiseptic (e.g., Chlorhexidine, povidone iodine, an iodophor, or 70% alcohol)
  ▪ Access catheters only with sterile devices
  ▪ Replace dressings that are wet, soiled, or dislodged
  ▪ Perform dressing changes under aseptic technique per MHS procedure

• Curos caps should be utilized on all IV needleless valves and are to be disposed of and replaced whenever removed (i.e. administration of medication, flushes, etc.)
  ▪ Each Curos disinfecting port protector contains 70% isopropyl alcohol (IPA). The IPA bathes the surfaces of the port and disinfects it in one (1) minute.
Catheter Associated Urinary Tract Infection (CAUTI)
National Patient Safety Goal (NPSG.07.06.01)

Safety Initiatives…

• Insert catheters only for appropriate indications
• Leave catheters in place only as long as needed
  • Remove catheters ASAP postoperatively, within 24 hours, unless there are appropriate indications for continued use (must have physician order for continuation)
• Ensure that only properly trained persons insert and maintain catheters
• Insert catheters using aseptic technique and sterile equipment
• Following aseptic insertion, maintain a closed drainage system
• Maintain unobstructed urine flow
• Follow Hand hygiene and Standard Precautions(or appropriate isolation)
Preventative Measures...

- **Preoperative:**
  - Patient receives shower
  - Patient receives clean gown and fresh linens
  - Removal of hand jewelry, artificial nails, and nail polish
  - Minimize staff movement
  - Antibiotic prophylaxis

- **Intraoperative phase**
  - Hand decontamination, use of sterile gowns and gloves
  - Iodophor-impregnated incise drapes
  - Antiseptic skin preparations (povidone-iodine, chlorhexidine)
  - Maintaining patient homeostasis: warming, optimal oxygenation, and adequate perfusion
  - Covering of incisions with appropriate interactive dressing

- **Postoperative phase**
  - Dressing changes (aseptic, non-touch technique)
  - Postoperative wound cleansing (sterile saline up to 48 hours after surgery)
  - Appropriate interactive dressings for wounds
  - Antibiotic treatment of surgical site infections (SSIs)
  - Referral for specialist wound care services
  - Enhanced education of healthcare workers, patients, and caregivers
Types of Restraints ~ Defined by CMS

• **Restraint** is any method, chemical or physical, with or without the patient’s permission of restricting a person’s freedom of movement, physical activity, or normal access to his or her body.

• **Physical Restraint** is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.

• **Chemical Restraint** is a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

• **Seclusion** is the involuntary confinement of a patient alone in a room or an area where the person is physically prevented from leaving and may only be used for the management of violent or self-destructive behavior.
Non-Restraining Devices may be used for patients without a physician order under these standard conditions:

- A safety strap may be used at any time that the patient is at risk for injury, i.e., for patient during transport.
- Mechanisms usually and customarily employed during medical, diagnostic, surgical procedures or related post procedure care process and are based on standard practice for the procedure (i.e. medical immobilization in the form of surgical positioning, single arm boards used during intravenous administration, papoose positioning, etc.)
- A device used to meet the assessed needs of a patient who requires adaptive support (i.e. postural support, halter devices designed to prevent a patient from falling out of a chair, orthopedic devices, etc.) or medical protective devices (i.e. helmets, freedom splints). Such use will be based on the assessed needs of the individual patient.
- Therapeutic holding and comforting of children without their permission for less than 30 minutes.
- Forensic and correction restrictions used for security purposes. Individuals under forensic and correction restrictions requiring restraints due to a medical condition will have restraints applied per established procedures or protocols.
Patient rights, dignity, and well-being are protected during restraint use and the following will be assured:

- Respect for the patient as an individual.
- Restraint use should not cause harm or pain to the patient.
- Safety and cleanliness of the environment.
- Protection of the patient’s modesty, visibility, and body temperature.
- Ability of the patient and family to receive education and participate in care.
- Verbal communication to assure the patient that he/she is not alone.
Restraints

• Department leadership and/or the House Supervisor will be notified as soon as possible after the initiation of restraints and will verify that the most appropriate, least restrictive device is in place.

• Assessments are documented every two hours on the non-behavioral patient and every 15 minutes on the behavioral patient on the restraint doc flow sheet in EPIC.

• Assessment includes: behavioral/mental status, skin care and assessment, neuro/vascular status, elimination, fluids and nutrition, activity, ROM, and restraint releases.

• Restraints will only be discontinued by a nurse after an appropriate assessment that the patient’s behavior is no longer a threat to self, staff or others. Removing the restraint completely from the patient will require a new doctor’s order to place the restraints back on the patient.
  – The temporary removal of restraints for the purpose of caring for a patient’s needs is not considered a discontinuation of the restraint, provided that the patient remains under direct staff supervision.

• Non-behavioral restraint orders are good for the duration of the admission unless removed.
Restraints ~ EPIC Documentation

1. Document once per shift.

2. Document upon initiation.

Review every 2 hours.
Pain Management

Pain can be a common part of the patient experience; unrelieved pain has adverse physical and psychological effects.

- All patients have the right to appropriate assessment and management of pain.
- The patient’s right to pain management is respected and supported.
- Pain will be managed through a collaborative effort by a multidisciplinary team that may include: patients, their significant others, physicians, nurses, nursing support, pharmacist, physical therapists, pastoral care, and social services.
The goal of pain assessment and management is to individualize the management of pain so that pain can be relieved while in the hospital - the patient may also be referred for pain management after discharge.

All patients will have their vital signs and pain level assessed every shift or per unit standards.

All patients will have their vital signs and pain level assessed at a minimum of every four (4) hours while on PCA.

Documentation of pain reassessment is documented as follows:
- 60 minutes post administration IV pain medication
- 60 minutes post administration oral and intramuscular pain medication

Don’t forget about non-pharmacologic interventions such as heat or cold, distraction techniques and relaxation techniques.
Forms are provided in the black boxes. You must chart all the information that you would normally chart in EPIC on paper.

Examples for inpatient RN’s to document on paper, during downtime:

- Vitals/Pain/Pain Re-assessments
- Physical Assessment/Wounds
- IV
- LDAs/I+O
- Daily Care
- Patient Education
- Critical Lab Values/Physician Phone Calls
- Admission completed? - if a new patient
- Code Status
- SBAR NOTE
How to Document on Paper!

• When documenting on paper REMEMBER:
  • Always sign your name at the bottom of the page
  • Always place a patient sticker on every page
  • Always date and time all entries
  • Always keep an up to date paper MAR of medication administrations
  • Keep all papers in that patient’s shell/shadow chart
  • All writing needs to be legible

• STAY ORGANIZED AND METHODICAL

• Please make sure no patient records go back into the black boxes!
Post Downtime Guidelines

• Downtime of less than four (4) hours - All information will be entered into the EHR when the “all clear” is announced and the system is returned to all users. A downtime note will be entered into the medical record for every patient that was admitted or treated during the downtime.

• Downtime greater than four (4) hours but less than 12 hours - All information will be scanned into the EHR by the HIM/Medical Records Department except for the following which nursing will enter into the EHR:
  • Allergies
  • Vital signs
  • Medication administration
  • Code status
  • Advance directive
  • Charges will be documented on charge capture

• Downtime greater than 12 hours - All information will be scanned into the EHR by the HIM/Medical Records Department except for the following which nursing will enter into the EHR:
  • Allergies
  • Code status
  • Advance directive
  • Charges will be documented on charge capture
1. Enter the “Notes” activity tab.

2. Type “downtime” into the smart phrase box and hit the enter key.

3. Select either the greater or the less than 4 hour downtime note.

4. When the paragraph appear F2 through and make your selections.
Blood Administration

Background Info:

• Approximately 14 million blood/blood component transfusions/year in US
• TJC mandates: blood transfusion protocol for patient safety because its considered a time-consuming & high-risk nursing task
• In July 2014, Martin Health System engaged in a patient blood management program
### Blood Component Types

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Red Blood Cells</strong></td>
<td>Prepared from whole blood by removal of most plasma; shelf life 35-42 days; Volume usually 325-350 ml per unit; Normally infused within 90-120 minutes and must be infused within 4 hours; On average 1 unit raises hemoglobin level by 1 g/dl</td>
</tr>
<tr>
<td><strong>Platelets</strong></td>
<td>Derived from whole blood and pooled at the blood center or collected from apheresis donations; shelf life 5 days; Volume 180-400ml; can be infused within 30 minutes; ABO-typing not required; Each unit can increase platelet count by 30-60 x 10⁹/L</td>
</tr>
<tr>
<td><strong>Plasma</strong></td>
<td>Frozen shelf life of 12 months; must be thawed to 37 degrees C before use (15-30 minutes); infuse within 5 days of thawing; Usually transfused at approx. 30 min/unit; contains multiple coagulation factors: used in factor deficiency, hemorrhage, liver disease, DIC, urgent reversal of warfarin anticoagulation</td>
</tr>
</tbody>
</table>
**Blood Component Types**

<table>
<thead>
<tr>
<th>Component</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cryoprecipitate</strong></td>
<td>Stored frozen for up to 12 months; Must be thawed (thawing takes 30-45 min); Must be transfused within 4 hours after thawing; 100-200ml (each unit =10 donors per pool); Can raise fibrinogen level by approximately 100 mg/dL; generally used in patients with hypofibrinogenemia at risk for hemorrhage</td>
</tr>
<tr>
<td><strong>Granulocytes</strong></td>
<td>Can only be stored for 24 hours; Typically administered in 1-2 hours; Volume varies; A unit of granulocytes contain red blood cells so must have ABO typing; febrile reactions common due to presence of leukocytes → usually irradiated in attempt to minimize occurrence of transfusion-associated graft-vs.-host disease Given to neutropenic patients with bacterial or fungal sepsis that is unresponsive to Antimicrobial therapy</td>
</tr>
</tbody>
</table>
General Overview of transfusion process:

AABB Guidelines

- **Equipment:** Y-tubing or standard tubing, mesh filter, pumps, in some instances- blood warmer (only when ordered) and rapid infusion devices (ICU, ER, OR, CVICU)
- **Special WBC filters are needed to leukocyte reduce at the bedside if this was not done at the blood center**
- **Needle-size:** preferably 20-gauge but even 24-gauge okay in peds or adults with small, inaccessible veins
- **Transfusion tubing limited to 2 units or 4 hours of use,** whichever comes first
- **For red blood cells,** start infusion at rate of 1-2 mL/min for first 15 minutes (equates to 60-120 ml), if no reactions, you may increase as rapidly as tolerated (or as directed by the physician) approximately 4mL/min or 240 mL/hr.
Process Standard

• **Informed Consent- once per admission**
• Type (ABO & Rh), Screen (antibody screen), Crossmatch (to donor unit) – renew every 72 hours
• Hang blood within **30-min of issue or return** to transfusion service; do NOT store in fridge on RN unit
• **Blood components may be administered by licensed clinical personnel who have completed the required initial and annual blood product training and education.**
• product information in presence of recipient
• Obtain VS: prior to administration, 15 min after the start of transfusion, prn, and at the completion of transfusion
Process Standard

• Patients should **not be transported** with blood components infusing unless accompanied by a clinician who can monitor and respond to a potential reaction. Additionally, the receiving area must have a clinician who can manage a patient while they are receiving blood components.

• Autologous- GREEN label designation- still needs type & cross match

• Platelets – **straight tubing comes up** from Blood Bank/transfusion service (No saline) infuse at 2-5 mL/min for the first 15 min then if no reaction, at 300 mL/hr or as fast as tolerated
Process Standard

• Plasma- ABO/Rh must be on file; infuse at 2-5 mL/min for the first 15 min then if no reaction, at 300 mL/hr or as fast as tolerated

• **On pump tubing**

• Cryo- ABO/Rh must be on file

• Transfusion service will notify floor if blood warmer needs to be used (or MD order)
  • Transfusion rate exceeds 100ml/minute
  • Severe cold agglutinin disease
Preparation

- **Equipment:**
  - Saline
  - Blood Administration Set
  - Data scope
  - Patent IV
  - Blood product request form

- **The Patient:**
  - Plan of Care
  - Informed Consent
  - Patient Education
  - **Discharge instructions must be provided if patient is transfused within 24 hours of discharge and on all outpatients**

- **Documentation:**
  - Informed Consent
  - Pre Transfusion
  - Vitals
  - Blood Admin Doc Flowsheet
  - Post transfusion

- **Communication:**
  - PCT
  - Clinical Coordinator/Relief Charge
  - MD
  - Transfusion Service
Verification

- Verification with 2 RNs, one of which is the qualified transfusionist who will administer the blood component
- Unit #, Expiration Date, Blood Type, and Rh factor
- Patient ID (name and date of birth), MRN# against EPIC and the actual blood product and the patient’s armband.
Required Documentation

Answer three questions

Pre Transfusion:
1. Previous Transfusion Reaction?
2. Pre-Meds Given?
3. Informed Consent Obtained?

Post Transfusion:
1. Changing the rate to “0” will stop the transfusion
2. Document your volume!!
3. Answer whether there was a reaction
Transfusion Reactions

- Important to know if patient has had previous reaction & notify MD (if 2 previous reactions a Leukocyte Reduction Filter will be issued by transfusion service for any subsequent transfusions)

- Which patient’s need the filters?
  - Immunocompromised pt’s
  - Organ-recipients
  - Bone Marrow recipients
  - Cancer Patients to prevent alloimmunization
  - Previous Transfusion Reaction Patients
  - Sickle Cell Patients
  - CMV negative patients

* C50 filters
Red Flags

- Coughing, respiratory distress, nausea, vomiting, tachycardia, hypotension, chest pain, rigors and loss of consciousness are symptoms of **circulatory overload**, **TRALI**, and **anaphylaxis**, any of which may progress rapidly to **cardiac arrest**.
- Nausea, vomiting, and/or diarrhea can occur during **hemolytic reaction**, **anaphylaxis**, or **sepsis**.
- Fever, chills, flushing, a feeling of warmth, headache, muscle pain, and nausea can indicate **hemolytic reaction**, **febrile non-hemolytic reaction**, **sepsis** or **TRALI**.
- Abdominal cramping, nausea, vomiting, and profound hypotension are additional signs of **sepsis**.
- **Cardiac dysrhythmias**, hypotension, and tingling may be caused by **hypocalcaemia**, which can develop when citrate (used as a preservative in some blood products such as plasma) combines with calcium in the patient’s blood.
Transfusion Reaction

• Actions to take: STOP TRANSFUSION
  • Patient: ABC’s- airway, breathing, circulation, obtain VS
  • Clerical check: verify patient identity against labels attached to blood product
  • Call MD/Rapid Response
  • Document in Blood Administration doc flow sheet
If yes to a reaction,

1. Discontinue transfusion
2. Notify Lab and Physician
3. Draw two lavender top tubes
4. Collect urine specimen if possible
5. Send specimens and the blood container (unit) with the blood administration set to transfusion services
6. Document in EMR
Transfusion Reaction - Treatment

• MD ORDER MAY INCLUDE:
  • IV steroids (Systemic), Pepcid (or antacid), Antihistamine (like Benadryl), sometimes Epinephrine
• IV Saline @ KVO(30 ml/hr)
  • NOT using the saline attached to blood!!!
• Supplemental O2 prn, VS q 15min, hypothermia blanket prn
• Transfer to ICU setting if needed
What is Patient Blood Management??

• In July 2014, Martin Health System (MHS) engaged in a patient blood management program.

• Patient Blood Management is the evidence-based multidisciplinary approach to optimizing the care of patients who may need a transfusion.

• In an effort to improve patient outcomes, PBM goals and objectives are the timely application of evidenced-based medical and surgical concepts designed to maintain hemoglobin concentration, optimize hemostasis and minimize blood loss.
PBM Consists of:

- Guidelines for Transfusion
  - Red Blood Cells, Platelets, Plasma, Cryoprecipitate
- Massive Transfusion Protocol (MTP)
  - Nursing may call blood bank Stat, only a physician may order a MTP
- Bloodless Medicine
  - Specific Instructions for those who refuse blood products, orange alert banner
- Patient Education
  - Handout prints with consent
- Transfusion Documentation Requirements
  - Vital Signs at start, 15 min after the start, and at end of transfusion (B/P, HR, RR, and Temp)
  - All requirements audited on regular basis by Blood Management Committee
Since the initiation of MHS’s PBM program in August 2014, there has been an overall reduction of 43% in the rate of transfusions.

The graph represents the number of transfusions given per the number of patient admissions.
Choosing Wisely Campaigns

Single Unit Transfusion Initiative to Reduce Unnecessary Transfusion of RBCs and Platelets

Don’t transfuse more units of blood than absolutely necessary.

Each unit of blood contains risks. A restrictive threshold (Hb < 8 g/dL) should be used for the vast majority of hospitalized, stable patients without evidence of inadequate tissue oxygenation (evidence supports a threshold of 6 g/dL in patients with pre-existing cardiovascular disease). Transfusion decisions should be influenced by symptoms and hemoglobin concentration. Single unit red cell transfusions should be the standard for non-bleeding, non-failed patients. Additional units should only be prescribed after reassessment of the patient and their hemoglobin values.

Don’t transfuse red blood cells for iron deficiency without hemodynamic instability.

Blood transfusion has become a routine medical response despite cheaper and safer alternatives in some settings. Pre-operative patients with iron deficiency and patients with chronic iron deficiency without hemodynamic instability (even with low hemoglobin levels) should be given oral and/or intravenous iron.

Don’t routinely use blood products to reverse warfarin.

Patients requiring reversal of warfarin can often be reversed with vitamin K alone. Prothrombin complex concentrates or plasma should only be used for patients with serious bleeding or requiring emergency surgery.

Don’t perform serial blood counts on clinically stable patients.

Transfusion of blood products should be based on the first laboratory value of the day unless the patient is bleeding or otherwise unstable. Multiple blood draws to check whether a patient’s hematocrit has fallen below the transfusion threshold (or unnecessary blood draws for other laboratory tests) can lead to excessive phlebotomy and unnecessary transfusions.

Don’t transfuse O negative blood except to O negative patients and in emergencies of women of child-bearing potential with unknown blood group.

O negative blood units are in chronic short supply due in part to overutilization for patients who are not O negative. O negative red blood cells should be restricted for: [1] O negative patients or [2] women of childbearing potential with unknown blood group who require emergency transfusion before blood group testing can be performed.
Immunization/Influenza (FLU) Vaccine
(starting September 15th ending March 31st)

- Patients can either choose to be vaccinated or refuse
- If a patient is unable to answer, please ask the family, or facility of origin as applicable
- If a patient is febrile, they will need to be re-screened prior to discharge
- Exceptions: There was documentation of an allergy/sensitivity to influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs OR is not likely to be effective because of bone marrow transplant within the past 6 months OR history of Guillain-Barre syndrome within 6 weeks after a previous influenza vaccination
- All patients aged 6 months or older will be screened by nursing & meet criteria
- If the patient prefers to wait until discharge to receive the vaccination, place a hold on the medication- do not cancel it on the MAR
- Give Vaccination Information Statements (VIS) to patient/caregiver prior to administering the flu vaccine and document it
Immunization/Influenza (FLU) Vaccine
(starting September 15th ending March 31st)

- Timeframe: outside FLU season

<table>
<thead>
<tr>
<th>Influenza Vaccine Screen</th>
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<tbody>
<tr>
<td>CURRENT FLU SEASON? Are dates between 09/15/2017 - 03/31/2018?</td>
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</table>

- Timeframe: during FLU Season

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<tr>
<td>CURRENT FLU SEASON? Are dates between 09/15/2017 - 03/31/2018?</td>
</tr>
<tr>
<td>Have you had an influenza vaccine YET THIS SEASON?</td>
</tr>
<tr>
<td>Patient or family DECLINED OR REFUSED flu vaccine?</td>
</tr>
<tr>
<td>Contraindications to giving Influenza Vaccine</td>
</tr>
<tr>
<td>Influenza Vaccine Indications</td>
</tr>
<tr>
<td>Patient to receive Influenza vaccine?</td>
</tr>
<tr>
<td>Patient/Family/Parent/Guardian given Influenza VIS Statement</td>
</tr>
</tbody>
</table>
Tobacco

• All patients 18 years & older will be screened for smoking and smokeless tobacco use upon admission
• Prior to discharge and at discharge, address nicotine replacement medications on everyday smokers and recently quit (within past 30 days) smokers
• Prior to discharge, offer outpatient tobacco cessation counseling to all patients who currently use tobacco in any form or who have recently quit
• **PC-01** Patients with elective vaginal deliveries or elective cesarean births at greater than or equal to 37 and less than 39 weeks of gestation completed, who are not in labor and have no history of prior uterine surgery (history of: classical C-section, myomectomy, perforation of uterus, uterine window or thinning defect, uterine rupture, cornual ectopic pregnancy, transabdominal cerclage, metroplasty and/or remove of vestigal horn requiring entry into uterine cavity)

• **PC-02** Patients with gestational age greater than or equal to 37 weeks but less than 39 weeks who are induced (not in labor) or have a planned C-Section will need a reason to justify early elective delivery (check with the scheduler for acceptable codes) or prior uterine surgery

• **PC-03** Patients at risk of preterm delivery at >=24 and <34 weeks gestation must have antenatal steroids addressed prior to delivering preterm newborns
Perinatal- Baby

• PC-04 Health Care-Associated Bloodstream Infections in Newborns (Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns)

• PC-05 Exclusive breast milk feeding during the newborn's entire hospitalization (exceptions: babies receiving critical care services admitted to the NICU, infants with galactosemia, or receiving parenteral nutrition)
VTE Prophylaxis (Mechanical and/or Pharmacological)

VTE Risk Assessment (Physician Responsibility)
1. Upon admission, the provider will conduct a VTE risk assessment using the VTE 3-Bucket Model that is presented to the provider in the BPA to determine if the patient is at low, medium or high risk for VTE.
2. The provider will select the appropriate mechanical and/or pharmacological prophylaxis based on the patient’s identified risk level.
3. If a patient is assessed to be low risk and no prophylaxis is ordered, a BPA will fire in 48 hours to prompt reassessment by the provider.

VTE Prophylaxis (Nursing and Physician responsibility)
1. The nurse must apply and/or administer VTE prophylaxis as prescribed and document the intervention(s) in the EHR following documentation guidelines.
2. The provider must be notified of a patient’s refusal of any prescribed prophylaxis, a confirmed DVT or if calf circumference (>26 inches) prohibits SCD application. Provider notification is documented in a note in the EHR
   • Upon notification, the provider may select alternative VTE prophylaxis as appropriate.
   • If no prophylaxis is ordered, the provider order must indicate the reason why.
3. Hospital approved protocol allows the pharmacist to adjust pharmacological prophylaxis based on renal function or other contraindications, with provider notification.

VTE Prophylaxis Contraindications: (Physician responsibility)
1. If the patient has a valid contraindication to pharmacological and/or mechanical VTE prophylaxis, the contraindication must be documented, by the provider, in the EHR using the allowable reasons given in the BPA.
2. Mechanical prophylaxis, if appropriate, is recommended when pharmacological prophylaxis is contraindicated.
3. A nurse may only document contraindicated when a valid “Contraindicated per physician order” has been entered in the EHR.
VTE Prophylaxis Documentation

- If physician does not want either Mechanical or Pharmacological VTE prophylaxis for his/her patient, they must have an order with a reason on why they are not ordering it in Epic.
  - **Reason for No Mechanical**
  - **Reason for No Pharmacological**
  - **Reason for No VTE Prophylaxis at Admission**

- If patient has an order for VTE Prophylaxis, RN must document in EPIC
  - Type of prophylaxis (TEDS or SCDs)
  - Type (SCDs- below knee, Knee TEDS, Entire leg TEDS)
  - Location (Bilateral, right lower extremity, left lower extremity)
  - OR Refused
  - A nurse may ONLY document contraindicated when a valid physician order has been entered in the EHR (as above).
STROKE (Hemorrhagic – INTRACEREBRAL Bleed OR SAH, Non-Traumatic)

• Can use ICB / Hemorrhagic standing Stroke Order Set
• Mechanical VTE Prophylaxis must be addressed by end of day 2 or documentation why not by MD/APN/PA (SCDs preferable, not TEDS alone)
• Hemorrhagic stroke education attached to AVS (auto-added at DC by EPIC)
• Medication reconciliation must match medication list printed on AVS for patients discharged home
• A member of the neuro-rehab (NRT) must see and document on the patient prior to discharge
STROKE (ISCHEMIC, TIA, R/O Stroke)

- Use TIA/STROKE- Non-thrombolytic standing Stroke Order Set
- VTE Prophylaxis (mechanical and/or pharmacological) must be addressed by end of day 2 or documentation why not by physician/APN/PA (not TEDS alone, not Heparin SQ alone)
- Anti-thrombotic must be given by the end of day 2 after arrival
- A member of the neuro-rehab team (NRT) must see the patient and document prior to discharge
- If patient has a history, remote history, or episode of ANY A-fib/flutter they will need to be discharged on an anti-coagulant or physician/APN/PA documentation why not
- Ischemic stroke specific education attached to AVS (auto-added at DC by EPIC)
- Must address anti-thrombotic at discharge
- Must address statin at discharge
- Medication reconciliation must match medication list printed on AVS for patients discharged home
# Sepsis and Septic Shock

## SEPSIS STEPS

### SEVERE SEPSIS*

- **SEPSIS AND ORGAN DYSFUNCTION**
- **Physician/APN/PA documentation of severe sepsis** (must all be met within 6 hours of each other)

*Time Zero starts when last criteria is met & starts 3 hour bundle

### SEPTIC SHOCK*

- **SEVERE SEPSIS AND PERSISTENT HYPOTENSION (SBP < 90/MAP < 65) 1 HOUR AFTER 30ml/kg BOLUS OR**
- **INITIAL LACTATE ≥ 4 OR**
  - **Physician/APN/PA documentation of septic shock (within 6 hours of severe sepsis)**

## CMS Sepsis Core Measure SEP -1

**INCLUDED**

- CMS Sepsis Core Measure SEP -1

**EXCLUDED**

- CMS Sepsis Core Measure SEP -1

### SIRS

- **Temp >100.9 OR <96.8**
- **Heart Rate >90**
- **Resp. Rate >20**
- **WBC >12 OR <4 OR 10% BANDS**

**SEPSIS**

- **Confirmed OR Suspected Infection**

**AND**

**2 OR MORE SIGNS OF SIRS**

*Starts 6 hour bundle - counting from TIME ZERO
Sepsis and Septic Shock

THE #1 QUESTION!

Does your patient have a new suspected or confirmed infection?

If NO STOP

CMS reporting requirements only apply to patients with SEVERE Sepsis or SEPTIC SHOCK!

If your patient doesn’t have an infection they can NOT have SEVERE Sepsis and if they don’t have SEVERE SEPSIS they can NOT be in SEPTIC SHOCK!
Severe Sepsis Criteria
Must be present within 6 hours of each other

Infection
- Documentation of infection or suspected infection
- Patient may already be taking antibiotics

SIRS criteria
- 2 or more
  - Temp >100.9 < 96.8 F
  - Heart Rate >90
  - Respiration >20 minute
  - WBC >12 or <4
  - or >10% bands

Organ Dysfunction
- Any 1 of the following
  - SBP <90 or MAP <65
  - Acute Resp failure requiring mechanical ventilation
  - Creat > 2.0
  - Total Bili >2
  - PLT <100
  - INR >1.5 or aPTT >60 sec
  - Lactate >2
Septic Shock Criteria

Severe Sepsis Present + Persistent Hypotension in the hour after fluid administration AEB 2 recordings = Septic Shock

OR

Documentation of Severe Sepsis present + Initial Lactate ≥4 = Septic Shock
When Severe Sepsis Criteria is met
OR physician (including extenders) document “Severe Sepsis/Septic Shock”
that is
TIME ZERO

Contact the Intensivist on duty, if none, call Hospitalist
What Happens After TIME ZERO?

3 Hour Bundle

- Administer broad spectrum antibiotics (AFTER blood cultures are draw)
- Administer 30ml/kg crystalloid BOLUS for SBP < 90 MAP < 65 or lactate > 4

6 Hour Bundle

- Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) ≥ 65 mmHg
- In the event of persistent hypotension after initial fluid administration (MAP < 65 mm Hg) or if initial lactate was ≥ 4 mmol/L, (Physician) re-assess volume status and tissue perfusion and document findings
- Re-measure lactate
We can all make a difference in fall prevention by.....

- Eliminating clutter in the patient’s room
- Implementing additional observation, if needed
- Leaving the room door open
- Providing adequate lighting
- Assisting the patient with transfers and ambulation
- Asking the patient about toileting needs every 2 (two) hours and PRN
- Offering distraction techniques if a patient is constantly trying to get out of bed.
  - Examples; folding a washcloth, playing music, provide a deck of cards or a puzzle.
Ask yourself these questions...

- Are the brakes locked?
- Upper side rails (X2) in up position?
- Bed in lowest position?
- Yellow non-skid socks on patient?
- Yellow fall sign on door?
- Fall Risk armband applied?
- Yellow room light on?
- Call bell and telephone within reach?
- Is the bed/chair alert on?
Bed / Chair Alert in Patient’s Room

- Bed / Chair Alerts are installed in all patient rooms.
- Please do not remove!
- All “FALL RISK” patient’s need to have bed/chair alerts set at all times!
What to Do When a Fall Occurs

• Patient care needs come first!
• Before moving patient, evaluate for injury
• Call Dr. Strong overhead. Ext 15741
• Notify supervisor / physician
• Complete occurrence report
• Include “lowered to floor or assisted fall”
• Document facts in patient record
• Complete post-fall huddle tool and fax to Risk Management
Sitter Protocol

• The need for a sitter, the selection of the most appropriate type of sitter and distribution of available resources is determined at the discretion of the physician, nurse or house supervisor.

• Situations that may justify the use of a sitter include, but are not limited, to the following:
  - Fall prevention
  - Elopement
  - Safety of tubes/lines
  - Alcohol/drug withdrawal or diversion
  - Aggressive/violent behavior
Sitter Protocol

The following situations require the use of a direct observer (sitter at bedside or in the room with the patient):

- Patients assessed to be at risk for suicide or self-harm.
- Patients at risk for harming others.
- Tele-Sitter monitoring has failed as evidenced by the following:
  - Numerous re-directions in a short amount of time that interferes with patient’s care
  - Activation of the STAT alert alarm more than three (3) times in 30 minutes
  - Ineffective re-direction:
    - Patient continues to pull at lines or tries to get out of bed resulting in numerous redirection attempts or calls to clinical staff for intervention
    - Patients’ speech, hearing or vision impairments does not allow the TST to re-direct the patient
Sitter Protocol

When sitting with a patient the following rules must be followed...

- Associate’s personal belongings cannot be in the room, please place in lockers or other designated area
- No electronics, including cellphones are permitted in the patient’s room
- Sitter should sit between the patient and the door
- No sleeping allowed
- No homework or activities not related to patient care allowed
- Blankets are not to be used for associate’s comfort
The Patient ID barcode is the CSN number found on the patient’s wrist band and this is the ONLY acceptable number to use unless you have a non-registered patient in the ER or a newborn. Do not use any other barcodes. If the wristband is not scanning, please reprint and report the error to the POC office EXT. 11324.
The non-registered patient forms used in the ER and Mother-Baby MUST filled out completely and RETURNED to point of care office by fax (15992) or interoffice mail. If they aren’t returned, I-Reports will be submitted.
• Once opened, the control solution can be used for up to three (3) months. After opening a new vial of controls, write the expiration date on the vial. This date will be either three (3) months from opening, or the date printed on the vial, which ever comes first.

• You should also check unopened vials for their expiration date before using.

• Labeled QC is distributed by the lab every three (3) months.
• **You must clean meters between patients.**
  
  When the meter needs cleaning and disinfecting, put on a new pair of gloves, then remove the meter from the base unit. Turn off the meter, and lay it on a flat surface.

• To clean, simply wipe the unit making sure not to get any liquid in the test strip port.

• To disinfect, wipe the outside of the meter three (3) times horizontally and then three (3) times vertically and carefully wipe around the test strip port area, making sure that no liquid enters the test strip port.

• Allow the solution to remain damp on the meter for the appropriate amount of time, according to the disinfection solution product labeling.
- Federally designated Organ Procurement Organization (OPO) that works with your hospital to facilitate organ donation
- Certified by Centers for Medicare and Medicaid Services (CMS) Agency for Healthcare Administration (AHCA) and Association of Organ Procurement Organization (AOPO)
- Works Collaboratively with Lions Eye Institute for the recovery of eyes and corneas
- Works with the local transplant centers, Tampa General Hospital, Gulf Coast Medical Center, Largo Medical Center, and John’s Hopkins All Children’s Hospital
CMS Regulations (Ruling 42 CFR Part 482)

- Hospital provides timely notification to LifeLink for every imminent or cardio-respiratory death
- OPO determines medical suitability
- OPO, as the trained requestor, discusses donation with the family *(MHS associates should not approach families for consent)*
- OPO operates in accordance with HIPAA regulations
Call **Life Link** at 1-800-64-donor (36667)
• Refer all cardiac deaths to LifeLink/Lions
• Call within an hour of death
• Have chart available
• LifeLink/Lions determines medical suitability and contacts next-of-kin or healthcare surrogate via phone
• LifeLink obtains authorization for tissue donation and medical/social history
• Decedent is released to LifeLink Tissue Bank, where tissues are recovered within 24 hours after time of death
• It is important healthcare providers show respect to the patient’s and/or family’s beliefs when it comes to organ donation
• Healthcare providers need to show support for the families going through this traumatic time.
• Show compassion and caring and be flexible with the interactions with the family
• Provide the family with privacy
• As healthcare providers, we have one of the greatest impacts on patient- and family-centered care at MHS
Metabolic and Bariatric Surgery Program at MHS

Why do patients have weight loss surgery?

• Only 2% of patients are able to achieve and sustain weight loss over 5 years with diet and exercise alone.

• With surgical options - Average 50-75% excess weight loss

• Medical co-morbidities resolved or improved
Procedures Performed at MHS

- Sleeve Gastrectomy
- Gastric Bypass
Potential Risks with Bariatric Surgery

- Death (less than 0.5%)
- Pulmonary Embolus
- Deep Vein Thrombosis
- Leaks
- Bleeding
- GERD
- Strictures

- Bowel Obstruction
- Hernias
- Vitamin/mineral deficiency
- Dumping Syndrome
- Weight Regain
- Ulcers
<table>
<thead>
<tr>
<th>Complication</th>
<th>Signs and Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE</td>
<td>Dyspnea, Tachypnea, Pain in the chest/back/shoulder, Pleuritic pain, Hemoptysis or Cardiac Arrhythmia</td>
</tr>
<tr>
<td>DVT</td>
<td>Redness/heat/swelling/pain of extremity, Decreased pedal pulses or Doppler study</td>
</tr>
<tr>
<td>Sepsis</td>
<td>Tachycardia, Hyperventilation, Fever or hypothermia, chills, shaking, hypotension, confusion or abnormal WBC (high or low)</td>
</tr>
<tr>
<td>Wound infection</td>
<td>Redness, pain, heat, swelling or purulent/foul drainage from incision</td>
</tr>
<tr>
<td>Herniation</td>
<td>Heartburn or bitter/sour taste in mouth</td>
</tr>
<tr>
<td>GI leak</td>
<td>Tachycardia, Tachypnea, Fever, “Sense of doom”, Pain, Oliguria, Hiccups and Swollen or painful legs</td>
</tr>
</tbody>
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# Post-Surgical Complication Signs and Symptoms

<table>
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<td>PE</td>
<td>Dyspnea, Tachypnea, Pain in the chest/back/shoulder, Pleuritic pain, Hemothysis or Cardiac Arrhythmia</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Fever, Increased sputum production, cough, respiratory distress, positive sputum culture or positive chest x-ray</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>Weak rapid pulse, slow and shallow breathing, cold/clammy skin, excessive bleeding from incision or excessive drain output – frank blood</td>
</tr>
<tr>
<td>Pickwickian Syndrome</td>
<td>Hypoventilation, prolonged drowsiness, twitching, cyanosis, periodic breathing, secondary polycythemia or right sided heart failure</td>
</tr>
<tr>
<td>Stricture</td>
<td>Nausea, vomiting, severe abdominal pain, may mimic gallbladder disease</td>
</tr>
<tr>
<td>Ulcers</td>
<td>Nausea, vomiting, slight tachycardia and dyspnea, decrease hemoglobin or melena</td>
</tr>
<tr>
<td>Bowel Obstruction/Stenosis</td>
<td>Abdominal pain, distension or decreased bowel sounds</td>
</tr>
</tbody>
</table>
Caring for the Bariatric Patient

- Early Ambulation – OOB same day as surgery!
- Nausea & Vomiting
- Pain Control
- Monitor Intake and Output
- PO Medications
- Wound Care

- Incentive Spirometer
- PO Fluids
- Patients can sip water right after surgery
- Bariatric Nurse will round on patient daily
- DVT Prevention
  - SCDs
  - Lovenox
Assessment of a Threatening Situation

• If you have a situation that is escalating and/or a patient may or becomes violent;
  
  • dial 15741 and state to operator “Dr. Strong for room ###”
  
  • use a panic alarm, if available.
  
  • Dr. Strong will be paged overhead three (3) times. Security officers, Nursing Supervisor, Nursing Director, (1) Respiratory Therapist, (1) Physical Therapist will respond to the designated area.
  
• Those not involved in the “Dr. Strong” will be responsible for clearing the area of other patients and/or visitors. Typically the more people added to a room/area the more a person will feel like they need to defend themselves. (Fight or Flight Response)
Talking to a Hostile Person

**Tips to Remember for De-Escalation...**

- Never block the exit.
- Never allow someone to block your exit from a room.
- Always have an egress door quickly available if needed.
- Position yourself in the room between the person and the door to allow for easy exiting if needed.
- Speak in a soft and slow manner.
- Stand facing them but never stand square in front of them, angle your body, so if they charge, you can move out of the way.
- Keep your hands open and in front of you when speaking, do not make a fist.
- Try not to intimidate the hostile person in any way.
Tips for Dealing with Hostility

- Stay calm, people can sense when you are scared
- Do not make threats
- Explain information and procedures to the person (may require repeating information in multiple different ways)
- Never say “I give up”
- Never turn your back to an aggressive person
- If the patient is confused, ask the family to come in to help re-orient and make them feel safe
- Every patient is different. Assess the triggers for anger/outbursts and try to avoid them, if possible
- Stay SAFE!
Our Mission, Vision, and Values drive everything. They outline a way of life at work that will help you and MHS be successful. Let the mission, vision, and values become part of your actions each and every day.
Our Mission is our reason for being. It is why we do what we do.

Mission:
“To provide exceptional health care, hope and compassion to every person, every time.”
Our Vision is what we set out to achieve.

Vision:
“To be an innovative healthcare system nationally recognized for clinical excellence and improving the health and well-being of the communities we serve.”
Our Values are how we behave.

I
Innovation
C
Collaboration
A
Accountability
R
Respect
E
Excellence

Vision
Mission
Summary

They are connected.
We cannot achieve one without the other.

Vision: “An innovative healthcare system nationally recognized for clinical excellence and improving the health and well-being of the communities we serve.”

Mission: “To provide exceptional health care, hope and compassion to every person, every time.”
The purpose of The Code of Conduct is to make sure that MHS meets the highest standards of excellence both legally and ethically. It is everyone’s responsibility to make sure that the principles outlined in The Code of Conduct are upheld.
A Patient’s Experience is their perception of all interactions with Associates, Physicians and Volunteers as they progress through their continuum of care.

Creating a positive patient experience is the responsibility of EVERYONE because every touch point makes a difference.

In every interaction, our goal is to create peace of mind for the Patient and family members.
• Every person wearing a Martin Health System name badge that a patient sees in their room or walking in the hallway adds to their perception (+ or -) of the experience.

• **You** make a difference irrespective of your job role.
Our Service Promise is the way that we bring our mission, vision and values to life every day.

Together we create peace of mind through exceptional, personalized, compassionate care, always.

Created by us and our patients for us and our patients
Human Business Human

- To create peace of mind, we make a human connection at the beginning of every interaction. This includes in person, on the phone and even in email. A simple good morning or good afternoon will work.

- Then we conduct our business with expertise and efficiency.

- Wrap up any interaction with another human connection such as a fond farewell.
Graffiti is defined as anything that distracts or detracts from the intended ideal patient and family experience.

We work constantly to eliminate the things our patients see, feel and hear that do not create peace of mind.
In our patient driven Operational Priorities, our patients want us to provide care in this order:

- **Safety & Quality**
- **Compassion**
- **Expertise**
- **Efficiency**

We want to use all four of these in harmony to provide **peace of mind**. When there are conflicting priorities, use this order to make decisions.
On the Spot Recognition

When you see someone creating **peace of mind** for patients or for our team, recognize them with a **Caring on the Spot** card. Simply fill out the card and hand it to the person you want to recognize!
The HEART Model

• Everyone is empowered to perform Service Recovery.

• Utilizing the HEART Model will ensure a positive outcome, not only for the patient, but also for the person performing Service Recovery.

**Service Recovery from the HEART**

**H - Hear** the patient
Listen actively. Re-state the situation to be sure you've heard everything. Paraphrase if necessary.

**E - Empathize** with the patient
Focus on the human or emotional side of the interaction. You should be as concerned as they are upset.

When a patient, customer or colleague is angry, showing them little or no emotion (in an attempt to remain calm) will only make them angrier. Instead, say, “I can understand why you are upset.” (Don’t tell them to “just calm down.”)

**A - Apologize**
It is OK to be sincerely sorry for the situation without accepting specific blame or fault. Remember, you should be sincerely sorry that the patient is upset, regardless of whether the problem is real or perceived, our fault or not.

**R - Respond** to the problem
Bottom line: if possible, try to fix it. Provide whatever was rightfully expected in the first place. If there is a misunderstanding, provide information.

If you are unable to do what is expected, explain why, and what you will do to get someone who can fix the problem.

**T - Thank** the patient
Remember, most people don’t complain. Instead, they just leave and tell others about their negative experience. A complaint is an opportunity to make it right.

Say, “Again, I am very sorry that happened to you, and thank you for telling us. Now we can work to make it better and hopefully prevent this from happening to anyone else.”

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MARTIN HEALTH SYSTEM

Together we create peace of mind through exceptional, personalized, compassionate care, always!
If you cannot resolve a problem

• If you cannot resolve a problem, then get help immediately by talking to your leader.

• Discuss solutions and agree on best action to solve the problem

• Follow up to make sure the customer is satisfied with the resolution. It is essential that we always follow through with what we have promised.
Ways to Provide Excellent Service

The Martin Health Way tips:

• Create **peace of mind** in every interaction.

• Greet people in a **warm and friendly manner**, in the halls and elsewhere; gain **eye contact** and **smile**.

• Give people **sincere care and concern**, which establishes trust and loyalty.

• **Ask how you can help**.

• **Listen with empathy**.

• **Walk with visitors** to help them find their destination or further assistance.
What is HCAHPS?

- HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems
- HCAHPS is a national, standardized publicly reported survey of patients’ perspectives of hospital care. It can be administered to patients’ from 48 hours to 6 weeks after discharge.
- HCAHPS measures key aspects of the patient experience via a survey sent out to our patients by a third party vendor (Press Ganey).
- The survey is nationally standardized and conducted by an outside agency. The results are publicly reported, available for all to see.
What our scores mean for **Our mission**
- These HCAHPS measurements are a great way to see how we are reaching our mission ‘to provide exceptional healthcare, hope, and compassion to every person, every time’.

What our scores mean for **Our facilities**
- The survey provides us with feedback, helping us to continuously improve
- We can see how we are performing in relation to other providers.
- High scores show positive patient experience of care. Positive patient experience can lead to fewer re-admissions, which is good for the patients!
The HCAHPS survey asks patients how well and how often we responded to their needs:

- Never
- Sometimes
- Usually
- Always

Ultimately, it is asking how we made them feel!
What the HCAHPS Survey Measures

- Nursing Communication
- Doctor Communication
- Responsiveness of Staff
- Communication About Medication
- Pain Management
- Cleanliness of Room and Bathroom
- Quiet Around Room
- Discharge Information
- Overall Rating of Hospital, Scale 0 to 10

It all comes down to...
Willingness to Recommend to Others
Our Patients, their families and visitors along with our colleagues come from a diverse range of cultures.

Diversity is about acceptance, understanding and respect in a safe, positive and nurturing environment. Diversity includes the various scopes of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, generations or other principles.

We aim to be inclusive in all our interactions. Your awareness, understanding and respect for cultural differences will help you provide exceptional health care, hope and compassion, every person, every time.
Here are some areas of potential cultural differences. Considering these areas can help you make sure that you are meeting needs respectfully.

People have
- Different accents
- Different languages
- Different rules relating to eye contact
- Different personal space boundaries
- Different roles of who make the decisions in the family
- Different on devoting time to come for follow-up care
- Different health focuses
- Different healthcare resources
- Different beliefs

Awareness of cultural backgrounds helps us to provide respectful, competent, and appropriate care to every person, every time.

Cultural sensitivity helps limit judgment of others

If you are unfamiliar with someone’s culture, ask them to help you understand what would be helpful to know when providing care to them and their family.
The top 3 causes of death in the US are
- Cancer
- Heart disease
- Preventable medical errors

Preventable medical errors cause 1,000 deaths per day. This could be compared to two 747 planes crashing per day.

Medical errors are a huge concern and even the best person can make mistakes, but it is important to always try to prevent medical errors.

*July 2014: Tejal Gandhi, MD, president of the National Patient Safety Foundation and associate professor of medicine, Harvard Medical School, Senate hearing, Washington DC*
Some actions that you can take to prevent medical errors are to:

- **Check Identifiers** (name and date of birth)
- **Slow down** and do not multi-task when you are doing something important (Do not rush so much that you are not paying attention)
- **Think** about what you are doing to **verify** that it is correct
- Regularly **verify** that the system or process is working correctly
- **Verify** e-mails, phone numbers, and fax numbers
- **Follow protocol and policies** (If you think there is a better way, then tell your leader about your idea. Do NOT just start doing something differently.)

For additional information:

→ National Quality Forum website
1. Identify patients correctly
2. Improve staff communication
3. Use medicines safely
4. Use alarms safely
5. Prevent infection
6. Identify patient safety risks
7. Prevent mistakes in surgery
To avoid errors such as wrong information, wrong treatment etc., correct patient identification is extremely important.

We use 2 identifiers to cross check

- name and date of birth.

**A 2-step method for checking is conducted for every patient, every time!**

1. Ask patients to state their full name and date of birth
2. Verify by checking the patient’s armband
• **Be aware of what is going on around you!**
  – If you don’t know or understand what is going on, then ask
  – If you hear or see something that you think needs to be addressed, please notify someone. Remember, voicing a concern is done out of care for others. You can notify:
    ▪ Your chain of command
    ▪ The person in charge in the location that the situation occurred
    ▪ Compliance Hotline 877-785-0002
    ▪ Corporate Compliance
    ▪ Risk Management
    ▪ Patient Experience
  – For example, if you see a patient doing something that you do not think is normal then communicate with someone to address it.

**Contact Information:**
- Compliance Hotline 877-785-0002
- Compliance Department at ext. 11983
- Compliance Officer at ext. 13957
- Risk Management at ext. 15899
- Patient Experience 771-223-4995
Positive Communication

• Healthy Groups that foster a culture of positive communication will:
  – Demonstrate a willingness to work through conflict rather than avoid it
  – Demonstrate a willingness to listen and pay attention to one another
  – Focus efforts on addressing one topic of discussion at a time
  – Help members feel comfortable in sharing thoughts & ideas
  – State decisions clearly so that all members can understand the outcomes
  – Provide avenues for feedback
  – Maintain consistent communication processes to help the group stay focused on its goals
Tips for Listening

• Tips for listening
  – Conversations means talking ‘with’, NOT ‘at’ someone
  – Keep yourself fully engaged
  – Ask yourself, have you ever felt this way, did someone listen to you?
  – Focus on what is being said, not on what you want to say
  – Value listening more highly than speaking
  – If you don’t agree or understand – let the speaker know why, be open to differences
  – Clarify feelings
  – Remember, people also communicate with tone of voice and facial expressions
  – Be aware of your body language
Tips for non-verbal communication

– Don’t assume a frown means someone disagrees with you – they may be thinking really hard
– People look to the eyes for how you really think and feel
– Your face is one of the most obvious indicators of your attitude and feelings
Check for Understanding

• When communicating with others, it is your responsibility to ensure that the message you send is received and clearly understood.
• You can do this by asking for a repeat back, and follow up with questions to check understanding.
Ticket to Ride

• Staff also communicate about where a patient is coming from and is headed to through a Ticket to Ride

• A Ticket to Ride ensures continuous care when transporting a patient from one department/diagnostic area to another.

• When patients travel between departments they should have a **TICKET TO RIDE**.
  – A nurse should initially fill out the *Ticket to Ride*
  – The Ticket to Ride has important patient information to keep patients safe
A rapid response (RR) is a way of calling for immediate help for a patient with a deteriorating condition.

It allows anyone to call for a specialty team to examine a patient at the first sign of decline to initiate immediate interventions that will improve the patient’s outcome.

The Rapid Response Team (RRT) is a team of ACLS trained clinicians who bring critical care expertise to the patient wherever it is needed. Their response time is within 5 minutes.
The Importance of Rapid Response

• Why do we need it?
  – It can reduce death rates in hospitalized patients.
  – You may see someone in a bad condition and it is crucial that you are aware of your ability and responsibility to call a Rapid Response.
  – A Rapid Response can help prevent Code Blues! Patients who experience code blues in hospitals often have observable signs 6-8 hours before the arrest occurs
    ▪ Once a patient codes, their survival rate greatly decreases.
    ▪ Early recognition of these signs and quick treatment can reduce the number of code blues
Who can call a Rapid Response?

• **ANYONE** can call a rapid response, including:
  – Family Member
  – Patient
  – Any staff member

• All associates, patients, and visitors are **required** to receive information on how to call a Rapid Response.
  – The information is located in the patient guide. It is reviewed with patients and their visitors upon admission.
Calling a Rapid Response

• A Rapid Response/Medical Emergency can only be called when you are at:
  – One of our 3 hospital locations
  – St. Lucie West campus

• If you are not in one of these locations, then call 911.

• Do NOT call the house supervisor directly
  – The emergent situation may not be attended to immediately because the house supervisor receives a large number of calls.
Steps to Calling a Rapid Response

1. Call the Command Center’s Medical Emergency Line ext. 14444 or 44444
   
   If the phone system is down, (ex: because of a disaster or power failure) use the Beige Emergency Phone (BEP) and dial 221-7738

2. Request a “Rapid Response” to the location (ex: patient room and bed number)

3. Remain with the patient until the Rapid Response Team (RRT) arrives

4. Provide the RRT with any information related to why you called the RR
Medical Equipment Alarms

- No matter your job role, if you hear an alarm sounding from medical equipment, you have a responsibility to respond.
- Promptly responding to alarms can save lives.
- Let your leader/team know if you have any ideas that could help
- Ensure that medical equipment and alarms are heard

**Alarms serve a purpose.** They notify us that something is wrong, even though they create noise and can be seen as annoying.

Do NOT ever do the following
- Disable alarms
- Disconnect alarms
- Ignore alarms
- Silence alarms
Below is a guide to help you take the **correct** action every time you hear an alarm.

<table>
<thead>
<tr>
<th>Do you know why the alarm is sounding?</th>
<th>Do you use this equipment to do your job AND know the appropriate response to the alarm?</th>
<th>Then you should...</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
<td>Respond and address the alarm</td>
</tr>
<tr>
<td>NO</td>
<td>NO</td>
<td>Notify the person in charge in that area about the alarm</td>
</tr>
</tbody>
</table>
Did you know that every 60 seconds, a working adult can touch as many as 30 items? That’s 1,800 items per hour!

**Hot zones** are areas/items where bacteria and viruses build up. This is because they are the items touched more often.

The top Hot Zones in Hospitals are:
- Door knobs
- Restroom lights
- Computers
- Stethoscopes
- Bedrails
- Telephones
- Keyboards
The green X marks in this picture show areas of risk for hand and glove contamination after contact with a VRE-positive patient.
Hand washing is the #1 way to stop the spread of illness and disease!

Correct hand hygiene reduces transmission of harmful organisms and reduces overall infection rates.
It is our duty to wash our hands to stop the spread of bacteria. There are hand washing requirements to make sure that everyone is properly protecting patients and associates from infection.

Hand washing is required **before** and **after**:

- Each time you provide patient care- for every patient, every time
- Have contact with the patient’s environment
- When using gloves for any purpose
- Using equipment including computers and telephone
- Visiting the bathroom
- Transporting a patient
- Preparing /serving food
- Removing waste or debris

*This Standard Precaution is always warranted for every patient, whether or not on contact isolation.*
5 Moments for Hand Hygiene

1. BEFORE PATIENT CONTACT
2. BEFORE ASEPTIC TASK
3. AFTER BODY FLUID EXPOSURE RISK
4. AFTER PATIENT CONTACT
5. AFTER CONTACT WITH PATIENT SURROUNDINGS
### Soap and Water vs. Alcohol-based Hand Sanitizer

<table>
<thead>
<tr>
<th>Use soap and water to wash:</th>
<th>Use an alcohol-based hand sanitizer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When hands are visibly soiled</td>
<td>• Before direct patient contact</td>
</tr>
<tr>
<td>• After handling</td>
<td>• After contact with</td>
</tr>
<tr>
<td>– Infectious materials (such as blood or body fluids)</td>
<td>– Patient’s skin</td>
</tr>
<tr>
<td>– Patients with diarrhea</td>
<td>– Body fluids</td>
</tr>
<tr>
<td>• When preparing and handling food</td>
<td>– Wounds</td>
</tr>
<tr>
<td></td>
<td>– Broken skin</td>
</tr>
<tr>
<td></td>
<td>– Equipment or furniture near patient</td>
</tr>
<tr>
<td></td>
<td>• After removing gloves</td>
</tr>
</tbody>
</table>
Kill/Dwell Times for Cleaning Wipes

**Kill/Dwell time** is the amount of time a surface must remain wet for a product to effectively kill all microorganisms present.

<table>
<thead>
<tr>
<th></th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Wipe</strong></td>
<td>Used on surfaces and objects to thoroughly clean off</td>
</tr>
<tr>
<td></td>
<td>• Heavy soil</td>
</tr>
<tr>
<td></td>
<td>• Blood</td>
</tr>
<tr>
<td></td>
<td>• Bodily fluid from surfaces or objects, if present.</td>
</tr>
<tr>
<td><strong>Additional Wipes</strong></td>
<td>Used to disinfect</td>
</tr>
<tr>
<td></td>
<td>• Make sure to use appropriate kill time and friction.</td>
</tr>
</tbody>
</table>
# Top Kill/Dwell Time

<table>
<thead>
<tr>
<th>Color of wipes</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purple</td>
<td>• 2 minute wet time</td>
</tr>
<tr>
<td></td>
<td>• Allow to air dry</td>
</tr>
<tr>
<td>Orange</td>
<td>• 4 minute wet time</td>
</tr>
<tr>
<td></td>
<td>• Allow to air dry</td>
</tr>
<tr>
<td></td>
<td>• Bleach wipes for C. diff*</td>
</tr>
</tbody>
</table>

*C. Diff is an extremely dangerous and infectious bacteria.*
Hand Washing and Gloves

- Gloves only reduce contamination and bacterial transmission by 70-80%
- If you wear gloves, you still **must** wash your hands after removing the gloves.
Gloves

Use gloves when touching:

- Blood
- Body fluids
- Secretions
- Excretions
- Contaminated items
- Mucous membranes
- Non-intact skin

*This is a Standard Precaution and is always warranted for every patient, whether or not on contact isolation.*
Mask/eye protection is required when procedures and/or activities are likely to produce splashes or sprays of blood and/or bodily fluids.

• Protects:
  – Eyes
  – Nose
  – Mouth

*This is a Standard Precautions and is always warranted for every patient, whether or not on contact isolation.
Gowns

Gowns are required when procedures and/or activities are likely to produce splashes.

• Protects
  – Skin
  – Clothing

*This is a Standard Precautions and is always warranted for every patient, whether or not on contact isolation.
• Follow isolation policy to prevent transmission of micro-organisms between patients
• Isolation signs are used to tell what type of personal protective equipment is required and what precautions need to be taken when entering a patient’s room. Below are some examples.
<table>
<thead>
<tr>
<th>Sign Color</th>
<th>Isolation Type</th>
<th>Required Personal Protective Equipment</th>
</tr>
</thead>
</table>
| Red*       | Contact Isolation | • Gown  
• Gloves |
| Orange*    | Contact Isolation | Used for C. diff **only  
• Gowns  
• Gloves  
• Strict hand washing with soap and water only, Purell gel is not effective against C. diff spores  
• Bleach cleaning only with Orange top wipes |
| Blue       | Airborne         | • Gown  
• Gloves  
• N95 mask |
| Green      | Neutropenic      | • Gown  
• Gloves  
• Surgical mask |
| Lime Green | Contact/ Droplet | • Gown  
• Gloves  
• Surgical mask |

*Red and Orange signs are often interchanged because both are contact isolation, but it is important to not interchange them to prevent cross contamination due to incorrect hand hygiene and cleaning after patient contact. Think Cdiff...Orange wipes, orange sign.

**C. Diff is an extremely dangerous and infectious bacteria.
What is the Flu?

• Flu (Influenza) is
  – Very contagious
  – A respiratory disease
  – Can cause serious complications, hospitalization, or death

• How is it spread?
  – By droplets from coughing and sneezing
  – By touching contaminated surfaces

• Do **NOT** come to work if you are exhibiting flu like symptoms
Getting Your Flu Vaccine

• You are **required** to:
  – Get a Flu Vaccine annually → You will get an identifier for your ID badge
    OR
  – Sign a Waiver to not get the Flu Vaccine → You **must** wear a mask in **all** patient care areas

• How to get your vaccine:
  – Get your flu shot annually as soon as it is available (usually August or September).
  – Occupational Health will give you a free flu shot at this time.
• Examples of suicide risk factors include:
  – Previously attempted suicide
  – Suicidal thoughts or behaviors
  – Family history of suicide or psychiatric illness
  – Currently taking antidepressants
  – Physical health problems, delirium or dementia, chronic or acute pain with poor prognosis
  – Social stressors (ex: divorce, financial, employment or relationship)
Suicide warning signs include:

– Irritability, Anxiety, Agitation, Impulsivity
– Decreased emotional reactivity
– Unrelenting pain
– Crying spells
– Declining medications
– Request of early discharge
– Hopelessness or helplessness
– Decreased interest in treatment or prognosis
– Feelings of worthlessness
– Refusal to eat
Suicide Precautions

• Ensure the suicidal patients have appropriate safety precautions in place
  – Sitter
  – Personal items removed
  – Ligature assessment performed and risks mitigated
• Pay attention to patients, associates, and visitors. If you feel someone is a suicide risk, then stay with them and call Command Center (ext. 15741).
  – Notify the nurse if applicable
  – RNs need to complete the Suicide Risk Assessment on Epic.

Contact Information:
→ Command Center at ext. 15741
→ Suicide Risk Policy
Patient Falls

• Falls can lead to more injuries or be fatal; however, patient falls can be preventable.
• We want to heal people who come into our facilities, not cause them more injuries.

  – RNs need to fill out the Fall Risk Assessment using the Hendrich Fall Assessment tool which identifies those at risk every shift and after any falls or changes in their condition.
  – Interventions may include the use of sitters at the bedside or telesitters.

• Move tripping hazards out of the way and be alert for signs that indicate that a patient is a fall risk.
Identify Patients that are a Fall Risk

• To identify patients that are a fall risk, look for:
  – Signs over patient bed
  – Yellow:
    ▪ “fall risk” patient armbands
    ▪ light over room door
    ▪ slipper socks

• Listen for bed and chair alerts
  – Respond as quickly as possible

• Patients travel throughout the hospital. These identifiers are a great visual and auditory indication that these people are at risk.
  – For example, if you see someone with yellow slipper socks going down the hallway by themselves, then you know that they are at an increased risk for falling. In such a situation you should call for assistance and stay with the patient until assistance arrives.
# Types of Abuse and Vulnerable groups

<table>
<thead>
<tr>
<th>Abuse can be:</th>
<th>Who might be abused?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Children</td>
</tr>
<tr>
<td>Psychological or Emotional</td>
<td>Adults</td>
</tr>
<tr>
<td>Sexual</td>
<td>Disabled</td>
</tr>
<tr>
<td>Neglect</td>
<td>Patients</td>
</tr>
<tr>
<td>Financial</td>
<td>Co-workers</td>
</tr>
<tr>
<td></td>
<td>Friends</td>
</tr>
<tr>
<td></td>
<td>Family</td>
</tr>
<tr>
<td></td>
<td>...anyone</td>
</tr>
</tbody>
</table>
# Signs of Abuse

<table>
<thead>
<tr>
<th>Signs of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poor eye contact</td>
</tr>
<tr>
<td>• Wary of physical contact</td>
</tr>
<tr>
<td>• Unusually quiet, withdrawn or tearful</td>
</tr>
<tr>
<td>• Hesitant to discuss nature or circumstances of injury</td>
</tr>
<tr>
<td>• Unusual nervousness, anxiety, self-blaming, or feelings of being undeserving</td>
</tr>
<tr>
<td>• Patient’s spouse/caregiver being reluctant to allow the patient to be interviewed alone</td>
</tr>
<tr>
<td>• Fear of a particular person</td>
</tr>
<tr>
<td>• Seems withdrawn or depressed</td>
</tr>
<tr>
<td>• Sudden weight change</td>
</tr>
<tr>
<td>• Shy away from physical contact</td>
</tr>
<tr>
<td>• Ran away from home</td>
</tr>
<tr>
<td>• Unexplained bruises</td>
</tr>
<tr>
<td>• Unusual burn</td>
</tr>
<tr>
<td>• Head injuries in very young infants/children</td>
</tr>
<tr>
<td>• Head or facial injuries, black eye, bruised cheek bones, suspicious marks on throat</td>
</tr>
<tr>
<td>• Abdominal injuries</td>
</tr>
<tr>
<td>• Suspicious fractures</td>
</tr>
</tbody>
</table>
Examples of neglect include:

- Not providing adequate
  - Nutrition
  - Hygiene
  - Clothing
  - Shelter
  - Access to necessary health care
- Failing to prevent exposure to unsafe activities and environments.
Your Responsibility to Act

If you suspect immediate danger:
Call Command Center ext. 15741 (or 911 if you are not at one of the main hospitals)

Non-Clinical Associates

- If you see a person (patient, associate, visitor, etc.) who shows signs of abuse or neglect, then communicate your concerns either to your leader or the person in charge of the area.

Clinical Associates

- If you admit, examine, or treat people then you must report any actual or suspected case of abuse of a child, elderly person, or disabled person. You must report to the Department of Children and Families Abuse Registry (1-800-962-2873) or online at https://reportabuse.dcf.state.fl.us/. Reports can be made 24 hours a day, 7 days a week.

- The FIRST Clinical Associate to encounter the alleged abuse or neglect has the obligation to report the abuse

- Note: All records concerning reports of abuse are confidential. You are required to include your name in the report. The name of the reporter is kept confidential by the Department, unless you consent to the release in writing. Florida law allows the phone conversation to be recorded.

- FAILURE TO COMPLY WITH REPORTING REQUIREMENTS MAY RESULT IN STATUTORY PENALTIES BEING IMPOSED.
To provide the best service to our patients and their families it is important that every person understands the procedure and medical care plan which has been agreed for them every time. Understanding is often a challenge when their first language is not English.

To be our best we want to communicate to the patient and family in the language they prefer.

Our policy and procedure is to use a Language Line at (800-643-2255, client ID #203019). We use this line always to ensure a reliable interpretation from healthcare professionals.

We DO NOT use staff to interpret for patients as this is at risk of being unreliable.

The line can be called 24/7. Please ensure it is used for every person, every time that it is needed. It will avoid the risk of inaccurate translation and confusion for the patient and their families.
Stroke symptoms include *sudden* changes such as:

– *Sudden* numbness or weakness (especially on one side of the body) of
  – Face
  – Arm
  – Leg
– *Sudden* trouble
  – Walking
  – Speaking
  – Understanding
  – Seeing in one or both eyes
– *Sudden* loss of
  – Balance
  – Coordination
– *Sudden* dizziness
– *Sudden* confusion
– *Sudden* severe headache with no known cause
# Stroke Signs

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **F** | **Face Drooping** | Ask the person to: smile  
Does one side of the face droop? (If YES → then ACT) |
| **A** | **Arm Weakness** | Ask the person to: raise both arms  
Does one arm drift downward? |
| **S** | **Speech Difficulty** | Ask the person to: repeat a simple phrase  
Is their speech strange? |
| **T** | **Time to Call for Help** | If YES to any of these signs → then IMMEDIATELY call CODE GRAY (ext. 15741) or call 911 |
If you see someone with *any* of these signs/symptoms then make a call immediately. Every second counts

- Call a **Code Gray at** ext. **15741** (if you are at 1 of the 3 main hospitals)
- Call **911** (if you are NOT at 1 of the 3 main hospitals)
• An IT Downtime is a period of time when any software systems are not working as expected to perform key functions to maintain hospital operations
  – Other terms include Epic Downtime and BCA (Business Continuity Access) Downtime
• Please be prepared by understanding your departments’ procedures and where to locate them.
• You have the responsibility to protect patient, associate, and organizational information.

• This means following:
  – HIPAA law
  – Standards on protected health information
  – MHS Information Security and Privacy Policy
  – MHS HIPAA Privacy and Security Policies
  – MHS Network Access Agreement

• For additional information on keeping protected health information (PHI) safe, contact
  – Information Security at ext. 14811
  – Corporate Compliance at ext. 11983
What is HIPAA and PHI?

<table>
<thead>
<tr>
<th>HIPAA</th>
<th>Health Insurance Portability and Accountability Act 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHI</td>
<td>Protected Health Information</td>
</tr>
</tbody>
</table>

HIPAA includes both the HIPAA Privacy Rule and HIPAA Security Rule. These rules outline National standards for protecting PHI and security standards to protect PHI that is held or transferred electronically. This includes how to keep PHI safe and confidential by taking certain administrative, physical, and technical safeguards.
It is your responsibility to protect the privacy and security of patient’s Protected Health Information (PHI).

PHI includes:

– Patient identification
– Demographic information
– Medical record information
– The fact that a patient is in the facility
Consequences of inappropriate access

• Do not access a record if you do not need to for patient care!

• Consequences of inappropriate access include:
  • Termination
  • Legal action
  • Written warning
  • Counseling / Education

• Any impermissible use or disclosure is presumed to be a breach, unless we can prove there is a low probability of compromise to the PHI.
MHS conduct audits of records to look for inappropriate access to files

- **Audits** of medical record access
  - Can confirm inappropriate access
  - Are done randomly and regularly.

- “High-profile patient” records are routinely **audited** for inappropriate access
• High profile patients include:
  – Famous people
    ▪ Patients who may attract (or whose families or significant others may attract) media and/or community interest
    ▪ Local, national, or international
  – Traumas
    ▪ Patients with extreme or unusual injury or illness, or patients whose injury or illness resulted from an extreme or unusual event
  – Criminals or protected witnesses
• If you become aware of a high profile patient
  – Call the Command Center at ext. **15741** so that a Lead Security Officer can be dispatched immediately to that location
We want to do what is right and helping law enforcement seems right. However, when it comes to PHI, we cannot just ‘answer’ or ‘release’ information. HIPAA and Florida Law have special requirements that must be respected.

It is your responsibility to follow policy when Law Enforcement asks for patient information.

*If Law Enforcement makes a request: be respectful, but do not be intimidated into disclosure!*
If a patient is not “in custody” of Law Enforcement, information can only be released in certain situations

<table>
<thead>
<tr>
<th>Situation</th>
<th>What to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the patient or personal representative has signed a valid authorization.</td>
<td>You CAN release information</td>
</tr>
<tr>
<td>If the patient has consented to being listed in Martin Health System (MHS) directory and Law Enforcement requests information on the patient by name, then</td>
<td>Law Enforcement can be told “directory” information (i.e., only patient location and condition in general terms--critical, good, etc.)&lt;br&gt;Law Enforcement cannot be told a time or plan for discharge.</td>
</tr>
<tr>
<td>If the patient poses imminent threat to himself or others and the information is needed to avoid harm to the public.</td>
<td>You CAN release information</td>
</tr>
<tr>
<td>If Law Enforcement requests information on a patient that is a suspected victim of a reportable offense under Florida Law, including child or vulnerable adult abuse.</td>
<td>Check with Risk Management, Legal, or Compliance on situations</td>
</tr>
<tr>
<td>If a Law Enforcement request involves possible criminal conduct occurring at MHS.</td>
<td>Check with Risk Management, Legal, or Compliance on situations</td>
</tr>
<tr>
<td>If a patient is a suspected victim in a crime</td>
<td>Information can be released if the patient signs a valid authorization</td>
</tr>
</tbody>
</table>
Privacy Incidents and PHI

• Privacy incidents include **patient** information
• Do not access or send a record if you do not need to for your job!
• Consequences of inappropriate access or use of PHI:
  • Termination
  • Legal action
  • Written warning
  • Counseling / education
Your Responsibilities

• You are accountable for the privacy and security of patient information

• Associates are required to follow HIPAA

• Associates are required to understand and follow MHS’s:
  – HIPAA Privacy and Security Policies
  – Network Access Agreement
PHI and Personal Identifiers

You must keep this information private because it can identify patients!

• Contact Information
  – Names
  – Street address, city, county, precinct, zip code
  – E-mail addresses
  – Telephone numbers
  – Fax numbers

• Other personal information
  – Social Security number
  – Medical record numbers
  – Account numbers
  – Certificate/license numbers
  – Biometric identifiers, including finger and voice prints
  – Health plan beneficiary numbers
  – Full-face photographic images and any comparable images

• All elements of dates (except year)
  – Birth date
  – Admission date
  – Discharge date
  – Date of death
  – Ages over 89

• Electronic Device and Internet Information
  – Device identifiers and serial numbers
  – Website addresses (URLs)
  – Internet Protocol (IP) addresses

• Vehicle information
  – Serial numbers
  – License plate number
  – Other vehicle identifier

• Any other unique identifying number, characteristic or code
• **Be aware of your surroundings** when discussing patients and sharing PHI. Think about:
  – Who is around you?
  – What you are sharing?
  – Where are you?
  – When are you sharing?

• If you obtain a patient’s verbal authorization to disclose PHI, be sure to document the authorization in the patient’s electronic medical record (EPIC).

• Review information prior to release to be sure you are giving it to the correct patient or authorized person.
De-identified Information

• Information is de-identified if:
  – All of the identifiers (listed on the PHI and Personal Identifiers slide) of the individual or of relatives, employers, or household members of the individual are removed.

  **AND**

  – The covered entity* does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

*Covered entities* are defined in the HIPAA rules as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.
Confirm Before Sharing and Sending

• Slow down and verify recipients and content.

• Before you share information, verify:
  – Identities
  – Phone number(s)
  – Fax number(s)
  – E-mail recipient(s)
  – Correct attachment(s)
Don’t leave printers or faxes unattended when confidential corporate or patient data is printing.

Secure interoffice mail

Dispose / shred in accordance with policies
How to Prevent: Paperwork Handoff Errors

• Check ALL papers before handing to a patient

• Use TWO patient identifiers to confirm you are handing to the correct patient
  – Name
  – Date of Birth
  – Use the **2 step method**
    1. Ask patient to confirm the 2 identifiers
    2. Check their arm band
Do **NOT** access records (electronic or paper) not needed to do your job.

Records that you should **NOT** access include:

- Records of patient not in your care
- Records of a friend, family, or fellow associate (even if they ask)
- Your own medical record
  - Instead use: My Chart or request your records through Health Information Management Team (HIM)
It is **OKAY** to access information that you need to do your job, such as for

– Patient treatment
– Patient scheduling
– Coding a patient chart
– Admitting a patient
– Obtaining authorization for treatment
A note on “medical record”

Accessing a medical record not for treatment, payment, or healthcare operations purposes is inappropriate.

But what is included in the “medical record”?

A patient’s medical record includes:
• Treatment information
• Demographic information
• Scheduling and appointments

Accessing any portion of a patient’s information, unless needed for work, is inappropriate.
“Break the Glass”

• This is a Special Privacy Setting in EPIC that Triggers an Audit Trail. (EPIC is our Clinical Information System, certain job roles have access)

• If you have a “need to know” to do your job, follow the instructions to “break the glass” and proceed. You are asked to give your reason for needing to be in the record and identify your entry once in a 24-hour period.

• If you do not need to be in the record, do not enter it. The automatic audit helps keep our patients’ information private, and also protects us from momentary lapses in judgment and accidental intrusion into sensitive matters.
Unauthorized Access

• If you do not need the information to do your job...then do NOT access it!
• Notify your leader if you have access to more information than you need on your computer.
Remember:

– You are held accountable for unauthorized access of information. This is outlined through procedures within:
  
  ▪ HIPAA (Law)
  ▪ MHS Policy
  ▪ MHS Access Agreement

– We run audits routinely to identify unauthorized access, taking our corporate responsibility to protect patient information.
• **Be aware of surroundings** when discussing patients and sharing PHI. Think about
  – Who is around you?
  – What you are sharing?
  – Where are you?
  – When are you sharing?

• Verify identities and phone numbers prior to disclosures
The Dangers of Social Media

• Remember…the world sees what you post
  – Represent MHS as a professional
  – Protect patient and MHS information and privacy

• PHI and personal identifiers can come out easily in an innocent post.

• Think before you tweet or post!
<table>
<thead>
<tr>
<th>Jamie Jones</th>
<th>June 15, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Works at: Martin Health System</td>
<td>“We were outstanding today!”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sam Miller</th>
<th>June 15, 2016</th>
</tr>
</thead>
<tbody>
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<td>Works at: Martin Health System</td>
<td>“I don’t know how you all did it!”</td>
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<td>“It was like an episode of Grey’s Anatomy.”</td>
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<td>Works at: Martin Health System</td>
<td>“Without the Dr. McDreamy...”</td>
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<tr>
<td>Works at: Martin Health System</td>
<td>“But we had Dr. Yang to crack the guy’s chest!”</td>
</tr>
</tbody>
</table>
• From this chat, you can tell that
  – This happened at Martin Health System
  – On June 15, 2016
• If there was a patient who got his chest “cracked,” this conversation went too far! This conversation has identifiable health information!
• And it could easily be worse. Suppose someone else commented and
  – Added a piece of PHI?
  – Referred to a news story with information?
• If this happened, you would be faced with consequences for being a part of a privacy breach.

Play it safe. Do not risk it.
Do you want to be the associate who needs to worry and explain? Compliance does not want that either.
Consequences of Posting

• You could:
  – Be terminated
  – Be fined
  – Face legal consequences
### Consequences of Posting: Examples

<table>
<thead>
<tr>
<th>Situation</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Several Employees here at MHS took pictures of a shark attack victim.</td>
<td>Employees involved received written warnings, demotions, and/or suspensions.</td>
</tr>
<tr>
<td>A Rhode Island ER doctor posted information online about a trauma patient. The doctor did not include the patient’s name, but she wrote enough that others in the community could identify the patient. <em>(Boston Globe, April 2011)</em></td>
<td>The doctor was fired, fined $500, and reprimanded by the Rhode Island Medical Board.</td>
</tr>
<tr>
<td>At a medical center in Oceanside, hospital managers discovered that five nurses had been discussing patients on Facebook.</td>
<td>The five nurses were fired.</td>
</tr>
<tr>
<td>The Phoenix Cardiac Surgery of Arizona was posting clinical and surgical appointments for its patients on an internet-based calendar that was publicly accessible. <em>(HHS, April 2012)</em></td>
<td>The practice agreed to pay the U.S. Department of Health and Human Services a $100,000 settlement and take corrective action to implement policies and procedures to safeguard PHI of its patients.</td>
</tr>
</tbody>
</table>
Follow the MHS Computer Network Access Agreement and MHS HIPAA Privacy and Security Policies.

For additional guidance, contact Information Security (ext. 14811) or Corporate Compliance (ext. 11983). If unavailable, you can also contact Command Center (ext. 15741).
Ways to Protect Information Security

- Make an effort to obscure PHI from public view on monitors and papers at your station.
- Lock your computer or log off if you need to walk away.
- Do not add, delete or change software without IT approval.
- Do not send PHI via email. It is like a postcard...anyone could turn it over and read it along the way.
- If you need to send PHI via email, enter [secure] anywhere in the subject line. This encrypts the message through a process set up by our IT department.
- Verify identities, fax, and phone numbers prior to disclosures.
Taking Information Outside of the Workplace

• Patient Information
  – Never take reports or computer media that contain patient information outside of your workplace.

• Other Confidential Information
  – Taking or accessing associate and organizational information outside of the workplace increases the risk of a security breach.
  – Protect paper documents, USB drives, and laptops.
    ▪ If information is taken outside of the workplace, make sure to secure the information in a locked area.
    ▪ Leaving items in a car increases risk because it can easily be broken into.
  – Protect information accessed electronically.
    ▪ If you access information electronically, make sure to use a proper device with security protection.
## Numbers to Call in an Emergency

<table>
<thead>
<tr>
<th>Need</th>
<th>Call</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Security / Police</strong></td>
<td>Command Center</td>
</tr>
<tr>
<td>at our hospital campuses</td>
<td>ext. <strong>15741</strong></td>
</tr>
<tr>
<td></td>
<td>223-5741</td>
</tr>
<tr>
<td><strong>Medical Emergency</strong></td>
<td>ext. <strong>14444 or 44444</strong></td>
</tr>
<tr>
<td>at one of our hospitals</td>
<td></td>
</tr>
<tr>
<td><strong>Police</strong> or <strong>Medical Emergency</strong></td>
<td>911</td>
</tr>
<tr>
<td>off sites</td>
<td></td>
</tr>
</tbody>
</table>

Note: If you call from an internal Martin Health extension number, then your call will be routed to the Command Center. The Command Center will conference in the 911 operator.
Emergency Codes

- **Code BLACK**: Bomb Threat
- **Code BLUE**: Medical Emergency
- **Code Yellow**: Facility Lockdown
- **Code GRAY**: Stroke Alert
- **Code GREEN**: Medical Surge/External Disaster
- **Code ORANGE**: Hazardous Materials Event
- **Code PINK**: Infant/Child Abduction
- **Code RED**: Fire
- **Code SILVER**: Active Shooter
- **Code WHITE**: Hostage Situation
- **Code H₂O**: Water Service Disruption
- **Code Purple**: Patient Elopement

Contact Information: → Command Center at ext. 15741
Fire Safety

• Never stack anything within 18 inches of a sprinkler head, so be careful when placing items on shelves and organizing furniture.

• Never block the following with furniture, supplies etc. There must be clear space around every:
  – Fire exit - doors are clearly marked as a fire exit
  – Fire pull station
  – Fire extinguisher
Fire Safety

• Know the location nearest
  – Smoke compartment
  – Fire extinguisher
  – Fire pull station
  – Fire exit

• Limit oxygen cylinders in a smoke compartment to 12

• Keep hallways clear in case of evacuation
Parts of a Fire Extinguisher

- Discharge Lever
- Discharge Locking Pin
- Discharge Hose
# How to Use a Fire Extinguisher

<table>
<thead>
<tr>
<th>P</th>
<th>Pull the discharge locking pin</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Aim the discharge nozzle at the base of the fire</td>
</tr>
<tr>
<td>S</td>
<td>Squeeze the discharge lever</td>
</tr>
<tr>
<td>S</td>
<td>Sweep the flames at the base of the fire with the discharge hose</td>
</tr>
</tbody>
</table>

![Image of a fire extinguisher with labels for discharge lever, locking pin, and hose]
If There Is A Fire
(North, South, Surgery Center, SLW, Tradition)

<table>
<thead>
<tr>
<th>R</th>
<th>Rescue</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Alarm</td>
</tr>
<tr>
<td>C</td>
<td>Confine</td>
</tr>
<tr>
<td>E</td>
<td>Extinguish</td>
</tr>
</tbody>
</table>
If There Is A Fire
(All Other Sites)

- **R**escue
- **A**larm
- **E**xit or **E**xtinguish
• Enforcing proper identification and controlling who accesses different areas of MHS is your responsibility.

• The following lesson will outline badge and access control policies. By following these policies, you will help
  – Decrease theft
  – Decrease access by unauthorized visitors and vendors
  – Increase safety and security
• Everyone must be visibly identified
  – Associates
  – Vendors
  – Visitors
• Wear your badge above your waist
Access Control

Main entrance

✓ **Do** direct visitors, guests, patients, and vendors to enter through the **main entrance** of the facility where a security officer can verify identification.

Secured associate entrances

**X Do NOT** allow visitors, patients or guests to enter through a secured associate entrance (instead direct them to the main entrance)
Access Control in an Emergency

• If it is an emergency and the person cannot get to an appropriate entrance, it is the associate’s responsibility to **escort the person to the nearest security post** for assistance.

• If you are at an off-site clinics/business office, then escort patients and visitors to the building’s entrance.
# Lost/Found Items

<table>
<thead>
<tr>
<th>Type</th>
<th>Examples</th>
<th>If These Items are Lost or Found</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuables</td>
<td>• jewelry • credit/debit cards • check book • money • personal IDs such as driver’s license or social security card</td>
<td>Call Command Center ext. <strong>15741</strong></td>
</tr>
<tr>
<td>Essential Items</td>
<td>• hearing aids • glasses • dentures • prostheses • assistive devices such as walkers or canes</td>
<td></td>
</tr>
<tr>
<td>Personal Belongings</td>
<td>• medications • clothing, shoes • umbrellas • electric razors • hair dryers • cell phones • radios</td>
<td></td>
</tr>
</tbody>
</table>
In Case of Workplace Injury or Blood/Body Fluid Exposure

If you have a work-related injury, illness, or exposure:

1. **Notify your leader** at once

2. In case of emergency, go to your nearest emergency room.

3. If after 5pm or weekend/holiday: Call the hospital operator and ask for the on-duty nursing supervisor to help you coordinate your care. Follow up with Occupational Health, ext. 14812, the next business day.

4. Contact Occupational Health at 223-5945, ext. 14812 immediately to help coordinate your care.

**Note:**
- Treatment must be authorized by Occupational Health.
- Call Occupational Health for follow up at x14812
- All injuries must be reported. Failure to report your injury timely could jeopardize your benefits.
The Globally Harmonized System (GHS) replaces the old Material Safety Data Sheets (MSDS).

Using GHS will improve work safety and health by:
- Reducing confusion regarding MSDS
- Providing consistent information
- Providing a standardized format for hazardous chemicals
Globally Harmonized System (GHS)

• GHS covers
  – ALL chemicals
  – Uses standardized pictograms and harmonized hazard statements
    ▪ in the workplace
    ▪ on consumer products
    ▪ (transportation changes are not expected to follow these new guidelines)

• The pictograms for non-transport have a
  – red- border
  – white background
  – black symbol
  – information is in the same place on all labels

• The word “Danger” is used for more severe hazards
• The word “Warning” is used for less severe hazards
These are the different GHS Pictograms.
**GHS Label Elements**

Symbols (hazard pictograms): Convey health, physical and environmental hazard information, assigned to a GHS hazard class and category.

Product Identifier (ingredient disclosure): Name or number used for a hazardous product on a label or in the SDS.

CHEMICAL X

CAS Number XX-XX-X
Category 3 Flammable Liquid
Category 2A Eye Damage/Irritation

Hazard Statements: Standard phrases assigned to a hazard class and category that describe the nature of the hazard.

DANGER
Harmful by inhalation and in contact with skin. Irritating to skin. Causes severe eye irritation.

Keep container tightly closed and in a well-ventilated place. Keep away from sources of ignition. No smoking. Avoid contact with eyes. Wear suitable protective clothing and gloves.

First Aid
Immediately remove any clothing soiled by the product. Call emergency medical care. Wash eyes with fresh water. Wash affected area of body thoroughly with soap and fresh water.

Precautionary Statements and Pictograms: Measures to minimize or prevent adverse effects.

Signal Words: "Danger" or "Warning" are used to emphasize hazards and indicate the relative level of severity of the hazard, assigned to a GHS hazard class and category.

Supplier Identification: The name, address and telephone number should be provided on the label.

Supplemental information: non-harmonized information.
Your safety is extremely important. Be careful when doing something where you can get injured or be exposed to biomedical material. Personal Protective Equipment (PPE) is a requirement to help protect you from injury or exposure. You are required to use PPE* when there is an actual or potential exposure to:

- Blood
- Body fluids
- Other regulated or biomedical items

Handle materials carefully and dispose of them correctly!

- Dangerous diseases can be spread if you do not take proper precautions. For example, be careful with sharps because HIV, Hepatitis B or C, and other viruses can be spread via needle sticks.

*Refer back to ‘Module 2: Patient Safety’ to review information related to personal protective equipment.
• Make the correct disposal decision. This will protect your health and the health of people who handle the waste after you.
Biomedical waste is any solid or liquid waste which may present a threat of infection to humans, including:

- Non-liquid tissue
- Body parts
- Blood
- Blood products and body fluids
- Discarded sharps
How to Dispose of: Biomedical Waste

Red Bag: Things saturated with blood or body fluid

Red Box: Needles, Scissors, Scalpels (NO non-sharps!)

Potential Sharps Box: Anything that could become sharp
Proper Tying of Red Bags

- While wearing gloves, twist the top of the bag to seal its contents. Secure the seal with a strong, hand-tied single or gooseneck knot to prevent any leakage if inverted. You can also use tape to secure the knot. Ensure that the bag is completely closed; No Bunny Ears!
Universal Pharmaceutical Waste (UPW)

- Common examples of UPW are:
  - IV formulations with additives
  - Partial vials or syringes of antibiotics
  - Medications
  - Creams
  - Lotions
  - Ointments
  - Inhalants
How to Dispose of: UPW

• Use the black boxes to dispose of any Universal Pharmaceutical Waste (UPW), which are “non-viable, partially-used” pharmaceuticals
  – This helps to achieve environmental compliance and to improve water quality

• Please keep the black box closed when not adding UPW items to it
### How to Dispose of: UPW

<table>
<thead>
<tr>
<th>Medical Center and Hospital South</th>
<th>All other sites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medications left in a sharp</strong></td>
<td><strong>All UPWs</strong></td>
</tr>
<tr>
<td><strong>Includes</strong></td>
<td><strong>Disposable Containers</strong></td>
</tr>
<tr>
<td>• Syringe (with meds)</td>
<td></td>
</tr>
<tr>
<td>• Ampoules (with meds)</td>
<td></td>
</tr>
<tr>
<td>*No empty items, trash, etc...</td>
<td></td>
</tr>
<tr>
<td>*No controlled substances or plain IV solutions</td>
<td></td>
</tr>
<tr>
<td><strong>Medications left in non-sharp format</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Includes</strong></td>
<td></td>
</tr>
<tr>
<td>• Partial IV bags/vials</td>
<td></td>
</tr>
<tr>
<td>• Pills/capsules</td>
<td></td>
</tr>
<tr>
<td>• Medicated creams</td>
<td></td>
</tr>
<tr>
<td>• Nicotine, Coumadin, &amp; Physostigmine wrappers</td>
<td></td>
</tr>
<tr>
<td>*No empty IVs, trash, gloves, etc.</td>
<td></td>
</tr>
<tr>
<td>*No controlled substances or plain IV solutions</td>
<td></td>
</tr>
</tbody>
</table>

**Send to Pharmacy in Ziploc bag**

**Includes**

- All items with “return to pharmacy” stickers
- Aerosols/Inhalers
- Corrosives/Oxidizers
Outlets

• Red Outlets
  – Are connected to the generator
  – Will have power in the event of an electric failure
  – Are only for critical patient care equipment (plug patient beds into “bed only” outlets)
Electrical Safety

• Do **NOT** use damaged or frayed electric cords. Take them out of service and report them to your supervisor to get fixed
• Only use 3-prognd plugs in clinical areas
• You **must** have bio-med approval for
  – Extension cords
  – Electrical devices
• Check for green bio-med sticker before using clinical equipment
**3 Rules to Improve Radiation Safety**

<table>
<thead>
<tr>
<th>Time</th>
<th>Shielding</th>
<th>Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limit exposure time</td>
<td>Use all required shielding items</td>
<td>Hazard decreases with distance from the source of the radiation</td>
</tr>
</tbody>
</table>

- **Time**: Limit exposure time
- **Shielding**: Use all required shielding items
- **Distance**: Hazard decreases with distance from the source of the radiation
• If you routinely work with or near radiation sources
  – You are required to wear a dosimeter that measures exposure
  – If you are also pregnant you should declare your pregnancy to
    your supervisor for assessment

• Rooms where radiation is used or stored are identified with
  the universal radioactive materials symbol (shown below).

• Specially trained Radiation Safety Officers are employed by
  MHS to ensure safe working conditions for associates
  working with or near radiation sources
When working with chemicals
  – Follow all labeling instructions
  – Use personal protective equipment as applicable
  – Make sure you are in a well-ventilated location (proper ventilation is required the majority of the time)

When mixing chemicals
  – Make sure the chemicals are supposed to be mixed
  – Make sure to use the right concentrations of the chemicals
The most common gas that is handled is in oxygen cylinders.

Simple safety rules:

- Separate full vs. empty cylinders
- Store upright when possible and only in approved holders or racks
- If chained to a wall, make sure they are individually chained
- Transport cylinders in approved holders only
- Make sure cylinders won’t fall over, or fall off a bed or stretcher
- Never have more than 12 e-size cylinders in a smoke compartment

A cylinder can quickly become a fast moving missile if it falls. Prevent damage, injury, and death by properly storing and securing cylinders.
Knowing MRI safety is important for everyone that:

- Has access to the MRI department
- Has a patient who will be going to the MRI department
Access to the MRI scan room is

– Only allowed for highly trained MRI staff
– Only permitted when accompanied by MRI staff
– **NEVER** enter into the MRI scan room without consulting the MRI technologists.
It is extremely important that you receive proper training and screening before entering an MRI area! If you enter an MRI area with no/poor training, then you could cause extreme injury or death to the patient or fellow associates.
• Ferro-Magnetic objects WILL become potentially deadly missiles.
  – Examples include:
    ▪ O2 tanks
    ▪ Wheelchairs
    ▪ Beds
    ▪ Monitors
    ▪ IV poles
    ▪ Scissors
    ▪ Pens
    ▪ Tools
    ▪ ID badge holders
  – Once an object attaches to the magnet, it will not come off. It will cause significant cost and down time.

• Not all MRI accidents involve projectiles. Some patients and staff have implanted devices that they need in order to function or even live.
  – Pacemakers / defibrillator
  – Nerve or bone stimulators
  – Medication pumps
  – Aneurism clips and any surgical implants or foreign bodies
• Call MRI at ext. 11111 for further information and questions about MRI Safety
Ball-in-the-Wall indicators

- Are visual pressure indicator of room air pressure
- Have been installed in rooms with regulated air pressure

View the Ball-in-the-Wall from the hall outside the room

A room’s air pressure can only be regulated when the doors are closed
How it works

• The ball-in-the-wall is a small tube that goes between the inside and outside of a room.
• There is a ball inside of the tube that moves from one side to the other depending on the pressure in the room.
• If you are standing in the hall and see a ball, then
  – The ball is being pushed out of the room. This indicates that the room has positive air pressure pushing germs out
• If you are standing in the hall do not see a ball, then
  – The room has negative air pressure and is not allowing the germs into the hall
# Ball-in-the-Wall

<table>
<thead>
<tr>
<th></th>
<th>Positive Rooms</th>
<th>Negative Rooms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>These rooms...</strong></td>
<td>Push airflow and germs out of the room</td>
<td>Pull airflow into the room so that germs are not getting into the hall</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td>Only applies to OR rooms at 509 building (ORs in the hospitals are monitored by Siemens computer-monitored DP system)</td>
<td>Such as isolation rooms</td>
</tr>
<tr>
<td>Look at the ball-in-the-wall from the outside of the room with the door closed.</td>
<td>Green ball</td>
<td>No ball</td>
</tr>
<tr>
<td><strong>Things are okay if you see...</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Look at the ball-in-the-wall from the outside of the room with the door closed.</td>
<td>No ball</td>
<td>Red ball</td>
</tr>
<tr>
<td><strong>Something is wrong if you see...</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you see a no ball—STOP and call Facilities Engineering to correct</td>
<td>If you see a red ball—STOP and call Facilities Engineering to correct</td>
<td></td>
</tr>
</tbody>
</table>
Every day you should make sure that you are:

– Using the proper personal protective equipment
– Taking breaks from sitting and staring at a screen
– Staying hydrated
Maintain Health and Safety at Work

MHS workplace injury prevention resources for associates

• To prevent falls, order your discounted, slip-resistant shoes [Shoes for Crews](#) by credit card or payroll deduct

• To avoid sprains/strains at your workstation or worksite, request an ergonomic evaluation [Ergonomic Evaluation Request](#)

• Watch videos that show you how to safely use patient lifting equipment and butterfly needles [Safety Videos](#)

• To find information on working if you have an infection, visit the [Infectious Disease Exposure Work Restrictions](#) guidelines

• Learn how to manage aggressive behavior and avoid injury by taking the MOAB course in iLearn
For any heavy lifting, use lift equipment and obtain help!

Direct Patient Care:

- Always assess patients prior to ambulation and transfer. Use the Egress Test to determine if the Arjo Maxi Move, Sit-to-Stand device, or Sara Stedy (TMC) is required.
- Never manually lift a patient who has fallen to the floor. Use the Arjo Maxi Move!
- Always use a Pink Slip for boosting patients up in bed.
- Use the Arjo Tenor for transferring bariatric patients.
- Practice the ten safety rules to avoid sharps injuries and exposure to blood and body fluids
  Ten Sharps Safety Rules (Printable Cards)
- Wear eye protection when flushing or irrigating patient tubing or whenever there is risk of blood or body fluid splashes

Give us your safety suggestions! Call or email Sandy Rogers, Ext 15454
Feeling Safe at Work

• You should feel safe at work.
• Workplace violence is NOT okay.
• If you feel **threatened or at risk, call** the Command Center at ext. **15741**
• The MHS Code of Conduct outlines this topic
• Violence can be
  – Verbal and/or physical
  – Minor or extreme
  – Committed by anyone
    ▪ (ex: Fellow associates, Patients, Visitors)
  – Directed towards anyone
Examples of unacceptable behavior include:

– Physical assault
– Sexual misconduct
– Threatening words or actions
– Ignoring or shunning another person/group
Sexual misconduct such as sexual abuse or harassment of any kind is unacceptable. Organizational consequences can include termination and legal consequences can include arrest.

Sexual acts of any kind are unacceptable while on the job or on MHS property. Additionally, any sexual acts without consent or sexual acts on a vulnerable person (ex: minor or vulnerable adult) are never okay. Sexual acts include, but are not limited to

- Touching sexual organs (clothed or unclothed)
- Exposure of sexual organs
Sexual Misconduct

- Sexual abuse or harassment is forbidden. This includes:
  - Unwelcome or offensive sexual comments, sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature.
  - Unwelcome or forcefully touching someone, such as on someone's inner thigh, breast, genitalia, buttocks, etc.
  - The use of someone else to solicit for or engage in prostitution or sexual performance
  - Rape
  - The exchange of sexual favors for beneficial employment conditions,
  - Verbal or non-verbal behavior which contributes to a hostile or offensive work environment. This may include, but is not limited to, offensive or unwelcome sexual flirtations, advances or propositions; verbal abuse of a sexual nature; graphic verbal commentaries about an individual’s body; sexually degrading words used to describe an individual; and the display in the workplace of sexually suggestive objects or pictures.
Policy and Procedure for Workplace Violence

• MHS has zero tolerance for any threats to the safety and security of our associates, patients and others at our facilities

• Immediately report any actual or potential threats to
  – Command Center at ext. 15741
  – **And** to your Leader or Human Resources (Associate Helpline ext. 12222)

• If you have a conflict with a coworker
  – contact your leader for guidance with conflict resolution
The signs of impaired behavior varies depending on the substance used, but the following are some different things that may indicate an issue.

Things that might indicate that someone is impaired
- Unable to walk straight
- Unable to remain balanced while standing or sitting
- Speech that is excessively loud, quiet, or slurred
- Mood and behavior changes such as being hostile, confused, erratic, or excessively sleepy.
- Eyes that are bloodshot or dilated
- Breath that smells of alcohol or the attempt to cover up the smell with excessive use of mints, mouthwash, or perfume
- Movements that are fumbling, jerky, slow, nervous, or hyperactive

Other warning signs
- The individual comes to work on their time off and may linger around where drugs are supplied
- Disappears while on duty and/or takes frequent bathroom breaks
- Increased or unexplained absence or lateness to work
Impaired Behavior: What to do

If you suspect impaired behavior...

1. Immediately notify your leader and Human Resources of suspected Associate impairment
   - During business hours: call Sibel Miglino ext. 11269 or Anna Little ext. 12983
   - Off shifts: Notify your Leader/Chain of Command and call the Switchboard Operator and ask them to contact Human Resources

2. Do NOT allow the associate with the suspected impaired behavior to
   - Go home
   - Have anything to drink
   - Use the restroom

A determination will be made by Human Resources if an Associate must undergo physical examination/drug and alcohol testing

Contact Information:
→ Sibel Miglino at ext. 11269
→ Anna Little at ext. 12983
Module 5

Obligation to Report
Recall that our **Vision** is “to be an innovative healthcare system nationally recognized for clinical excellence and improving the health and well-being of the communities we serve”.

There are laws, regulations, and MHS policies around reporting that you must follow for us to:

- Reach our vision
- Be a safe environment that effectively addresses incidents
- Prevent future incidents or occurrences

You are obligated to report

- **Misconduct**: associate misconduct concerns
- **Compliance Concerns**: failure to comply with laws, regulations, and department policies
- **Occurrences**: risk events and feedback
Reporting requirements differ based on the event, concern, urgency, severity, etc. Below are a few notes about reporting.

- In general, it is advised to notify your Leader/Chain of Command for advisement if you are unsure what to do.

Unsure how to report?

- Your Leader should be able to advise
- Risk Management, Corporate Compliance, or Human Resources are also available to provide guidance on reporting
<table>
<thead>
<tr>
<th>MHS Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leader</td>
</tr>
<tr>
<td>Chain of Command</td>
</tr>
<tr>
<td><strong>Risk Management</strong></td>
</tr>
<tr>
<td>Risk Management</td>
</tr>
<tr>
<td>Department</td>
</tr>
<tr>
<td>ext. 15899</td>
</tr>
<tr>
<td><strong>Corporate Compliance</strong></td>
</tr>
<tr>
<td>Corporate Compliance</td>
</tr>
<tr>
<td>Department</td>
</tr>
<tr>
<td>ext. 11983</td>
</tr>
<tr>
<td>Chief Compliance Officer</td>
</tr>
<tr>
<td>ext. 13957</td>
</tr>
<tr>
<td><strong>Human Resources</strong></td>
</tr>
<tr>
<td>Associate Helpline</td>
</tr>
<tr>
<td>ext. 12222</td>
</tr>
<tr>
<td><strong>Compliance Hotline</strong></td>
</tr>
<tr>
<td>1-877-785-0002 or</td>
</tr>
<tr>
<td><a href="http://www.mycompliancereport.com">www.mycompliancereport.com</a> code</td>
</tr>
<tr>
<td>MMH</td>
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</table>
Generally, these are the type of reporting topics the following departments handle.

<table>
<thead>
<tr>
<th>Risk Management</th>
<th>Corporate Compliance</th>
<th>Human Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For Risk Events</strong></td>
<td><strong>For HIPAA related concerns</strong></td>
<td><strong>For associate conduct concerns</strong></td>
</tr>
<tr>
<td>• Patient or non-patient safety events</td>
<td>• any unauthorized access, use or disclosure of Protected Health Information [PHI])</td>
<td></td>
</tr>
<tr>
<td>• Patient/visitor lost/stolen/damaged property</td>
<td>For concerns related to the Code of Conduct</td>
<td></td>
</tr>
<tr>
<td>• Associate injuries</td>
<td>• examples include: Patient Gifts, Conflicts of Interest, Vendor Relations, Billing and Coding, and False Claims. (see the MHS Code of Conduct for full list of topics).</td>
<td></td>
</tr>
<tr>
<td>For Feedback</td>
<td>For any suspected failure to comply with state or federal laws or regulations or MHS policy</td>
<td></td>
</tr>
<tr>
<td>• Patient/client complaints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patient grievances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Compliments</td>
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<tr>
<td>• Suggestions</td>
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</tbody>
</table>
Associates and patients **ALWAYS** have the option to report **ANY** concerns to the following resources. Throughout this module you will be told how to report within MHS, but please remember that these are also options.

### External Reporting Options

<table>
<thead>
<tr>
<th><strong>The Joint Commission</strong></th>
<th><strong>Agency for Health Care Administration (AHCA)</strong></th>
</tr>
</thead>
<tbody>
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<td><strong>Agency for Health Care Administration (AHCA)</strong></td>
</tr>
<tr>
<td>Hopefully this will be your last resort, but if you have a concern that you feel was not adequately addressed, you may file a safety or quality of care concern directly to Joint Commission:</td>
<td><strong>Consumer Services Unit</strong></td>
</tr>
<tr>
<td>• Print a Quality Incident Report Form from <a href="http://www.jointcommission.org">www.jointcommission.org</a></td>
<td><strong>PO Box 14000</strong></td>
</tr>
<tr>
<td>• Email: <a href="mailto:complaint@jointcommission.org">complaint@jointcommission.org</a></td>
<td><strong>Tallahassee, FL 33317</strong></td>
</tr>
<tr>
<td>• Fax: (630) 792-5636</td>
<td>• (888) 419-3456</td>
</tr>
<tr>
<td>• Mail Joint Commission Office of Quality Monitoring, One Renaissance Blvd., Oakbrook Terrace, IL 60181</td>
<td>• <a href="http://www.ahca.myflorida.com/contact/links.shtml">http://www.ahca.myflorida.com/contact/links.shtml</a></td>
</tr>
<tr>
<td>• Questions? Call Joint Commission at (800) 994-6610, 8:30 am to 5 pm central time, weekdays</td>
<td></td>
</tr>
</tbody>
</table>
In case of an Emergency

If there is an immediate safety or security concern, you should immediately let the relevant people know in-person or via phone...

• Your Leader/Chain of Command
• Security/Police (Call Command Center at ext. 15741. If offsite, call 911)
• Risk Management
• Corporate Compliance
• Human Resources
When unsure, question.
When concerned, report.

MHS and the law prohibit retaliation for good-faith reporting.

The Chief Resource Officer will closely examine claims of retaliation to ensure that legitimate, non-retaliatory reasons motivated any action taken. If retaliation played an influential part in the action taken, then the Chief Executive Officer will take prompt and appropriate corrective action against the offender.
Administrative Policy: Non-Retaliation

- You **cannot be retaliated against** for making a good-faith report of a compliance concern
- Any form of retaliation against an associate who identifies a perceived problem or concern, in good faith, is strictly prohibited

Other references to non-retaliation and reporting in the Associate Handbook

- You **cannot be retaliated against** for
  - Voicing a concern regarding legal regulatory issues, policies and procedures, and/or seeks the aid of Human Resources or files a grievance
  - Filing a complaint of harassment
  - Acting in good faith and reporting a real or implied violent behavior
  - Reporting variances or medical errors
All associates have the responsibility to immediately report misconduct. This includes

– Theft
– Impaired behavior
– Arrests (If you are arrested, you must self-report to MHS within 48 hours of the arrest)
– Sexual harassment

MHS is committed to investigating all reports of misconduct. If you need assistance or have questions, contact the Associate Helpline at ext. 12222.
### Reporting Options for Misconduct

<table>
<thead>
<tr>
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<tr>
<td><strong>Human Resources</strong></td>
</tr>
<tr>
<td>Corporate Compliance Department ext. 11983</td>
</tr>
<tr>
<td>Chief Compliance Officer ext. 13957</td>
</tr>
<tr>
<td><strong>Compliance Hotline</strong></td>
</tr>
</tbody>
</table>
Recall from Module 4:

- Immediately report any actual or potential threats to
  - Command Center at ext. 15741
  - And to your Leader or Human Resources (Associate Helpline ext. 12222)
Recall from Module 4: If you suspect impaired behavior...

1. **Immediately notify your leader and Human Resources** of suspected Associate impairment
   - *During business hours:* call Sibel Miglino ext. 11269 or Anna Little ext. 12983
   - *Off shifts:* Notify your Leader/Chain of Command and call the Switchboard Operator and ask them to contact Human Resources

2. **Do NOT** allow the associate with the suspected impaired behavior to
   - Go home
   - Have anything to drink
   - Use the restroom

A determination will be made by Human Resources if an Associate must undergo physical examination/drug and alcohol testing
A Compliance Concern includes:

– *HIPAA violations*: any unauthorized access, use or disclosure of Protected Health Information (PHI)

– *Violations of the MHS Code of Conduct*: examples include Patient Gifts, Conflicts of Interest, Vendor Relations, Billing and Coding, and False Claims (see the MHS Code of Conduct for full list of topics)

– *Any suspected failure to comply with state or federal laws or regulations or MHS policy*
Per our Code of Conduct, associates have an 
**obligation to report suspected failure to comply** with laws, regulations, and 
department policies.

Failure to report compliance violations will result in disciplinary action.

If something is troubling you, please call—it’s the right thing to do.
• All Associates have the responsibility to immediately report any suspected violations of regulations, laws, or MHS policy.
• MHS is committed to investigating all reports of violations.
• If you need assistance or have questions, contact your leader or chain of command. You can also reach out to Corporate Compliance directly who will either answer your questions or direct you to the correct person/department.

Corporate Compliance

Corporate Compliance Department ext. 11983

Chief Compliance Officer ext. 13957
Consequences for Non-Compliance

• MHS will apply consequences to associates and medical staff for failure to comply with
  ▪ HIPAA
  ▪ MHS Privacy and Security Policies

• Failure to comply with HIPAA
  – Information on Corrective Actions and consequences for non-compliance can be found in MHS HIPAA Privacy Policy
    ▪ HIPAA Privacy Policy #29: Corrective Actions
      – Procedures for applying corrective action
    ▪ HIPAA Privacy Policy #29.A: Privacy and/or Security Incident Matrix
      – Categories of violations, examples of violations, and possible consequences that may result
      – These sanctions range from **verbal warning** to **termination** depending on the severity of the violation.
  – HIPAA violations can have criminal or civil penalties
Consequences for Non-Compliance

- Other consequences for failure to comply with HIPAA and other laws and regulations can include:
  - Criminal and Civil charges
  - Notification to licensing boards
    - MHS may be required to report the incident to the associate’s licensing board for unprofessional conduct.
    - For example, the Nurse Practitioner Act includes unprofessional conduct as grounds for disciplinary action. Unprofessional Conduct is defined, in part, by Florida Administrative Code – 649B as “Violating the confidentiality of information or knowledge concerning a patient.”
# How to Report Compliance Concerns

## Reporting Options for Compliance Concerns

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**Compliance Hotline**

1-877-785-0002  
or [www.mycorporatehotline.com](http://www.mycorporatehotline.com)  
(code: MMH)

| Department of Health and Human Services (HHS) at www.hhs.gov |
| Office of Inspector General (OIG) at 1-800-HHS-TIPS |
Using the Compliance Hotline

• Use the hotline to report compliance issues if you do not feel comfortable, cannot, or do not want to report something up your chain of command.
• The hotline is
  – Available 24/7
  – Anonymous, if you want
  – For feedback and follow-up

Compliance Hotline

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<tr>
<td>By phone at:</td>
</tr>
<tr>
<td>1-877-785-0002</td>
</tr>
<tr>
<td>On the web at:</td>
</tr>
<tr>
<td><a href="http://www.mycompliancereport.com">www.mycompliancereport.com</a></td>
</tr>
<tr>
<td>use code: MMH</td>
</tr>
</tbody>
</table>

*You can be anonymous*
HIPAA Violations

• Recall *Module 3: Information Safety* about HIPAA and Protected Health Information policies

• HIPAA violations are handled by Corporate Compliance.

*Violations of a Patients’ HIPAA Rights can be reported like any other compliance concern.*
Accidental accesses and information slips happen. Report if you accidentally disclose Protected Health Information (PHI) OR if you receive PHI (ex: via email) that you should not have received.

- You must immediately report
  - Unauthorized disclosure of PHI (intentional or accidental)
  - Any patient complaint regarding the use or disclosure of PHI
- Let Compliance know so they can
  - Help manage the situation
  - Understand what we find on an audit

Violations of a Patient’s HIPAA Rights can be reported like any other compliance concern.
Patients have the right to:

• Ask to see and receive a copy of their health records

• Have corrections added to their health information

• Receive a notice that tells them how their health information may be used and shared

• Decide if they want to give their permission before their health information can be used or shared for certain purposes, such as marketing

• Get a report on when and why their health information was shared for certain purposes

Violations of a Patient’s HIPAA Rights can be reported like any other compliance concern.
If a patient believes their rights are being denied or their health information is not being protected, they can file a complaint with MHS Corporate Compliance Department or the Department of Health and Human Services (HHS) at www.hhs.gov
All associates are obligated to report unexpected, unanticipated events that either did result in harm, or have potential to result in harm (near miss) including:

- Adverse Incidents (can include Code 15 incidents)
- Sentinel Events
- Grievances
- Professional Conduct Concerns
- Threats of litigation
- Suspicion of neglect or abuse
- Suspicions of suicide risks
- Patient or visitor falls
- Lost valuables
- Allegations of sexual misconduct
- Medication variances
- Surgical or procedure complications
Patients have the right to:

- Know their diagnosis, treatment plan, alternatives, risks, and prognosis
- Refuse treatment
- Treatment for an emergency medical condition that will deteriorate from failure to provide treatment
- Effective pain management
- A patient has the right to designate and receive visitors of their choosing. Visitors will be allowed equal access regardless of race, color, national origin, religion, sex, gender identity, sexual orientation or disability, subject to hospital visitation policies. (this includes their support person)
- (Refer to Patient’s Bill of Rights and Responsibilities for full list which is located in the patient’s guide and in the ED and admitting lobbies)

Violations of a Patient’s Bill of Rights and Responsibilities can be reported through the Occurrence Reporting method
What to do: If an Error or Unexpected Event Occurs

- If an Error or Unexpected Event Occurs (including Adverse Incident or Sentinel Event)
  - Take care of the patient first
  - Notify your supervisor and the physician
If you have a work-related injury, illness, or exposure:

1. **Notify your leader** at once
2. For blood/body fluid exposure, **follow BLEX Quick Reference**
3. **Seek treatment**
   a) In case of emergency, go to your nearest emergency room! Then follow the procedure described below.
   b) Contact Occupational Health at 223-5945, ext. 14812 immediately to help coordinate your care.
   c) If after 5pm or weekend/holiday: Call the hospital operator and ask for the on-duty nursing supervisor to help you coordinate your care. Follow up with Occupational Health, ext. 14812, the next business day.

**Note:**
- Treatment must be authorized by Occupational Health.
- Call Occupational Health for follow up.
- All injuries must be reported. Failure to report your injury timely could jeopardize your benefits.
## Patient Complaint vs. Grievance

### Complaint

A complaint is: an issue that is *unrelated to patient care*.

Examples:
- Housekeeping of a room
- Food preferences
- Billing issues

### Grievance

A grievance is: an issue that is *related to patient care*, but was not resolved by the staff that was present at the time of the issue.

Examples:
- Unmet patient care expectations
- Premature discharge
- HIPAA concerns
- Lack of informed consent

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**All written complaints are grievances**

(an email or fax is also considered a written complaint)
Please report grievances to your supervisor as soon as you receive them. The hospital must respond to grievances within a reasonable time frame (average of 7 days or less) and review, investigate, and resolve each patient’s grievance within a reasonable timeframe.