This packet is intended for initial orientation and annual reorientation of all hospital employees and volunteers. More information about the policies, procedures and protocols summarized in this packet can be found on the hospital intranet RMCBP Home Page under “Policy and Procedure”.

Regional Medical Center Bayonet Point  2016 Orientation/Reorientation Program
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Who We Are

Regional Medical Center Bayonet Point (RMCBP) has been serving the community since 1981 and is well known for The Heart Institute and the Level II Regional Trauma Center. The Medical Center offers a wide continuum of care and specialized programs including:

- 24-hour Emergency Department
- Acute Care for the Elderly (ACE)
- Cardiopulmonary Rehabilitation
- Cardiovascular Services
- Diagnostic Imaging Services
- Graduate Medical Education (GME)
- Infusion Center
- Level II Trauma Center
- Neurosurgery
- Oncology Services
- Orthopedic and Spine Center
- Rehabilitation Services
- Sleep Lab
- Stroke Center
- Wound Care Center / Hyperbaric Medicine

Our Mission & Values

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve. In pursuit of our mission, we believe the following value statements are essential and timeless.

We recognize and affirm the unique and intrinsic worth of each individual. We treat all those we serve with compassion and kindness. We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives. We trust our colleagues as valuable members of our Healthcare team and pledge to treat one another with loyalty, respect and dignity.

Governance

Regional Medical Center Bayonet Point (RMCBP) is owned by HCA Healthcare Services of Florida, Inc. The Corporation establishes a local Board of Trustees as an overseer and advisor for each owned facility. The primary responsibility of the Board of Trustees is to support the role and purpose of the Hospital by providing oversight of Regional Medical Center Bayonet Point thereby facilitating the establishment of policies, the maintenance of quality patient care and the provision of institutional planning and management, all in a manner that is responsive to the needs of the Pasco/Hernando community and the mission and vision of Regional Medical Center Bayonet Point. The Board of Trustees is the governing body of the facility.
Nursing Staff

The Chief Nursing Officer oversees all nursing practice at RMCBP. The Plan for Provision of Patient Care is the document that outlines RMCBP’s plan for providing nursing care. Staffing needs are determined by assessing patient acuity and unit volume which is coordinated at Bed Board meetings held twice daily.

Medical Staff

All medical staff must be credentialed to have privileges to practice at RMCBP and with the approval of the Board of Trustees. If an employee needs to know if a physician is on staff they should check the physician directory. If a question arises pertaining to what privileges the physician has, the employee should ask their manager or the nursing supervisor. Physician privileges may also be verified via the hospital intranet home page > clinical applications > iPrivilege: enter user name 30951 and password 30951.

All patients scheduled to have an invasive procedure or surgery are required to have a signed, informed consent and current history and physical on the chart prior to the start of the procedure. If a physician attempts to proceed with the procedure/surgery without the appropriate documentation on the chart, the nursing staff is to immediately report the infraction through the appropriate chain of command. (Reference Policy/Procedure # LD 235.900 – Chain of Command)

If a physician should request the nurse do something that is not within the nurses’ scope of practice, the nurse should refuse, explaining the reason for the refusal. The incident should be reported through the normal chain of command. (Reference Policy/Procedure # LD 235.900 – Chain of Command)

If a Medical Staff member, Allied Health Professional or Hospital employee witnesses warning signs of impairment, they should report the incident. Patients, family members or others who witness warning signs of impairment shall be encouraged to report the incident to an appropriate patient care representative. Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene or unexplained frequent illnesses. (Reference Policy/Procedure # LD 235.900 – Chain of Command)
**Patient Experience**

What is the patient experience? Individualized care, tailoring of services to meet patient needs; engage them as partners in their care and communicating with the patient at their level of understanding. We can use the acronym **GUEST** to help us remember how to begin.

**G**reet - Acknowledge the patient, introduce yourself, and make eye contact, smile

**U**nderstand – Listen, hear and gain knowledge of the person

**E**ducate - Explanation of care, use words the patient can understand, explain how long tests and procedures may take

**S**atisfaction/ **S**how me the way – Ensure patient needs are met; Take them to their destination

**T**hank – Thank them for allowing you to participate in the patients care

Patients want us to:
- Show them courtesy and respect, listen carefully when they speak with us
- Explain what is happening to them at their level of understanding
- Communicate with them about their new medicines and medicine side effects
- Discuss discharge information with them
- Help manage their pain
- Be responsive when the call bell is used, especially for bathroom or bedpan assistance
- Maintain a quiet environment to help with healing, rest and comfort
- Maintain a clean environment

Patients also want us to demonstrate empathy. Empathy is the ability to see the world as another person, to share and understand another person’s feelings, needs, concerns and/or emotional state. Empathy is a selfless act; it enables us to learn more about people and encourages relationships with people. It is a desirable skill beneficial to ourselves, others and society.

Being empathetic requires two basic components - effective communication and a strong imagination; shared experiences can also help you to empathize. Empathy is a skill that can be developed and, as with most interpersonal skills, comes naturally to most people. You can probably think of examples when you have felt empathy for others or when others have been empathetic towards you.
**Code of Conduct**

Our Code of Conduct provides guidance and assists us in carrying out our daily activities within appropriate ethical and legal standards. These obligations apply to our relationships with our stakeholders:

- Patients
- Colleagues
- Physicians
- Volunteers
- Regulatory Agencies
- Third Party Payers
- Suppliers
- Shareholders
- Communities we serve
- Joint venture partners

It is required that all new employees attend Code of Conduct Orientation (A Tradition of Caring) training within 30 days of hire. Contract and agency personnel may complete the self-study version of orientation Code of Conduct training.

In addition, annually, all current employees hired prior to September 1st are required to complete Code of Conduct Refresher training on Healthstream by October 31st.

To get help with an ethics or compliance concern or to report a potential violation of our Code of Conduct contact your supervisor, Human Resources (HR), another member of management, your facility Ethics and Compliance Officer (ECO) - Dajana Yoakley / Ralph Uzzi Co-ECO, or call anonymously the Ethics Line: 1-800-455-1996.

**Questions for Review**

1. According to our Mission & Values statement, we are to act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.  
   True or False

2. The Board of Trustees is the governing body of the hospital that establishes policy and approves medical staff credentialing.  
   True or False

3. Patients want us to show them courtesy and respect and listen carefully when they speak with us.  
   True or False

4. Empathy is the ability to see the world as another person, to share and understand another person’s feelings, needs, concerns and/or emotional state.  
   True or False
5. The Plan for Provision of Patient Care is the document that outlines RMCBP’s plan for providing nursing care.  
   True or False

6. Our Code of Conduct Orientation program entitled “A Tradition of Caring” provides guidance to ensure that our work is done in an ethical and legal manner.  
   True or False

7. If you are hired prior to September 1st, you have to complete the annual Code of Conduct Refresher training in addition to Code of Conduct Orientation.  
   True or False

Patient’s Rights and Responsibilities

Patients have a fundamental right to considerate care that:
- Safeguards their personal dignity.
- Respects their cultural, psychosocial, and spiritual values.
- A medical center’s behavior toward its patients and its business practices has a significant impact on the patient’s experience and response to care.
- All patients/surrogates receive a copy of the Patient’s Rights and Responsibilities upon admission.

Management of Information: Confidentiality for All

- Every patient treated at RMCBP has the right to expect that personal and medical information will be kept confidential. Access to patient medical and non-medical information is permitted only to provide appropriate and necessary care.
- All employees and volunteers are responsible for protecting and preserving the confidentiality of our patients.
- All employees and volunteers sign a Confidentiality Statement which becomes part of all employee and volunteer personnel files.
- If applicable, all employees sign an Information Security Agreement for the use of computerized systems that becomes part of all employee personnel files.
- The Marketing Department coordinates release of patient information to the media.

To protect patient confidentiality:
- Avoid discussing patients in public places such as elevators, hallways, and cafeterias.
- Protect the patient’s medical record from use by unauthorized persons.
- Protect computer screens and phone conversations from unauthorized observers.
- Do not discuss patient information unless authorized by the patient or law.
- Do not look at medical record information unless you have a “need to know.”
• Avoid giving information on the telephone. Directory information is permitted: this consists of the patient's presence on the unit and condition (e.g., good, fair, poor, guarded -- not a lot of detail).
• Always log off computer system before leaving the work area.
• Never share your computer password.
• Only access, review, and share information necessary to perform your job.

**Patient Family Needs**

Regional Medical Center Bayonet Point recognizes the importance of family, spouses, partners, friends and other visitors in the care process of patients. We adopt and affirm as policy the following visitation rights of patients /clients who receive services from our facilities:

- To be informed of their visitation rights, including any clinical restriction or limitation of their visitation rights.
- To designate visitors, including but not limited to a spouse, a domestic partner (including same sex), family members, and friends. These visitors will not be restricted or otherwise denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity, gender expression, sexual orientation or disability. All visitors will enjoy full and equal visitation privileges consistent with any clinically necessary or other reasonable restriction or limitation that facilities may need to place on such rights.
- To receive visits from one’s attorney, physician or clergyperson at any reasonable time.
- To speak privately with anyone he/she wishes (subject to hospital visiting regulations) unless a doctor does not think it is medically advised.
- To refuse visitors.
- Media representatives and photographers must contact the hospital spokesperson for access to the hospital.

**Culturally Competent Care**

Cultural competence means understanding & respecting the patient’s cultural values, beliefs & practices when providing health care. *(Reference Cultural Diversity Table > Hospital Intranet > Department Page > Education > Shared Documents)*

**Steps in becoming culturally competent:**
- Understand your own cultural beliefs.
- Learn about other cultures, especially attitudes toward health care and ways of communicating/interacting.

*Ask for help. You cannot be expected to know all the nuances of each of the world cultures and customs and languages. However, you are expected to ask for help when needed.*

*Family members, particularly children, should NOT be used for interpreting medical information.*

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Tips for Providing Culturally Competent Care  **DO:**
- Try to understand people’s values, since values will influence their beliefs.
- Keep in mind that there are always individual variations within a group.
- Use translated patient education materials from Krames on Demand Intranet (KODI). Include the family as much as possible.
- Refer to Cultural Diversity table on the Hospital Intranet >Education>Shared Documents
- Call for a professional interpreter (Reference Policy/Procedure #90-E.910 - Interpreter Services – Language and Hearing Impaired)

Tips for Providing Culturally Competent Care  **DO NOT:**
- Stereotype. Do not project your own cultural perceptions and biases.
- Expect that all patients make their own decisions. In some cultures that value family, the family makes important decisions. In cultures where males are dominant, the husband may make the final decisions regarding the health care of their wife and children.
- Make clinical decisions based on communications in a language that you are not proficient with.
- Assume the patients want to be informed of a fatal diagnosis. Ask the patients upon admission to whom they would like information about their condition to be given.

**Need an Interpreter?**

To ensure patients of all languages have a means of communicating with health care providers and support departments within the Medical Center. It is recommended and encouraged that patients utilize the professional interpreter services. This will ensure patient confidentiality and effectively communicate the services and benefits at the Medical Center. This will assure comprehension of needed information so that informed decision-making can occur and assure the understanding and acknowledgment of Medical Center staff of that individual’s special needs.

American Sign Language is available via computer linkup and can be accessed through Nursing Administration or Nursing Supervisor. A PVX computer is located in the nursing office.

Crycom Language Line Service is available. A staff member can dial the PBX Operator from the patient’s room and tell the operator the foreign language they need. The operator will connect them with someone that speaks the language. The interpreter will ask the needed question of the patient and translate the answer into English for the staff member.

TDD (Telecommunications Device for the Deaf) is available through the PBX Operator as we have one in the facility. For assistance with sign language please contact our Case Manager at extension *95596. After hours contact the house supervisor. *(Reference Policy/Procedure #90-E.910 – Interpreter Services – Language and Hearing Impaired)*
Age-Specific Care

- In general, people grow and develop in stages that are related to their age and share certain qualities at each stage.
- The charts on the next few pages describe some basic facts about human growth and development that you can use in providing age-appropriate patient care.
- These facts should be used only as guidelines, and you should treat each patient as an individual and avoid stereotyping.

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<th>Age</th>
<th>Normal VS</th>
<th>Communication</th>
<th>Comfort</th>
<th>Safety</th>
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<tr>
<td>Infant (0-12 mos.)</td>
<td><strong>Heart Rate:</strong> Resting, awake: 80 – 150&lt;br&gt;Resting, asleep 70 – 120&lt;br&gt;<strong>BP:</strong> 65 – 91 / 50 – 54&lt;br&gt;<strong>Respiration:</strong> 30 - 35</td>
<td>Introduce self to caregiver&lt;br&gt;Explain procedures to caregiver&lt;br&gt;Talk slowly, calmly to infant&lt;br&gt;Infant has stranger anxiety beginning at 6 – 9 months&lt;br&gt;Minimize separations from parent or caregiver</td>
<td>Keep pt. warm &amp; dry&lt;br&gt;Allow for usual feeding schedule&lt;br&gt;Avoid continuous bright lights&lt;br&gt;Cuddle, allow caretaker nearby&lt;br&gt;Allow pt to keep pacifier, blanket, comfort toy</td>
<td>Keep side rails up&lt;br&gt;Give nonflammable toys&lt;br&gt;Avoid small objects within reach that could cause choking&lt;br&gt;Transport in size appropriate means</td>
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<tr>
<td>Toddler / Preschooler (1 – 5 yrs)</td>
<td><strong>Heart Rate:</strong> Resting, awake: 60 – 100&lt;br&gt;Resting, asleep 70 – 110&lt;br&gt;<strong>BP:</strong> 90 – 95 / 54 – 56&lt;br&gt;<strong>Respiration:</strong> 21 - 25</td>
<td>Introduce yourself&lt;br&gt;Can understand simple commands, but may choose to not cooperate&lt;br&gt;Do not rush pt&lt;br&gt;Allow to touch equipment&lt;br&gt;Include parent in explanations&lt;br&gt;Ask parent to explain directions in familiar words&lt;br&gt;Use familiar characters (like Barney) to older toddlers&lt;br&gt;Preschoolers may view illness as punishment for bad behavior.</td>
<td>Keep pt warm if not active&lt;br&gt;Do not separate from favorite toy, blanket, comfort toy, or adult&lt;br&gt;Allow older toddler to talk, verbalize fears&lt;br&gt;Can tolerate short separation from parent&lt;br&gt;If frightened, may accept explanations / exams given on “Teddy” or favorite toy&lt;br&gt;Invasive procedures are especially stressful to toddlers&lt;br&gt;Regression occurs with hospitalization</td>
<td>Do not leave unsupervised – does not recognize danger&lt;br&gt;Keep side rails up&lt;br&gt;Transport in crib, stroller, or wagon with side rails&lt;br&gt;Give nonflammable toys&lt;br&gt;Avoid small objects within reach that could cause choking</td>
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<tr>
<td>Age</td>
<td>Normal VS</td>
<td>Communication</td>
<td>Comfort</td>
<td>Safety</td>
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<td><strong>School Age</strong></td>
<td><strong>Heart Rate:</strong> 60 – 110</td>
<td>Introduce yourself</td>
<td>Be subtle in encouraging child to keep comfort objects with him / her</td>
<td>Curious</td>
</tr>
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<td>(6 – 12 yrs)</td>
<td><strong>BP:</strong> 97 – 112 / 57 – 71</td>
<td>Able to understand more complex explanations</td>
<td>May need parent</td>
<td>Able to accept limits</td>
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<td></td>
<td><strong>Respiration:</strong> 18 - 30</td>
<td>Talk to child directly</td>
<td>Use calm, unrushed approach</td>
<td>Transport in wheelchair or cart with side rails</td>
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<td>Allow time for questions</td>
<td>Allow child some input on decisions</td>
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<td>Likes to explore equipment before use</td>
<td>Maintain contact with peers</td>
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<td></td>
<td></td>
<td>Likes to get involved and make decisions</td>
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<td>Allow time for repeated questions</td>
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<td>Maintain privacy for older child</td>
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<td><strong>Heart Rate:</strong> 60 – 100</td>
<td>Introduce yourself</td>
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<td>Can recognize danger</td>
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<td>(13 – 17 yrs)</td>
<td><strong>BP:</strong> 102 – 128 / 60 – 80</td>
<td>Use adult vocabulary</td>
<td>Very modest – allow privacy</td>
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<td><strong>Respiration</strong> 16-20</td>
<td>Do not talk down to youth</td>
<td>Sometimes comfortable knowing parent is nearby</td>
<td>Transport as an adult</td>
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<td>Very curious – take time for explanations</td>
<td>Permit caretaker to accompany pt if desired</td>
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<td>Allow time for questions</td>
<td>Body image is very important</td>
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<td>Needs privacy</td>
<td>Remain non-judgmental</td>
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<td>Independence is important in later adolescence</td>
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<td>Permit choices</td>
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<td>Set realistic goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adult</strong></td>
<td><strong>Heart Rate:</strong> 60 – 100</td>
<td>Introduce yourself</td>
<td>Maintain adult’s privileges – decision making, privacy, routine of personal habits</td>
<td>If condition may put pt at risk of falling – put on fall precautions</td>
</tr>
<tr>
<td>(18 – 65 yrs)</td>
<td><strong>BP:</strong> 90 – 130 / 60 – 85</td>
<td>Call pt by title and last name</td>
<td>Offer assistance with personal care</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respiration</strong> 16-20</td>
<td>Do not address by “honey”, “dear”, “sweetie”, etc.</td>
<td>Inform of available amenities / services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain procedures, giving details</td>
<td>Inform of hospital policies</td>
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<tr>
<td></td>
<td></td>
<td>Allow time for questions</td>
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<td></td>
<td></td>
<td>Be respectful</td>
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</tbody>
</table>
The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced “H-caps”), also known as the CAHPS® Hospital Survey, is a standardized survey instrument and data collection methodology for measuring patients’ perceptions of their hospital experience.

While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally, and nationally.

The HCAHPS survey asks discharged patients 27 questions about their recent hospital stay. The survey contains 18 questions about critical aspects of patients’ hospital experiences (communication with nurses and doctors, the responsiveness of hospital staff, the cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and would they recommend the hospital).
**Point It Out**

Patient comments and suggestions are very valuable to us. All patients are given a *Point It Out* brochure at discharge. The brochures are also available at the Welcome Center and at the Nursing Stations. These are meant for patients and visitors to express their comments, suggestions, and compliments about the care and services received at our facility. The brochures are returned to us postage paid.

**Bioethics Program**

The purpose of the Ethics Committee is to serve as an advisory body to patients and their families and the facility’s medical, nursing, and administrative staff on matters relating to the moral and ethical decisions and/or issues which may arise while care/treatment is being rendered to patients at Regional Medical Center Bayonet Point.

The committee membership is multi-disciplinary. When conflicts of an ethical or moral nature arise between health care providers or between the providers and the patient or the patient’s family or surrogate/ proxy, an ethical consultation may be requested.

Anyone may request an ethics consultation by completing an *Ethics Committee Consultation Request* form. These forms are available at all nursing stations. It is the committee’s expressed intent to assist involved parties in coming to a mutually acceptable resolution felt to be in the best interest of the patient. The findings of the committee are strictly advisory and are in no way legislative or binding.

**What are Ethical Issues?**

Clinical and organizational ethical issue decisions are made daily at the Medical Center. They are conflicts arising from the admission, treatment, or discharge of a patient.
- Patients, family members, physicians, nurses, and other members of the healthcare team may present them.
- The purpose of the Ethics Committee is to serve as an advisory body to patients and their families and the facility’s medical, nursing, and administrative staff on matters relating to the moral and ethical decisions and/or issues which may arise while care/treatment is being rendered to patients at Regional Medical Center Bayonet Point.

**What should I do if I anticipate an ethical issue?**

Follow the appropriate chain of command and refer to the Ethics Committee Policy in the Administrative Policy and Procedure Manual for detailed information *(Reference Policy/Procedure # 918.208 – Bioethics Consults)*
Guideline for Organ and Tissue Donation

A potential donor is someone who has suffered an irreversible brain injury or insult, is on a ventilator, and the progression of brain death is imminent. All imminent brain deaths must be referred to Life Link before ventilator is discontinued. A potential tissue donor may result from brain death or cardiac expiration.

LifeLink is the hospital’s official requester for organ donation. The LifeLink Coordinator is the only person that should approach the family for consent of organ donation.

The primary nurse or designee will call LifeLink/Lions at 1-800-64-DONOR (36667) (Reference Policy/Procedure # RI 010.600 - Life Link Organ Donation)

Questions for Review

8. RMCBP provides various ways to assist with communication with any patient or visitor. Some of these ways include: a) translator, b) Crycom Language Line Service, and c) Telecommunications Device for the Deaf -TDD. True or False

9. Patients have a fundamental right to considerate care that safeguards their personal dignity, and respects their cultural, psychosocial, and spiritual values. True or False

10. A Medical Center’s behavior toward its patients and its business practices has a significant impact on the patient’s experience and response to care. All patients/surrogates receive a copy of the Patient’s Rights Responsibilities upon admission. True or False

11. The hospital provides care that optimizes the dying patient’s comfort and dignity and addresses the patient’s and his or her family’s psychosocial and spiritual needs. True or False

12. The attending physician and the hospital determine medical suitability for organ or tissue donation. True or False

13. When communicating with a toddler (1-5 years of age) the following techniques should be used: Introduce yourself, do not rush patient, allow them to touch equipment, exclude parents from explanation to establish a relationship with the child. True or False

14. Family members, including children should be used for interpreting medical information when necessary. True or False
Quality Management

Regional Medical Center Bayonet Point’s Plan for Performance Improvement are:

- Maintain and improve the quality of patient care
- Enhance appropriate utilization of resources
- Design efficient processes of care/services
- Measure, assess, and improve performance
- Reduce or eliminate unnecessary risks and hazards within the facility. These goals are accomplished through our coordinated, systematic, hospital-wide approach to performance improvement.

Sentinel Event: A Sentinel Event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

Root Cause Analysis: A Root Cause Analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. It must be completed within 45 days of the incident.

Failure Mode Effect Analysis: A systematic way of identifying and preventing problems in processes and products before they occur. It is aimed at prevention. It does not require a prior accident or close call to be instituted. It is a performance improvement tool designed to proactively identify risks and reduce unanticipated adverse events. At least annually a high risk process is selected based on, at least in part; information published about most frequent sentinel events and risks. The completed process is reported through the Safety and Quality Coordinating Committee.

Tracer Methodology: A process surveyor uses during the on-site survey. They follow individual patients through the organization’s health care process in the sequence experienced by the patient. Depending on the health care setting, this may require surveyors to visit multiple care units, departments or areas within an organization or single care unit to “trace” the care rendered to a patient.

Regional Medical Center Bayonet Point has three objectives:

- To achieve recognition as the safest hospital in the healthcare community,
- To achieve a safety oriented culture that embraces excellence in safe patient care,
- **Patient Safety: Patient safety is no accident! It is everyone’s responsibility!**

Performance Improvement Teams: A selected group of individuals, who know the process best, are assigned the task of identifying opportunities to improve a process. Teams are sanctioned and prioritized by the Quality Coordinating Council (QCC) based on the hospital’s goals and the needs of its customers and community.
The hospital's method for improving processes is known as the Quality Method/Quality Model. Regional Medical Center uses the FOCUS – PDSA method.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Find a process to improve - What do you want to accomplish? What are the customer’s needs or expectations; what needs to be improved? Study the process. What can be done to improve the process?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do</td>
<td>Start applying process changes; try improvement methods on a small scale first; do a pilot study.</td>
</tr>
<tr>
<td>Study</td>
<td>Measure and analyze results of the improvement effort. Was it successful; did you accomplish what you want? Is the customer satisfied? Are additional changes needed?</td>
</tr>
<tr>
<td>Act</td>
<td>If improvements were successful, implement measures on a larger scale. Change procedures and / or policies to make the changes permanent throughout the organization. If not successful, begin again at the planning phase.</td>
</tr>
</tbody>
</table>

Core Measures

The Joint Commission in conjunction with the Center for Medicare and Medicaid Services launched a new generation of reporting health care information about the quality and safety of care provided in its accredited health care organizations across the country. The Core Measure statistics provide clear, objective data to individuals that will permit them to compare local hospitals with others on state and national levels.

Core Measures data provides hospital specific information about clinical performance in the care of patients in the following major categories:
- Acute Myocardial Infarction (AMI)
- Surgical Care Improvement Project (SCIP)
- Stroke (STK)
- Out Patient – Surgical Care (OP-Surg)
- VTE prophylaxis
- Immunization
- Sepsis

Disease Specific Certifications by The Joint Commission (TJC)
- Advanced Stroke Certification
- Chest Pain
- Acute Myocardial Infarction (AMI)
- Coronary Artery Bypass Graft (CABG)
- Joint Replacement – Hip & Knee
- Cancer from the Commission on Cancer
What is Sepsis?

Sepsis is a potentially fatal disease that can affect anyone, any time, at any age. Knowing your sepsis criteria saves lives. Use of the “bundle” is evidence-based practice. “Every Patient, Every Time!” RMCBP is abstracting the charts of those that fall under the sepsis guidelines and measuring performance. If you have any questions, please feel free to call the sepsis coordinator at (727) 389-4207.

What Is a Heart Attack?

According to the American Heart Association, every 36 seconds, someone dies from heart and blood vessel diseases – America’s No. 1 killer. Since most of those deaths are from coronary heart disease — about 452,000 each year — it’s important to understand risk factors, early warning signs and the importance of early recognition and activation of the emergency response system.

A heart attack occurs when the blood flow to a part of the heart is blocked most often by a blood clot. This happens because coronary arteries that supply the heart with blood slowly become thicker and harder from a buildup of fat, cholesterol and other substances, called plaque. If the plaque breaks open and a blood clot forms that blocks the blood flow, a heart attack occurs. Then the heart muscle supplied by that artery begins to die. Damage increases the longer an artery stays blocked. Once that muscle dies, the result is permanent heart damage.

Heart attacks have beginnings that may include chest discomfort, shortness of breath, shoulder and/or arm pain and weakness. These “beginnings” occur in over 50% of patients. Most importantly, if recognized in time, these “beginnings” can be treated before the heart is damaged.

What is EHAC?  EARLY HEART ATTACK CARE

85% of heart damage occurs within the first two hours of a heart attack. Early Heart Attack Care (EHAC) is knowing the subtle danger signs (Prodromal Symptoms) of a heart attack and acting upon them immediately and receiving early treatment and/or activating emergency medical services (911).

What are the signs and symptoms?

*Chest discomfort (Angina):* This discomfort or pain can feel like a tight ache, pressure, fullness or squeezing in the center of the chest lasting more than a few minutes. These feelings may come and go.

*Stable Angina:* occurs as a predictable event after exercise or increased activity.

*Unstable Angina:* occurs when exercise is prolonged, and frequently worsens with each episode. Unstable Angina can also occur at rest. It is associated with Left Main and Proximal LAD Coronary Artery Disease with 70% to 100% stenosis.
Upper body pain - Pain or discomfort may extend beyond their chest to the shoulders, arms, back, neck, teeth or jaw. The patient may complain of upper body pain without any chest discomfort.

Stomach pain - Pain may extend downward into the abdominal area.

Shortness of breath - The patient may pant for breath or try to take deep breaths. This often occurs before chest discomfort develops.

Anxiety - The patient may express a sense of doom or feel like a “panic attack” for no apparent reason.

Light-headedness - The patient may complain of feeling dizzy or feel like “passing out”.

Sweating - The patient may suddenly break out into a sweat with cold, clammy skin.

Nausea and vomiting - The patient may complain of a feeling of stomach sickness.

A woman’s heart attack has more varied symptoms than a man’s symptoms. While women can experience the powerful chest and arm pain typical in men, they more often experience mild symptoms and NO CHEST DISCOMFORT. Approximately one third of women experience no chest pain when having a heart attack.

A woman may complain of:
- Many report flu-like symptoms.
- Pounding heartbeats (palpitations or feeling extra heartbeats)
- Upper abdominal pain
- Sudden extreme fatigue
- Unexplained weakness
- Discomfort/pain between shoulder blades
- Women are usually 7 to 10 years older and more likely to have diabetes mellitus than men at the time they first experience an MI.
- **The delay in seeking care is greater in women than in men.**
- When women seek medical care, they are 3 times more likely than men to receive a psychological rather than a cardiac diagnosis.
- Even when a cardiac problem is suspected, women are referred for invasive testing less often and receive medical management rather than surgical treatment more often than men.

ACS Symptoms in children:
- Unlike adults, chest pain due to a cardiac cause is extremely uncommon in children.
- Children may experience a "typical" crushing mid-sternal chest pain that radiates to the neck and chin or to the left shoulder and arm. More likely, children will have less specific complaints.
Not all chest pain is cardiac in nature. However when a person reports or complains of “chest pain” it should be treated as cardiac, until other possible causes can be ruled out.

**Risk Factors**
- Hypertension—elevated blood pressure
- High cholesterol
- Smoking
- Physical inactivity
- Obesity
- Diabetes
- Family history
- Sex
- Age
- Race
- Stress
- Alcohol
- Diet and Nutrition

**Time is muscle** – so it is imperative to seek immediate emergency cardiovascular care within one hour of experiencing signs or symptoms of a heart attack. Call 9-1-1 to activate the Emergency response system.

Learn the signs, but remember this: Even if you’re not sure it’s a heart attack, have it checked out (tell a doctor about your symptoms). Minutes matter! Fast action can save lives — maybe your own. Don't wait more than five minutes to call 9-1-1 or your emergency response number.

Calling 9-1-1 is almost always the fastest way to get lifesaving treatment. Emergency medical services (EMS) staff can begin treatment when they arrive — up to an hour sooner than if someone gets to the hospital by car. EMS staff is also trained to revive someone whose heart has stopped. Patients with chest pain who arrive by ambulance usually receive faster treatment at the hospital, too. It is best to call EMS for rapid transport to the emergency room.

**What makes the EHAC campaign different?**
- Unlike most programs that promote recognition of the signs and symptoms of an impending heart attack, the EHAC initiative encourages early recognition when symptoms may be mild.
- For the 50% of people experiencing these symptoms, the heart attack can be prevented with early treatment – BEFORE ANY DAMAGE TO THE HEART CAN OCCUR!
- A campaign intended to educate everyone as to the early symptoms of a heart attack in order to prevent the heart attack from ever occurring. Preventing the heart attack prevents heart damage.
- A plea to the public to be responsible, not only for themselves, but for those around them who may be experiencing early heart attack symptoms, and to help them obtain immediate treatment.
• A public education program that concentrates on the benefits of receiving early treatment, and activating emergency medical services.

Identify your risk factors: change what you can, foster a healthy lifestyle.
• Stop smoking.
• Treat high blood pressure.
• Eat a healthy diet low in saturated fat, trans-fat, cholesterol and salt.
• Exercise at least 30 minutes on most days of the week.
• Manage your weight within the normal range for your body type.
• Control your blood sugar if you have diabetes.
• Take medications as prescribed and see your doctor for regular check–ups.
• Call 911 if chest pain is unrelieved by nitroglycerin, becomes severe, radiates to the arms, neck, or jaw, or is associated with sweating or nausea. Do not ignore worsening or persistent symptoms.

If an inpatient develops chest pain:
• The nurse at the bedside applies O2 at 4 to 6 Liters to maintain O2 saturation > 90%
• A stat ECG is obtained and stat vital signs with BP in both arms
• Call *31999 for the operator to call the Rapid Response Team
• The nurse places the crash cart in the patient room

Processes to Know at RMCBP

STEMI: Door to Balloon (D2B) goal = <90 min. from arrival in ED to Inflation of Balloon (reperfusion of vessel) in Cardiac Cath Lab (CCL).

Inpatient STEMI – Recognition and immediate activation of the Rapid Response Team (RRT); 12 lead EKG, notification of Cardiologist/PCP /CCL team.

NSTEMI - 12 Lead EKG: Cardiologist/PCP

ACS / UA - Recognition of signs & symptoms; rapid assessment, 12 Lead EKG, PCP/Cardiologist for appropriate management.

Questions for Review

15. The goals of RMCBP Plan for Performance Improvement are to: Maintain and improve the quality of patient care, enhance appropriate utilization of resources, design efficient processes of care/services, measure, assess and improve performance, reduce or eliminate unnecessary risk and hazards within the facility. True or False

16. Prodromal symptoms such as mild chest pain, intermittent or stuttering chest pain can be indicative of a heart attack. True or False
17. If you found a patient in cardiac arrest, you should call for help; have someone dial *31999; initiate CPR (if BLS certified) unless there is a Do Not Resuscitate order then stay with the patient and call for help. **True or False**

18. Heart attack warning signs can include: chest pain or pressure, discomfort in arms, back, neck, jaw or stomach; lightheadedness, sweating, nausea or indigestion; shortness of breath and fatigue. **True or False**

19. For the 50% of people experiencing symptoms, the heart attack can be prevented with early treatment before any damage to the heart can occur. **True or False**

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### 2016 Hospital National Patient Safety Goals*

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

<table>
<thead>
<tr>
<th>Identify patients correctly</th>
<th>Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.01.01.01</td>
<td></td>
</tr>
<tr>
<td>NPSG.01.03.01</td>
<td>Make sure that the correct patient gets the correct blood when they get a blood transfusion.</td>
</tr>
</tbody>
</table>

**Improve staff communication**

<table>
<thead>
<tr>
<th>Use medicines safely</th>
<th>Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.03.04.01</td>
<td></td>
</tr>
<tr>
<td>NPSG.03.05.01</td>
<td>Take extra care with patients who take medicines to thin their blood.</td>
</tr>
<tr>
<td>NPSG.03.06.01</td>
<td>Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.</td>
</tr>
<tr>
<td>Use alarms safely</td>
<td>NPSG.06.01.01</td>
</tr>
<tr>
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</tr>
</tbody>
</table>

**Prevent Infection**

<table>
<thead>
<tr>
<th>NPSG.07.01.01</th>
<th>Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.07.03.01</td>
<td>Use proven guidelines to prevent infections that are difficult to treat.</td>
</tr>
<tr>
<td>NPSG.07.04.01</td>
<td>Use proven guidelines to prevent infection of the blood from central lines.</td>
</tr>
<tr>
<td>NPSG.07.05.01</td>
<td>Use proven guidelines to prevent infection after surgery.</td>
</tr>
<tr>
<td>NPSG.07.06.01</td>
<td>Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.</td>
</tr>
</tbody>
</table>

**Identify patient safety risks**

<table>
<thead>
<tr>
<th>NPSG.15.01.01</th>
<th>Find out which patients are most likely to try to commit suicide.</th>
</tr>
</thead>
</table>

**Prevent mistakes in surgery**

<table>
<thead>
<tr>
<th>UP.01.01.01</th>
<th>Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body.</th>
</tr>
</thead>
<tbody>
<tr>
<td>UP.01.02.01</td>
<td>Mark the correct place on the patient’s body where the surgery is to be done.</td>
</tr>
<tr>
<td>UP.01.03.01</td>
<td>Pause before the surgery to make sure that a mistake is not being made.</td>
</tr>
</tbody>
</table>


**Specimen Labeling Requirements**

Containers used for blood and other specimens are labeled in the presence of the patient.

The following information is required for acceptance of specimens. Specimens, which fail to meet criteria, must be rejected.

Routine and non-blood specimens.

1. Patient name on specimen
2. 3-4 ID number
3. Collection date/time/by initials
Critical Values and Critical Tests

Critical Value
A critical value shall be defined as any test result that is beyond the normal variation with high probability of a significant increase in morbidity and/or mortality in the near future, thus requiring immediate attention/treatment. The time interval for notifying the physician is one hour. The Chain of Command Policy is initiated if the physician cannot be contacted within 60 minutes. (Reference Policy/Procedure # LD 235.900 – Chain of Command)

Critical Test
A critical test will always require rapid communication of the test result even if the test is normal. The time interval for notifying the physician is dependent on the test ordered.

Label all Medications/Solutions on and off the Sterile Field
Elements of safe medication practices should include, but not be limited to, specification of methods for:
- Verifying medication labels
- Delivering medications to the sterile field
- Labeling medication on and off the sterile field
- Confirming labeled medications on the field
- Communicating medication, strength, and dosage as the medication is passed to the person who will administer the medication

Throughout the hospital (not just in the operating room), all medications are labeled to help prevent potentially tragic errors.
- Labels must be verified and include:
  - Drug name
  - Strength
  - Amount (if not apparent from container)
  - Expiration date when not used within 24 hours
  - Expiration time when expiration occurs in less than 24 hours
- Labels must be used even if only one medication is being used
- Do not label more than one medication at a time
- Sterile pens are available for labeling purposes

Reduce the Risk of Health-Care Associated Infections: Comply with the current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- Perform Hand Hygiene when hands are obviously soiled
- After using the restroom
- Before and after eating
- After blowing nose/coughing
- At the start of shift duty
- Upon entering the patient’s room
• Before touching a patient
• Before clean/aseptic procedure
• After body fluid exposure risk
• After touching a patient
• After touching a patient’s surroundings
• After removing gloves
• Upon exiting the patient’s room
• On completion of your shift duty

**Medication Reconciliation**

The medication reconciliation process can help reduce medication errors in our hospital. Creating an accurate medication list is important to patient safety. Medication errors can be reduced by capturing a complete and accurate list of the medications a patient is taking including non-prescription and alternative medications, and documenting them in Meditech accurately.

**Anticoagulation Management**

Nurses will provide patient education, including written information that addresses the importance of follow-up monitoring, compliance issues, dietary restrictions (food-drug interactions), and potential for adverse drug reactions and interactions. Patient education leaflets are printed from the Krames on Demand database.

Patients will be placed on bleeding precautions and protected from potential bleeding from IM injections and monitored for signs of bleeding.

**Universal Protocol**

Ensures that there is verification of patient, procedure, site, and a time out is performed for any invasive procedure requiring consent. Confirms appropriate documents have been reviewed and are consistent with each other, and that they are consistent with the patient's expectations and the staff's understanding of the intended patient, procedure and site. Universal protocol also confirms relevant images, required implants, and special equipment are available.

**A Pre-procedure Checklist** is completed in PCDM to review and verify that the following items are available and accurately matched to the patient:

- Relevant documentation – (H&P, nursing assessment and pre-anesthesia assessment)
- Accurately completed and signed procedure consent form
- Correct diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly labeled
- Any required blood products, implants, devices and/or special equipment for the procedure
Marking the operative site
The site marking has the following characteristics:

- It is made at or near the procedure site or incision site.
- The mark must be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep and sterile draping. Adhesive site markers should not be used as the sole means of marking the site.
- It is positioned to be visible after the patient has his or her skin prepped, is in his or her final position and sterile draping is completed.
- The procedure site is marked by a licensed independent practitioner or other provider who is privileged or permitted by the hospital to perform the intended surgical or nonsurgical invasive procedure. The individual will be involved directly in the procedure and will be present at the time the procedure is performed.

A “Time out” must be completed immediately before starting the procedure

- The “time out” is consistently initiated by a designated member of the team and includes active communication among all relevant members of the procedure team. It is conducted in a standardized fail-safe mode (that is, the procedure is not started until all questions or concerns are resolved). The time out is conducted prior to starting the procedure and ideally prior to the induction of the anesthesia process (including general/regional anesthesia, local anesthesia, and spinal anesthesia), unless contraindicated.

The “Time out” has the following characteristics:

- It is standardized throughout the facility.
- It is initiated by a designated member of the team.
- It must involve the immediate members of the procedure team including the proceduralist(s), the anesthesia provider, the circulating nurse, the operating room technician, and other active participants as appropriate for the procedure, who will be participating in the procedure at its inception; and noted in the patient record.
- It involves interactive communication between all team members, and any team member is able to express concerns about the procedure verification.
- It includes a defined process for reconciling differences in responses.

The “Time out” must include:

- Correct patient identity
- Confirmation that the correct side and site are marked
- An accurate procedure consent form
- Agreement on the procedure to be done
- Correct patient position
- Relevant images and results are properly labeled and appropriately displayed
- The need to administer antibiotics or fluids for irrigation purposes
- Availability of correct implants and any special equipment or special requirements
- Safety precautions based on patient history or medication use
During the time out, other activities are suspended, to the extent possible without compromising patient safety, so that all relevant members of the team are focused on active confirmation of the correct patient, procedure, site, and other critical elements.

When two or more procedures are being performed on the same patient, a “time out” is performed to confirm each subsequent procedure before it is initiated. Whenever there is more than one procedure being performed by separate procedure teams, there needs to be a time-out prior to each team commencing their procedure. This does not apply to those situations where the same team is performing multiple components during a single procedure. A specific situation requiring two time-outs is when hospital policy or law/regulation require two separate consents, such as for a Cesarean section and a tubal.

**Prevention of Retained Foreign Bodies**

Failure to remove surgical instruments at the end of a procedure is a more common occurrence nationally than one might suspect. Regional Medical Center Bayonet Point makes every effort to avoid this error. Reference policy  *Policy / Procedure # PC 526.001* describes the process for careful counts of all items that have potential for injury to the patient as a result of not being removed. The definition of a retained foreign body as well as the details of this important process are carefully outlined in the policy / procedure noted. (Reference *Policy / Procedure # PC 526.001 Count Policy*)

**Patient’s active involvement in their own care:**
- Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.
- The hospital provides the patient with information regarding infection control measures for hand hygiene practices, respiratory hygiene practices, and contact precautions according to the patient’s condition.
- By engaging patients in the care process clinicians can learn information that may have been missed if the patient did not raise the point.

**Identify patient safety risks: Suicide Prevention**

A. All patients admitted to acute care services will be screened for their risk of suicide through defined questions.
B. Any patient making suicidal statements shall be considered at risk and immediately fall within the group of patients identified as being a potential risk. The Admission Assessment will include specific screening questions. If the patient answers yes to any of the questions the patient is at risk for suicide and must be placed in suicide precautions.

C. **A positive Suicide Risk Screen requires notification of the attending physician to obtain an order for suicide precautions. Two levels of precautions can be ordered:**
   1. **MONITOR/OBSERVE EVERY 15 MINUTES – ICUs ONLY**
   2. **LINE OF SIGHT (SITTER) - MED/SURG**
ALL PATIENTS ASSESSED TO BE A SUICIDE RISK:
Staff members will complete the safe patient/safe room check list with the primary nurse, charge nurse or supervisor for any patient screened “at risk”. The reason why any item on the checklist could not be implemented must be documented in the comments.
- The ICU primary nurse will validate that the every 15 minute checks were completed by signing off on the Suicide Precautions at the end of the shift.
- Notify Dietary for a food tray with Styrofoam and paper items only.
- Remove any unnecessary equipment or supplies from the patient room.
- Remove the cabled telephone – a portable telephone will be made available.
- Place in a colored patient gown designated as elopement risk.
- Nursing staff administering medications are to verify the ingestion of medication to prevent “cheeking” or hoarding.
- Staff shall ensure safety when the patient is in the restroom, shower, or changing clothes.
- Staff shall attempt to maintain the patient’s privacy as much as possible; however the safety of the patient must be the main consideration. Staff can be outside the open door but the patient must be in sight.
- Patients going off the unit for testing must be accompanied by the sitter/nurse.
- Visitors may be limited per physician’s order.
- Assess the risk of patient experiencing detoxification - place as problem on care plan.
- **BELONGINGS AND MEDICATION WILL BE REMOVED FROM THE PATIENT'S POSSESSION**

ICU PATIENTS:
- Plastic bags will be removed from the patient room.
- Ambulatory patients in the ICU will have the sharps box and boxes of gloves removed.
- Remove any unnecessary equipment or supplies from the patient room.
- The 72 hour time frame for a BA-52 is suspended until the patient is medically cleared, but the presence of the BA-52 allows the hospital to contain a patient against their will.

**If a Baker Act patient tries to leave the hospital**
- Call Code Grey (*31999) to determine if a presence or "show of strength" will dissuade them from leaving.
- Verbally persuade or convince them to stay but DO NOT physically prevent them from leaving.
- If they are successful at leaving the premises - immediately notify the police and the nursing supervisor.
- Complete an occurrence report for "elopement: involuntary patient".

Once patient is medically cleared the “72" hours begin. It is the Medical Center's responsibility to notify the Baker Act receiving facility within two hours of medical clearance that the patient is ready to transfer and to actually transfer the patient within 12 hours. Patients that are high risk for suicide are prioritized for placement based on bed availability.
**Fall Prevention**

**Fall:** A sudden or gradual unexpected movement of a patient from a sitting or lying position to a floor or lower surface or from a standing position to the floor (not due to any intentional movement or extrinsic force such as a stroke, fainting or seizure).

**Near fall:** Sudden loss of balance that does not result in a fall or other injury. This can include slip, stumble, trip, but regains balance prior to fall or is assisted to the floor in a controlled fashion.

The nurse will perform and document a Fall Risk Assessment
- On admission
- Every shift
- When a patient’s condition changes (as in after surgery)
- When a fall or near miss occurs
- When transferred to a new unit

**Universal Falls Precautions used on all patients as follows**
- Orient patient to surroundings
- Ensure patient wears eyeglasses, if applicable
- Ensure patient’s footwear is adequate. If none is available, provide non-slip socks
- Keep bed in low position
- Lock all moveable equipment before transferring patient
- Assure that all furniture and equipment in the patient room is and remains organized in an orderly fashion
- Clean up spills immediately
- Ensure adequate lighting at night
- Ensure that no towels or other soiled linen is placed on the floor
- Assure nurse call system, telephone and personal items are accessible at all times
- Educate patient / family about safety and fall prevention

**If you witness a fall or find patient who has fallen, immediately post fall**
- Be sure the patient is cared for and the environment is safe.
- Get help to assist patient.
- Notify Director, House Supervisor, Resource Nurse, or Clinical Coordinator.
- Notify Physician.
- Complete Patient Notification Occurrence Report.
- Perform Fall Huddle and complete Huddle Form.
- Families must be notified of the fall, at the time of the fall, regardless of injuries.
- Assess mental / physical status of patient to identify changes from pre-fall status and degree of injury.
• Assess whether patient can be moved and returned to bed / chair. Assess need to transport patient by stretcher and / or with assistance.
• Treat sustained injuries.

If a fall-related injury occurs, make a follow-up assessment of patient’s post-fall condition as needed (no earlier than 8 hours and no later than 24 hours) to identify delayed complications.

Restraints

The definition of a restraint is any physical or pharmacological means used to restrict a patient's movement, activity, or access to their own body. Patients have a right to be free from restraints unless restraining is necessary to treat their medical condition or symptoms, or to prevent them from harming themselves or others.

Allergy Identification Bracelets

The Admitting Nurse will identify patient allergies:
• Identifies allergies through the admission interview with the patient, family or other caregivers.
• Writes all allergies on the white portion of the red armband legible in ink. More than one armband may be used for multiple allergies.
• Identify any food allergies, especially shellfish, for possible Iodine allergies and eggs for possible allergies to vaccines.
• Identify no allergies by writing “NKDA” (No Known Drug Allergies) on the armband and placing it on the patient.
• Attach the red allergy band securely to the wrist and check routinely to insure no restriction of circulation or movement. If unable to use the wrist, the patient’s ankle may be used.

Latex Allergy

There are 3 types of problems associated with rubber products:
• Irritation
• Contact dermatitis/Type IV hypersensitivity – (generally confined to the area of the rubber contact) are related to rubber chemical exposure, occurs within 24 to 48 hours of exposure, and are rarely life threatening.
• IgE-antibody mediated allergies/Type I hypersensitivity) – manifest as a spectrum of local to systemic reactions, are related to rubber protein exposure (sometimes attached to glove cornstarch powder), occurs within minutes of exposure, and can be life threatening.

Signs/Symptoms of Type I Hypersensitivity to Latex Include:
• Skin: rash, swelling, hives, itching, redness, irritation
• Eyes: itchiness, tearing, watering, redness
• Upper airway: runny nose, throat tightness / swelling, sneezing
• Lower airway: asthma, wheezing, cough, shortness of breath, chest discomfort
• GI: nausea, vomiting
• Cardiovascular: chest pain, palpitations, hypotension, lightheadedness, tachycardia

While it is uncommon, life threatening anaphylactic shock may occur within minutes of exposure. It is most likely to occur when the skin barrier has been broken or exposure is across a mucous membrane (e.g., inhaling glove cornstarch powder with absorbed latex protein, blowing up a balloon, using a condom, with a rectal/colon examination, urethral catheterization, or dental surgery). Direct skin contact with latex is not necessary for a reaction to occur. For example; allergenic latex proteins are absorbed on glove powder which, when latex gloves are snapped on and off, become airborne and can be directly inhaled.

**Identification of Latex Allergy Patients**

- While obtaining the patient history, the nurse will ask about past reaction to any latex/rubber product, allergy to banana, avocado, apricot, kiwi, papaya, passion fruit, chestnuts, or milkweed and history of neural tube defects and congenital GU abnormalities.
- The admitting nurse will identify allergies as part of the admission assessment and document in the Patient Care Documentation Module.
- An allergy bracelet must be placed on the patient listing the allergies.
- A latex allergy sticker will be placed on the front of the patient’s medical record.
- A latex allergy sign will be placed on the door of the patient’s room.
- Send out a Meditech message “Y.Latex” to alert all procedural areas.

**Prevention of Allergic Reactions**

- Limit patient exposure.
- Use only synthetic (non-latex) gloves in the patient's room. This includes gloves used for other patients and for cleaning the room.
- Use latex-free products. If you think there is a chance that there is latex in a product, avoid using it or use a barrier. If no latex-free alternative exists, use stockinette or kling as a barrier (i.e., blood pressure cuff, tourniquet).
- Keep the door of patient’s room closed.
- Avoid patient exposure to latex when transported off the unit.

**Instruct the patient to:**

- Wear Medic-Alert bracelet at all times.
- Tell all health care providers (do not count on it being in chart).
- Carry auto-injectable epinephrine/B-agonist inhaler.
- Identify natural latex rubber containing products.

**Diagnosis and Treatment of Latex Anaphylaxis**

Anaphylaxis generally occurs 20 to 60 minutes after exposure to latex, and presents with hypotension, bronchospasm, and rash. (Hypotension is the most common sign. Rash does not
always occur.) Treatment is similar to the treatment of severe allergic reactions caused by other antigens.

**Emergency nursing care includes:**
- Stop contact with latex.
- Do not leave patient. Call for help.
- Have epinephrine and other emergency medications readily available.
- Maintain airway. Initiate CPR if indicated.
- Monitor vital signs.

**Pain Management**

- Pain is one of the most common reasons that patients seek medical attention.
- Pain is a subjective experience and the patient’s self-report of pain is the most reliable indicator.

*Pain is assessed upon admission, before and after any procedure, and when patient condition requires further assessment.*

**Questions for Review**

20. An allergy band is only placed on patients who have an identified food or medication allergy.  **True** or **False**

21. Allergies to latex are treated as any other allergy and simply need to have the allergy identified on their allergy band.  **True** or **False**

22. If you witness a fall or find a patient who has fallen, immediately post fall - be sure the patient is cared for and the environment is safe.  **True** or **False**

23. Patients’ self-report of their pain level is the most reliable indicator.  **True** or **False**

**Prevention of Medical Errors**
This facility is committed to preventing the occurrence of any medical errors. A system is in place to report any and all errors in a non-punitive environment. In accordance with Joint Commission and the Centers for Medicare and Medicaid Services we support the “SPEAK UP” Program:

Speak up if you have questions or concerns, and if you don't understand ask again. It’s your body, you have a right to know.

Pay attention to the care you are receiving. Make sure you’re getting the right treatments and medications by the right healthcare professionals.

Educate yourself about your diagnosis, the medical tests you are undergoing and your treatment plan.

Ask a trusted family member or friend to be your advocate.

Know what medications you take and why you take them. Medication errors are the most common healthcare mistakes.

Use a hospital, clinic, surgery center or other type of healthcare organization that has undergone a rigorous on-site evaluation against established state-of-the-art quality and safety standards, such as that provided by The Joint Commission.

Participate in all decisions about your treatment. You are the center of the healthcare team.

**Security and Photo ID Badges**

- **Faculty/Students**: Required to wear School ID Badge above the waist.
- **Local Agency**: Required to wear agency ID Badge above the waist.
- **Traveling Agency/Contract**: Required to wear a RMCBP ID Badge above the waist.
- **Visitors/Vendors**: Required to sign in with photo ID and badge provided at that time.

**Parking**

Due to severely limited parking on the RMCBP campus, it is important to only park in designated staff parking areas.

**Emergency Codes**

*Dial *31999 - State the emergency situation and the location. The PBX operator will announce the code overhead. To report an emergency or “emergency code” within the hospital dial *31999 if accessible to the medical center operator or 911 if not accessible to the medical center operator.*

These codes include the recommended Florida Hospital Association names. The last six code titles are Regional Medical Center’s internal code titles. The safety codes are placed on a card to be worn with your hospital identification badge.
Questions for Review

24. To report an emergency or “emergency code” within the hospital dial *31999 if accessible to the medical center operator or 911 if not accessible to the medical center operator.

True or False

25. It is important that you always wear your RMCBP ID badge at all times. If someone is in your area and they do not have an ID badge you have the right to ask them who they are.

True or False

Environment of Care

1. Safety and Security Management Plan
2. Fire Prevention Management Plan
3. Utilities Management Plan
4. Equipment Management Plan
5. Hazardous Materials Management Plan
6. Emergency Management Plan
Safety Management Plan

Co-safety officers are assigned to the medical center. (Refer to your Resource List). There is an Environment of Care Committee for the medical center. The Safety Officers are appointed on an annual basis by the Board of Trustees and are empowered with authority to take action when conditions exist that pose immediate threat or harm.

The committee is responsible for the overall monitoring of the safety program and oversees the goal to provide safety for patients, employees, medical staff, students, volunteers, and visitors. The Safety Management program identifies and resolves problems, provides the continuous monitoring of safety, and evaluates and looks for areas of improvement. The enactment of “safety indicators” by The Joint Commission (TJC) as Performance Standards has resulted in a continuing measurement and analysis through statistical measures for the Environment of Care programs. Any and all questions/concerns should be directed to the safety officers or any member of the Environment of Care Committee.

Security Management Plan

Security of the facility is also accomplished through proper identification. Therefore, it is important that you wear your employee I.D. badge above the waist at all times. Others with official identification include volunteers, patients, contract/construction workers, and vendors. Visitors will be issued a badge upon providing photo ID.

If someone is in your area who does not have an I.D. badge or whom you do not know, you have the right to ask who he or she is. You may call Security by dialing the Operator at “00”.

Another way to keep the facility safe is to keep external doors closed. This is especially true when the front doors are locked. If you see anyone at the outside locked doors, contact Security. Do not let them in. External doors should never be propped open.

Certain areas in the facility have been determined to be classified as sensitive areas. This means that both staff and visitors have limited access to them. Examples include: Operating Room, Laboratory, Pharmacy, Nuclear Medicine, and the Emergency Department. These areas have more pass-through inspections per shift by Security.

Special reminder: Any prisoner who enters our facility escorted by a forensic (law enforcement) guard, contact Security immediately. Security will orient the guard.

Fire Prevention Plan

Life safety program addresses safety from fire, fire related hazards and similar emergencies within the center’s buildings and grounds.

- Define R-A-C-E: Rescue  Alarm  Contain  Extinguish
- Our emergency number is *3-1-9-9-9.

Regional Medical Center Bayonet Point  2016 Orientation/Reorientation Program
• Tell the operator the nature of your emergency.
• Define P-A-S-S: Pull pin  Aim   Squeeze   Sweep

Utilities Management Plan

Plant Operations (Maintenance Department) through the Utility Management Plan is responsible to reduce the risk of injury to patients, visitors, etc. This is done through monitoring equipment and systems’ operation, maintenance, inspection, and testing procedures. They are also to provide emergency response in utility and equipment failure. All equipment is assigned an equipment maintenance number so as to determine purchase and repair history. Monthly reports on utility maintenance, failures, and repairs are given to the Environment of Care Committee. In each of your departments/areas there should be a department specific Utility System Failure plan to follow between the time of the utility failure, and the time that contingency plans are put into place to reestablish services. If you are in a patient care area, know the location of your medical gas shut off valves and what rooms they affect. Part of the Utility Plan includes our electrical source. Remember that the red receptacles are connected to emergency power. Life support equipment should be plugged into these at all times.

Nursing Management, Plant Operations, Respiratory, Security, and Fire Department personnel have the authority to shut off the medical gas valves.

Communications

During all emergency situations, the telephone should be used for urgent communications only. This will free the telephone lines to be used for an emergency. If the phone rings in your area, answer it! Walkie-talkies will also be used for communication by designated staff and security. Walkie-talkies will not be used during bomb threats. Cell phone usage is prohibited.

Equipment Management Plan

Biomedical equipment is defined as any equipment that is directly involved in patient care and is monitored through the Biomedical Equipment plan. Biomedical equipment is checked upon entry into the hospital (7 days a week) and at certain time intervals (determined by either regulations or manufacturer’s recommendation) and repaired as needed by the Clinical Engineering (Biomed) Department. An identification tag is placed on the equipment. The Clinical Engineering technicians will place a written summary of preventative and corrective maintenance work orders in each department's National M.D. Biomedical book. 

(Reference Policy/Procedure # 830.801 EQUIPMENT FAILURE RESPONSE PLAN)

Biomedical Services 7:00 am to 4:00 pm, Monday through Friday
Phone extension: *95492
Emergency: 877-252-8761
After-hours: 800-874-8862
E.R. Repairs: 727-419-9531
If Equipment Fails To Work Properly
1. Submit a biomedical work order through Meditech.
2. Complete the information requested on the work order (your name, phone number, describe problem).
3. Attach the work order to the equipment.
4. State clearly “Do not use”.
5. If it is an emergency - call the medical center's operator at (00) who in turn will contact the Clinical Engineering (Biomed) Department.
6. If the equipment is portable - take it to the Clinical Engineering (Biomed) Department.

Safe Medical Devices Act
In 1990, Congress passed the Safe Medical Devices Act (SMDA). The intent of this law is to track medical devices and report incidents that result in patient illness, injury, or death. Federal law requires that these incidents be reported to the Food and Drug Administration (FDA). Each employee has an obligation to report these incidents. This responsibility also includes physicians and allied health contract staff.

What should be reported?
- An Occurrence Report is to be completed if a medical device contributes to serious illness or injury that is life threatening or requires surgery or medical treatment.

Which equipment is included?
- IV pumps, monitors, defibrillators, beds, syringes, dressings, etc. It also includes equipment such as lab equipment. If lab results are inaccurate due to equipment malfunction, contributing to patient illness, then this becomes a reportable occurrence under SMDA.

What do you do in the event of a patient injury from a medical device?
- Take care of patient first. Notify physician and immediate manager.
- Remove equipment and secure it so it will not be used again.
- Complete Occurrence Report.
- Save any materials that are connected with the equipment (e.g. box, tubes).

What happens to the equipment?
- Equipment shall be secured by Risk Management, Biomedical Services, or Plant Operations Department.

Biomedical Equipment
Biomedical Equipment failures, user errors, and preventative maintenance are reported monthly to the Environment of Care Committee. This ensures that equipment is being checked, repaired, and used properly by staff. Test the alarms for proper function/audibility prior to use on a patient and set parameters appropriately. If a piece of medical equipment causes a patient illness or injury, remember to follow the “Equipment Failure Response Plan”. (Reference Policy/Procedure # 830.801 EQUIPMENT FAILURE RESPONSE PLAN)
Hazardous Materials Management Plan

According to OSHA and other regulatory agencies’ requirements, employees will be trained on hazardous materials and waste. The facility’s hazardous communication training plan begins in orientation and continues throughout employment. Drugs and chemicals are safe and useful if handled properly; however, many can be hazardous if not treated with caution. Always follow recommended procedures and protocols. Read all warning labels and Safety Data Sheets (SDS).

Never open or use an unlabeled container. Notify and give the container to your supervisor. Any secondary container must be labeled with the name of the chemical in it at all times. As cleaning solutions often contain hazardous chemicals, do not handle them if you have not been trained on its use. Special training in their use and the required personal protection equipment (PPE) is necessary before you use the chemical. Wear lead aprons/shields and gloves if you work with x-rays. Your film badge will be checked regularly to make sure you are not being overexposed to radiation. Follow all drug and chemical procedures carefully. Wear appropriate PPE and wash your hands thoroughly after completing the job. Also, remember that hazardous chemicals require special cleanup for spills. Each department has a chemical inventory that outlines all chemicals in your department.

Safety Data Sheet (SDS)

Occupational Safety and Health Administration (OSHA) developed the SDS form as part of the Hazard Communication Standard or the Right-to-Know regulation. The SDS is an easy reference for information on a hazardous substance. Many chemicals that you use contain substances that could be harmful if used improperly. SDS of all the chemicals used in your department are available on the hospital intranet and available to all staff at all times. A complete listing of all the SDS in the facility is kept in the Emergency Department.

The SDS contains the following parts:
- Identity of the chemical
- Name, address and phone number of the manufacturer
- Hazardous ingredients, chemical I.D. and common names
- Chemical's physical characteristics
- Recommended safe exposure limits
- Effects of over exposure
- Fire and explosion risks and the types of extinguishers to use
- Specific safety precautions to take when using the chemical
- Appropriate symbols are listed on the SDS to indicate the hazards rating.

Florida Right-to-Know Law

Florida’s Right-to-Know law was passed in 1985. It ensures that all employees in the state are given information concerning the nature of toxic substances with which they are working.
The Employees Right to Know
- The right to know the listed toxic substances present in the workplace.
- The right to obtain a copy of the SDS for each listed toxic substance present in the immediate work area by printing it from the Haz-Soft program.
- The right in limited circumstances, to refuse to work with a listed chemical, if not provided an SDS.
- The right to protection against discharge, discipline, or discrimination for exercising these rights.

Emergency Management (Preparedness) Plan

The Emergency Preparedness plan is located on line on the hospital intranet, department pages, “Disaster Area”.

Emergency Preparedness includes natural disasters as well as fire, bomb threats, and other internal situations. Because our goal is the safety of our patients, staff, and visitors, emergency planning is high on our priority list. All staff, physicians, volunteers, students, etc., knowing their proper role at the time of a disaster, can save lives. Therefore, knowing your department’s responsibility is extremely important and essential.

Employee Responsibilities
All staff/volunteers are expected to be familiar with their department’s role when participating in emergency situations. There will be a minimum of two disaster drills per year. All staff (if on duty) are expected to participate in accordance with the plan.

Call System
The “call system” is established to obtain additional staffing during a disaster/mass casualty incident. Each department manager maintains a “call roster” of his or her staff.

Evacuation of patients should occur by the following methods:
- Ambulatory patients: Assist to safe area.
- Bed-ridden patients: Roll bed to safe area or use emergency carry.
- Wheelchair patients: Wheel to safe area. If necessary, carry down stairs.
- Use of evacuation chairs if going down the stairwell.

Be thoroughly familiar with the locations of these items on your unit:
- Fire alarm boxes
- Fire extinguishers
- Medical gas zone valves and areas served by the valves (labeled near the valve)
- Back up oxygen cylinders
- Evacuation routes and refuge areas
**Electrical Safety Guidelines**

*Use common sense around electricity!*

- Don't place cords near heat or water.
- Don't touch anything electrical with wet hands.
- Make sure equipment is properly grounded.
- Check electrical equipment for inspection stickers.
- Don't pull any electrical cord from the wall outlet by the cord.
- Don't use cheater (adapter) plugs that allow non-grounded plugs to be utilized.
- Keep power cord out of walking paths that might cause someone to trip.
- Notify Plant Operations (Maintenance) whenever power cords/plugs/outlets are damaged.

**Oxygen Safety Guidelines**

*The basic principles of oxygen safety are:*

- Clearly identify when oxygen is in use.
- Smoking is not permitted campus wide.
- Be familiar with the medical center's central oxygen system.
- Stabilize oxygen cylinders in an approved stand or rack to prevent tipping.
- When using an oxygen cylinder, use the appropriate regulator and safe regulations.
- Full and empty cylinders must be stored in separate racks.
- Full cylinders are defined as new sealed cylinders.
- Empty cylinders are defined as open down to 0 PSI. Do not use any cylinder less than 500 PSI on the gauge.
- Protect the patient by delivering oxygen according to the physician’s orders.

**Questions for Review**

26. Empty cylinders are defined as open down to 0 PSI. Do not use any cylinder less than 500 PSI on the gauge. **True** or **False**

27. Some electrical safety guidelines are: a) don’t touch anything electric with wet hands from either water or alcohol based sanitizers, b) don’t place cords near heat or water, and c) check electrical equipment for inspection stickers. **True** or **False**

28. Those in a patient care area should know the location of your medical gas shut off valves and what rooms they affect, however; only Nursing Management, Plant Operations, Respiratory, Security, and Fire Department personnel have the authority to shut them off. **True** or **False**

29. Florida Right-to-Know Law requires that employees are given information regarding the nature of toxic substances with which they are working. **True** or **False**
30. Biomedical equipment failures, user errors and preventative maintenance are not reported to the Environment of Care Committee. True or False

31. The basic principle of oxygen safety are: a) identify when oxygen is in use, b) stabilize oxygen cylinders in an approved stand or rack to prevent tipping, and c) smoking is permitted campus wide. True or False

32. The intent of the Safe Medical Devices Act (SMDA) is to track medical devices and report incidents that result in patient illness/injury or death. It is the responsibility of the equipment company to keep track of their own equipment, so employees do not need to report any incidents. True or False

33. Safety Data Sheets (SDS) provides information concerning the nature of toxic substances and a complete listing of all the SDS in the facility is kept in the Emergency Department. True or False

34. R·A·C·E is the fire response acronym that is on your I.D. badge and stands for Rescue, Activate alarm, Confine/contain the fire, and Extinguish. True or False

**Biomedical Waste**

In addition to OSHA requirements regulating waste management, the State of Florida has a required “Biomedical Waste Rule” and compliance to the rule is as follows:

**Biomedical Waste: Any solid/liquid waste that may present a threat of infection to humans.** This includes:

- Liquids (secretions and excretions)
- Non-liquid tissue and body parts from humans
- Laboratory waste which contains disease causing agents
- Discarded sharps (used/unused) including:
  - Scalpels
  - Suture/Syringe Needles
  - Vacutainer Tubes with blood
  - Contaminated intact/broken glass or hard plastic

**Segregation at the Point of Origin**

Biomedical Waste is identified and separated from other solid waste at the point of origin, i.e., the patient’s room or other areas where biomedical waste is generated. These also include Operating Room, Intensive Care, Emergency Department, Imaging, Lab, Exam Rooms, etc. Biomedical Wastes must not be mixed with hazardous waste or any other waste.
**Containment**

Containing Biomedical Waste is appropriate for the type of waste generated and types of treatment anticipated. Included are any absorbent materials that are stained or contain any blood/body secretions/excretions. Those disposable devices, such as, chest drainage systems, hemovacs, Jackson Pratts, and suction canisters are included into this standard for biomedical waste disposal. According to the State guidelines, we must use all of the following for final disposal of biomedical waste.

**Bags:**
Biomedical Waste (except sharps) shall be packaged in impermeable red, polyethylene or polypropylene plastic bags. The medical center has a file on the bag quality test report supplied by the bag manufacturer and performed by an independent testing laboratory.

**Labeling:** All packages containing Biomedical Waste shall be labeled with the biohazardous waste symbol. A label is secured to the sharps container and each bag.

Outer containers and sharps containers are labeled at the generator facility prior to offsite transport.

**SPILLS**
- Cover with a plastic backed absorbent pad with the plastic side facing up.
- Notify others in the area of the spill and remove visitors and other patients from the area.
- If the spill is small, the nurse or other appropriately trained personnel will clean. If the spill is large, call Environmental Services for assistance.
- If the there is a large chemotherapy spill and assistance is needed, call Environmental Services.
- All mercury spills must be cleaned by Environmental Services.

**Violence in the Workplace**

Managing aggressive and violent behavior has become an essential skill pertinent to all staff providing human services. This is not an illusion or difference in perception of potential dangerousness. We live in a more violent society. The typical comment heard from today’s healthcare provider is “We are treating more and more violent people these days”. This is in part a reflection of the very stressful environment and the state of our society.

Nonviolent crisis intervention is a safe, non-harmful behavior management system designed to aid healthcare providers in the management of disruptive and assaultive individuals. As a general rule, there are two ways a hostile person will vent his or her aggression or hostility: verbally or physically. This is one of the essential tenets of managing aggressive behavior, which at first seems obvious, but upon closer examination is a critical key to intervening.
<table>
<thead>
<tr>
<th>Crisis Development</th>
<th>Staff Attitude</th>
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<tbody>
<tr>
<td><strong>Anxiety</strong> – a noticeable increase or change in behavior which is manifested by a non-directed expenditure of energy, for example pacing or frequent shifting of position.</td>
<td><strong>Supportive</strong> - Staff should be empathetic and actively listen to what is bothering the person. Avoid being judgmental and avoid dismissing the person as a complainer. Make attempts to address the complaint, and validate their feelings.</td>
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<tr>
<td><strong>Defensive</strong> – signifies the beginning stages of loss of rationality. The person begins to give you cues either verbally or nonverbally indicating he is beginning to lose control. He may be belligerent or become hostile.</td>
<td><strong>Directive</strong> – The staff member should set limits and guidelines for the individual. This will help the individual regain rational control. These limits need to be clear, simple, reasonable and enforceable. Don’t assume they know why the directive is being issued. Limit setting should be done as objectively as possible and should not be delivered in a threatening manner. For example: if a person is getting too loud, point out the fact that he will be allowed to stay in this area if he quiets down, the loud noises are disturbing others. If the noise continues he will be asked to leave/escorted out of the area. Thank him for his compliance.</td>
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<tr>
<td><strong>Acting Out (Physical)</strong> – this level is defined as the total loss of control, which usually involves physical aggression. The person may assault staff, other people or even attempt to harm himself.</td>
<td><strong>Nonviolent Physical Crisis Intervention</strong> - At this point help is needed to maintain a safe environment. Individuals who have been trained in these techniques should use only as a last resort. By utilizing safe, non-injurious restraint techniques you are providing the ultimate care and welfare for the individual by initiating physical control for his or her own safety.</td>
</tr>
<tr>
<td><strong>Tension Reduction</strong> - this is both physical and emotional. The person ‘comes down’ from the peak of energy output. Often one can actually feel the tension reduce in the muscles and the person will feel emotionally drained.</td>
<td><strong>Therapeutic Rapport</strong> - This is the healthcare provider’s opportunity to reestablish communication with the person. Only one staff member needs to begin this phase so as not to confuse the person as he regains rational control. Remember not to be judgmental and to reassure the person he is safe and will be cared for. Later you can discuss alternatives to the acting out behavior in an attempt to prevent further outbursts.</td>
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</table>
These two types of ‘acting out’ behaviors often become somewhat muddled or confused and are not separated from each other. This leads to inappropriate actions on the part of the staff intervening in the situation. Therefore, the first principle which must be established is: avoid overreaction and under reaction. Use verbal intervention skills to intervene with a verbally acting out person. However when the aggression becomes physical, you must also have in your repertoire of skills safe physical intervention techniques and obtain help to control the physical acting out behavior to maintain a safe environment for all concerned.

In any crisis development situation there are four distinct and identifiable behavior levels. The purpose of defining each level is to attempt to meet each level with the appropriate staff response to defuse or de-escalate the crisis development.

The crisis development model shown above is an extremely valuable tool that can be utilized to determine where a person is during an escalation process. Granted, human behavior is not an orderly progression. Yet, determining the behavior level of a potentially violent individual can help healthcare providers determine how to respond to the different stages of escalation and as a result, improve de-escalation efforts.

Non-Violent Crisis Intervention (NVCI) programs are held monthly at RMCBP. The goal of the NVCI program is to provide a safe, non-harmful behavior management system designed to help healthcare providers and other hospital personnel to provide the best possible Care, Welfare, Safety and Security® of disruptive, assaultive and out of control individuals – even during their most violent moments.

(Non-Violent Crisis Intervention is a registered trademark of the Crisis Prevention Institute, Inc. 2005)

Questions for Review

35. The Definition of Biomedical Waste is any solid or liquid waste that may present threat of infection to humans including: liquids (secretions and excretions), non-liquid tissue and body parts from humans, laboratory waste which contains disease causing agents, discarded sharps (new and used).  True or False

36. Sharps containers do not need to be emptied until they are 100% full.  True or False

37. It is not important to use Personal Protective Equipment (PPE) to clean up a biomedical waste spill to prevent exposure from blood borne pathogens.  True or False

38. In any crisis development situation there are four distinct and identifiable behavior levels. The purpose of defining each level is to attempt to meet each level with the appropriate staff response to defuse or de-escalate the crisis development. These levels include: anxiety, defensive, acting-out and tension reduction.  True or False
Radiation Safety Guidelines

The Radiation Safety Officer (RSO) is appointed by hospital administration and approved for the facility’s license by the State of Florida. The RSO has oversight of all policies and procedures regarding the safe use of ionizing radiation in the facility. They have the authority to take action when an existing condition poses an immediate threat or harm.

Radiation technology has dramatically changed healthcare and has helped to extend the quality of life of society as whole. Through its use we can diagnose, cure, and improve outcomes of many ailments, not to mention radiation’s contribution toward curing many types of cancer. Most healthcare workers receive no more occupational exposure than what they receive from naturally occurring radiation in our environment provided safe practices are followed.

Radiation is energy in transit in the form of high-speed particles and electromagnetic waves. We encounter electromagnetic waves every day. Some examples are microwaves, radio waves, light, and x-rays.

Radioactivity is a natural and spontaneous process by which the unstable atoms of an element emit or radiate excess energy in the form of particles or waves. These emissions are called ionizing radiations.

Ionizing radiation has the ability to penetrate cells and deposit energy within them in a random fashion. This form of energy, when sufficiently intense, kills cells by inhibiting their division. The sensitivity of cells to ionizing radiation varies considerably in different stages of cell life. Cells changed permanently may go on to produce abnormal cells that divide. In the right circumstances, these cells may become cancerous.

There are two main sources of radiation in a healthcare facility. The sources consist of ionizing radiation produced from an x-ray machine (such as a portable x-ray unit, CT, and fluoroscopic equipment) and radionuclides.

1. **X-rays** only generate radiation when making the image using a focused beam. X-rays are used to visualize anatomy and provide information pertinent to the patient’s recovery. X-rays do not make patients or objects radioactive.

2. **Radionuclides** are radioactive material used to diagnose and treat disease. Radionuclides may be implanted, swallowed, inhaled, or injected. In the hospital setting, radionuclides are used for nuclear medicine scans. Unlike x-rays, radionuclides have a half-life. That half-life can be anywhere from several hours to several days during which time the patient emits low levels of radiation.

Employees, students, physicians, and volunteers are educated on radiation safety before working at our facility.
All physicians and staff who are likely to receive an occupational exposure in excess of established levels, during the course of their employment, will be assigned annual radiation safety training and participate in our personnel dosimetry program, monitoring exposure levels using a dosimetry device.

Acceptable annual occupational exposure levels have been determined by the Nuclear Regulatory Commission and are enforced by the State of Florida and the facility’s Radiation Safety Officer. There are additional policies and procedures in place to safeguard our patients who receive exposures during imaging and interventional procedures.

Occupational exposures are reviewed by the RSO monthly or as worn and reported quarterly to the facility’s Radiation Safety Committee. Generally speaking, dosimetry levels trending greater than 10% of the annual limit are scrutinized. We are always looking for opportunities to reduce dose by minimizing time, increasing distance, shielding, or heightening awareness. The ALARA (as low as reasonably achievable) concept guides our staff toward minimizing patient dose, thus lessening their likelihood for occupational exposure. If x-rays are performed in your area and you do not have a badge, follow the directions of the imaging staff for your safety.

There are various radiation therapies provided in the medical center. The first involves an unsealed radiation source called iodine-131 (I-131). I-131 is ingested orally for the treatment of thyroid cancer. Patients receiving I-131 are considered radioactive. I-131 is excreted in all body fluids including urine, saliva, and perspiration. All surfaces in the room should be considered potentially contaminated. This contamination can be ingested by surface-to-hand-to-mouth contact.

- The patient (if hospitalized) will be placed in a private room and staff will use standard precautions when handling body fluids.
- A cautionary sign defining the safety precautions required will be placed on the patient’s room door. Pregnant individuals should not enter the room.
- If there is a spill of this patient’s body fluids, call Nuclear Medicine for directions and secure the area so that the staff/patient do not cross-contaminate the spill.

The second type of radiation therapy uses a sealed source and is known as Brachytherapy. This involves the insertion of a sealed implant into the patient. The implant is a small capsule containing radioactive material that can be placed directly into a tumor. Implants are commonly used in cervical and prostate cancers. The patient is considered radioactive while the implant is in place. Some implants are permanent, but do not present a radiation hazard due to the minimal activity and the type of emitter which stays localized.

Radiation Area Signs are displayed on the door of a therapy patient’s room as a warning. These rooms should not be entered unless you have received specific training. Please check with the patient’s nurse or Nuclear Medicine if there are any questions. Additionally, there are signs in radiology or cardiac catheterization suites. When the sign above the door indicates, “X-ray is in use”, it is unsafe to enter. Watch for and obey all signs related to radiation therapy or exposure.
Principles of Radiation Protection

- Time
- Distance
- Shielding
- Awareness

If you directly observe a safety hazard involving radiation, report this event to the Radiation Safety Officer immediately. If the hazard involves radioactive materials or spills, eliminate non-essential traffic and isolate any spill or contamination. When authorized personnel arrive at the scene, follow their instructions.

In case of emergency or radiation spill, contact the facility RSO (Radiation Safety Officer) through Nuclear Medicine at extension *95452 or after hours via the operator; or the Nuclear Medicine Technologist at extension *35654 or Carol Corder, Director of Radiology, at extension *95541.

Questions for Review

39. By following our policies and procedures, on average our staff receives more exposure from naturally occurring background radiation outside of work than they do on the job. True or False

Safe Handling of Hazardous Drugs/Medication Safety/Storage

Prevention of Inhalation of Aerosolized Particles

- Hazardous drugs should never be diluted, mixed, crushed, dissolved, or transferred from one syringe or intravenous container to another outside of the Bio-Safety Cabinet.
- Prime IV administration sets in a way that avoids aerosolization.
- Minimize disruptions of the IV administration set used to infuse the hazardous drugs. If you must disconnect the tubing from side injection ports, stopcocks or extension tubing, wrap the connection with gauze to prevent aerosolization.
- Paper masks do not protect against aerosolized hazardous drugs; however, they are helpful in preventing skin from being splashed. The nurse is most at risk for this type of exposure when priming tubing, disconnecting tubing or syringes, and disposing of contaminated excreta and bodily fluids.

Avoiding Contact with Skin and Mucous Membranes

- Wash hands prior to administering medications.
- Use nitrile gloves and an impermeable gown while working with hazardous drugs and contaminated body fluids or excreta.
- Change gloves to maintain an effective barrier and wash hands before and after working with hazardous drugs, and whenever contamination is suspected.
- Wear approved chemo-gown.
- Limit work area and use an absorbent plastic pad to contain any accidental spillage.
- Wear goggles or facial splashguard during drug handling or disposal if there is any risk of splashing.
- Follow correct procedures quickly and efficiently in case of a spillage or contamination.

**Avoiding Accidental Ingestion of Hazardous Drugs**

- Separate hazardous drug work and storage areas from locations where people eat and drink.
- Wash hands before & after working with hazardous drugs or contaminated body fluids.
- Avoid hand to mouth or hand to eye contact while working with hazardous drugs or contaminated body fluids.

**Excreta & Body Fluids:**

- Excreta and other body fluids from patients who receive hazardous drugs are considered contaminated for 48 hours after the last drug dose. A hazardous drug sign or sticker should be on the front of the chart to alert staff when the patient is traveling to different departments in case of body fluid spillage.

**Disposal of drug administration materials and patient body fluids contaminated by hazardous drugs:**

- Dispose of used needles, syringes and any small breakable items in an impervious BLACK sharps container.
- Do not recap, remove from syringes, or cut needles.
- Dispose of all supplies by wrapping in a plastic backed absorbent pad and putting in a YELLOW Hazardous Drug Waste Container or return to pharmacy (See Pharmaceutical Waste).
- Protective gowns and linens that may have been contaminated with hazardous drugs or with body fluids of patients who have received these drugs should be handled by personnel wearing protective gowns and gloves and disposed of in the laundry hamper.

**Pharmaceutical Waste**

The hospital has designated a list of medications that should be handled as hazardous pharmaceutical waste. Partially used containers of medication listed below should be put in the BLACK waste container. Insulin and MDI are considered hazardous by the EPA because of the preservative in insulin and the propellants in the MDI. These should be returned to pharmacy for appropriate segregation and waste.

Chemotherapy: Designated chemotherapy trained nurses administer chemotherapy and will handle disposal of oral or injectable chemotherapy by placing in the BLACK waste container. Gloves, disposable gowns and PPE should be discarded in the YELLOW waste container.
NON-HAZARDOUS pharmaceutical waste is disposed of in the BLUE waste container. Only approved IV solutions without drugs are disposed of down the sink. See accessory badge card for the list of these “sewerable 7”.

**Controlled Substance waste is always down the sink with a witness.** This includes Propofol for our hospital. This also includes fentanyl patches, which should be “flushed” down the toilet with witness. Any witness of controlled substance waste is done at the Pyxis machine.

Any whole, unused, and uncontaminated medication obtained from the Pharmacy should be returned to the Pharmacy by placement in the Pharmacy return bin. Refrigerated items should be left in the refrigerator for pharmacy pick up.

The BLACK, BLUE and YELLOW pharmaceutical waste containers will be stored in secured, locked and restricted areas, like nursing med rooms.

**BLACK bucket Hazardous Pharmaceutical Waste List**
- Amyl Nitrite
- Benzoin
- Chloral Hydrate (CIV)
- “Isovue” radiology contrast
- Nicotine
- Nitroglycerin
- Racemic Epinephrine (single ingredient)
- Silver Nitrate
- Aromatic Ammonia
- Chemotherapy drugs
- Epinephrine (single ingredient)
- Lindane
- Nitroprusside
- Physostigmine
- Warfarin
- Silvadene Cream

**Medication Security**

It is a requirement in our hospital that ALL medications are locked. In addition to the medications being behind a locked door it also means that these locked areas are restricted to ONLY those employees who need to access the room in order to perform their duties.

The definition of a MEDICATION includes traditional over the counter and prescription medications, IV solutions, irrigation solutions, oral contrast media, IV contrast media, and medical kits that contain a medication as one component of the kit.

Medications are most commonly stored in the Pharmacy Department or medication rooms in patient care areas. Other locations include the Point of Use (POU) rooms for example, supply rooms, anesthesia rooms, materials management department, and radiology.

When job duties require that you access these areas, it is important that you ensure the security of medication by **never** leaving the area unlocked when leaving. **Never** share the door combination to rooms where medications are stored with other staff. **Never** allow individuals to access these areas unless you are sure they are authorized to be there.
**Medication Storage**

Many IV fluids or other medications are shipped in protective overwrap which must be removed prior to administration, but should not be removed during the storage or handling process. The expiration date of the product is almost always greatly reduced once the overwrap is removed. For this reason, if products are found in storage areas with the overwrap removed, they should be discarded. Items should not be stored on the floor, or within 18 inches of the ceiling.

In the process of handling/restocking medication, the expiration dates should be observed to ensure that adequate time remains for the product to be used. Products that have exceeded their expiration date should be removed from stock immediately.

During the restocking process, products should be rotated from back to front to ensure that product with a shorter time to expiration is used first. This will minimize the amount of expired product in the facility. Remember – *never* leave medications unattended for any reason.

**Unapproved Abbreviations:**

The following list of abbreviations has been adopted as the “Do not Use” abbreviation list for RMCBP. In the interest of patient safety, prescribers and those individuals responsible for the transcription of Physician’s Orders are required to eliminate the use of the following dangerous abbreviations in the documentation of all orders and medication-related documentation that is handwritten or typed in free-text computer entry.

<table>
<thead>
<tr>
<th>Dangerous Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (for unit)</td>
<td>Mistaken for “0” (zero), the number “4” or “cc”</td>
<td>Write ‘unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (Intravenous) or 10 (ten)</td>
<td>Write “International unit”</td>
</tr>
<tr>
<td>Q.D. / Q.O.D. (Everyday/every other day)</td>
<td>Mistaken for each other</td>
<td>Period after the Q can be mistaken for an “I” and the “O” can to mistaken for an “I”</td>
</tr>
</tbody>
</table>
| Trailing zero (X, 0 mg) | Decimal point is missed | Write X mg
Write 0.X mg |
| MS                    | Can mean morphine sulfate or magnesium sulfate Confused for one another | Write “morphine sulfate”
Write “magnesium sulfate” |
**Look alike and sound alike Medications**
Confusing drug names is a common system failure. In order to reduce the likelihood of harmful medication errors as a result of similar looking and sounding drug names, RMCBP has adopted a list of LOOK ALIKE-SOUND ALIKE MEDICATIONS. Determining the purpose for use of a medication prior to dispensing and administration can reduce the possibility of error.

- The SALAD acronym is used to as a reminder for Look-Alike Medications
- SALAD includes: Tall man lettering is used to help decipher the differences in certain drug names (For example hydroXINE vs. hydraLAXINE).

**Questions for Review**

40. Never allow individuals to access storage areas where medications are stored unless you are sure the individual is authorized to be there. **True** or **False**

41. The following abbreviations are approved for use at Regional Medical Center Bayonet Point: ‘U’ for (unit) and ‘QD’ for (every day). **True** or **False**

42. Black Hazardous Waste Buckets should be used to waste narcotics. **True** or **False**

43. Blue Pharmaceutical Waste Buckets should be used for non-hazardous drug waste. **True** or **False**

44. Insulin and MDI should be returned to pharmacy for waste. **True** or **False**

**Risk Management**
Risk Management activities contribute to the quality of care and help to promote a safer environment for patients, visitors, volunteers and employees, as well as reduce the cost of the risk to the facility. In order to accomplish these goals, all employees must participate in the system that provides a reporting mechanism for those occurrences that may cause a risk. Through identification of the risk, we can take steps to correct, reduce, modify, or eliminate risk situations. Everyone at RMCBP must be aware and involved in the process to eliminate risk events. Examples of reportable occurrences:
- Falls
- Medication deviations
- Allergic reactions to food, drugs or dyes
- Blood transfusion reactions
- Equipment failure or improper use of equipment that resulted in or could result in patient injury
- No written consent for procedure performed or improper consent
• Patient leaves against medical advice
• Lost or broken valuables or property
• Wrong patient or wrong procedure performed
• Violation of medical center policy and procedure

**Occurrences are reported through the “Risk Management” module located in Meditech. The Risk Manager/Patient Safety Officer must review these reports within 72 hours of the occurrence.**

Our Risk Management program is part of our quality improvement activity and contributes to identifying opportunities to improve processes.

• Advance directives
• Confidentiality
• Do Not Resuscitate (DNR)
• Informed consent
• Living wills
• Lawsuits/subpoenas
• Patient grievances
• Safe Medical Devices Act
• Surrogates/power of attorney/proxy
• Withholding/withdrawing life support

**Occurrence Reports**

The person who discovers or is directly involved with the occurrence should begin completing the Meditech electronically generated Occurrence Report form.

An occurrence is reported using the Meditech generated Occurrence Report form. This form is used for all occurrences. Occurrence Report forms can be accomplished on any Meditech terminal in our facility.

**Any event that involves an unusual situation with a patient, visitor, employee, or volunteer that results in injury or potential injury can be considered an occurrence. Examples:**

• Occurrences that are not considered within routine patient care (i.e., lost dentures, medication errors, wrong test)
• Procedures not performed as ordered
• Violation of established policies and procedures that involve patient care (i.e., wrong preparation of test, invasive procedure performed without consent)
• A fall, an accident, an injury to patient, visitor, employee, or volunteer
• Mishaps due to faulty or defective equipment (i.e., burns from K-pad, IV pump alarm did not work causing patient to receive overload of fluid)
• Medication errors
• Patient leaving against medical advice
• Wrong diagnostic or surgical procedure performed on a patient
• Missing or damaged property (lost issued keys, patient’s valuables)
• Unexpected adverse results of professional care and treatment, which necessitates additional hospitalization or a dramatic change in patient or treatment regimen.

**Serious Incident:**

If an unfavorable incident (occurrence), whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, results in:

The death of a patient or
Brain or spinal damage to a patient or
The performance of a surgical procedure on the wrong patient or

A surgical procedure, unrelated to the patient’s diagnosis or medical needs, being performed on any patient (Includes: surgical repair of injuries resulting from planned surgical procedures, wrong site or wrong procedure surgery, and procedure to remove foreign objects remaining from surgical procedure.)

*Serious incidents must be reported to Risk Management immediately.*

**Define Risk Prevention**

Following are examples on how we practice Risk Prevention:

• Credentialing and Licensing
• Education and Training
• Employee Health Program
• Human Resources Processing of Employees
• Infection Control Program
• Performance Improvement
• Policy and Procedures
• Quality Control Program
• Safety Committee Activities
• Scope of Practice

The Seven Plans of the Environment of Care also support Risk Prevention

**Reporting Abuse /Neglect /Exploitation**

*At Regional Medical Center Bayonet Point, we prevent occurrences by providing risk prevention activities on a day-to-day basis.*
**Abuse**
- Physical Abuse
  - Non-accidental use of physical force that results in bodily injury, pain, or impairment
  - Unreasonable confinement or restraint
  - Physical coercion, pushing, and shoving
  - Watch for signs of unexplained or suspiciously shaped or placed burns, bruises, fractures

**Sexual Abuse**
- Non-consensual sexual contact of any kind with another person

**Emotional or Psychological Abuse**
- Willful infliction of mental or emotional anguish by threat, intimidation, frightening, name-calling, insulting, ignoring, isolation, humiliation, etc.

**Neglect**
- Willful or intentional failure to provide adequate care.
- The withholding of food, medications, medical care, or personal hygiene as a type of punishment.

**Passive Neglect by a Caregiver**
- Inadequate care is provided but it is not intentionally harmful, but rather based on lack of skill as a caregiver or lack of knowledge about a disease and how to care for it. There may be a lack of concern, attention, respect, privacy, or lack of supervision. The outcome may be life threatening.

**Self-Neglect**
- When anyone responsible for self-care lives or behaves in a way that threatens his/her health or safety. This usually occurs as a result of a physical or mental health impairment, or isolation and lack of support.

**Exploitation:**
- Unauthorized use of a person’s income, assets, property, or other resources for personal gain.
- Coercing or harassing a person in order to gain access to their funds or forcing them to change a will.
- Not using a person’s resources for needed care in order to preserve an inheritance.
- Forcing a person to relinquish income and assets in trade for personal care.
- Duping a person into giving away an item of value without fair compensation or an understanding of its value.

**IF suspected notify your immediate supervisor / director who will involve case management / social worker**
(Reference Policy/Procedure PC 406.689 - DOMESTIC VIOLENCE, ABUSE-PRENATAL CHILD, Required Reporting)
Legal Requirements of Reporting

Child Abuse & Neglect (Any person under the age of 18)
- Abuse/neglect of children must be reported to Risk Management or Case Management.
- Risk Management or Case Management will report to the Florida Abuse Registry.

Adult Abuse & Neglect (Any person 18 - 65 years old)
- Should be reported to Case Management or Risk Management.
- Consent to report cases or suspected cases is necessary.

Elderly Abuse & Neglect (Any person over the age of 65)
- Abuse/neglect of elderly must be reported to Risk Management or Case Management.
- Risk Management or Case Management will report to the Florida Abuse Registry.

As employees, we have an ethical responsibility to report all cases of suspected abuse and neglect even if the victim refuses to report it.

- All reports are considered confidential.
- Any reports of abuse to a patient by a staff member are also reported to the Risk Manager/Patient Safety Officer.
- Cases involving domestic violence where the patient is neither elderly nor a child do not legally have to be reported if the victim does not want to press charges.
- In cases of domestic violence, contact the Case Manager. The Case Manager will contact law enforcement as indicated.
- Case Management receiving a referral (i.e. from a M.D. or family) will handle these cases and assume responsibility for notification of Risk Management.
- The administrative policy/procedure provides a Checklist - Recognition of Abuse, which includes physical indicators and emotional indicators for you to use as an assessment tool.
- Refer to the Medical Center policy/procedure to guide you through the reporting procedure. (Reference Policy/Procedure PC 406.689 - DOMESTIC VIOLENCE, ABUSE- PRENATAL CHILD, Required Reporting)

Immediately notify your immediate supervisor or director and Risk Management for any reports of sexual misconduct.

Reporting Abuse/Neglect/Exploitation to the Florida Abuse Hotline

- Victims name, address or location, approximate age, race, and sex
- Physical, mental, or behavioral indications that the person is infirm or disabled
- Signs or indications of harm or injury, including a physical description if possible
- Relationship of the alleged perpetrator to the victim, if possible. If the relationship is unknown, a report will still be taken if other reporting criteria are met.
To make a Report:
Call 1-800-96ABUSE (1-800-962-2872)
TDD (Telephone Device for the Deaf): 1-800-453-5145
Fax: 1-800-914-0004

Common Indicators of Abuse:
Please be aware that the following indicators do not mean that abuse or neglect certainly has occurred, but should raise questions. The more indicators present, the greater the risk:

Physical Indicators:
- Bruises: On the face, mouth; clusters; reflecting shape of object; old and new bruises on feet or legs of person who cannot walk.
- Burns: Reflecting shape of object
- Unexplained fractures
- Bedsores (decubiti)
- Dirty and unkempt
- Inadequate clothing
- Evidence of malnutrition

Environmental Indicators:
- Nervous or agitated
- Avoiding eye contact
- Hesitant to talk openly
- Depressed
- Withdrawn
- Hopelessness
- Denies problems
- Covers up for caregiver
- Confused or disoriented
- Suspicious

Advance Directives

What are they? Documents that patients use to communicate their wishes about medical care they want to receive; for example, Healthcare Surrogate, Living Wills, or Durable Power of Attorney for Health Care.

How do they affect our facility? The Medical Center has the legal responsibility to inform all competent, adult patients that they have a right to an advance directive. This is done in both the Admitting Department and in the nursing unit. It is our responsibility to obtain a copy and honor it. If they don’t already have one, we will supply an information packet about advance directives to the patient.
**What is my role?** All adult patients, even those with advance directives, must have the **Advance Directive** form completed. If the patient has an advance directive, a copy should be placed inside the chart. The information packets are available in the Admitting Department and in the nursing units. If the patient does have an advance directive, the intent questions need to be answered.

**Health Care Surrogate**

A competent adult has the right to designate a surrogate to act on his/her behalf and to make all health care decisions for him/her during their incapacity (incompetent to make medical decisions), in accordance with their prior instructions.

**Living Will**

- Living Will is a set of written instructions to provide, withhold, or withdraw life-prolonging procedures and designates a health care surrogate to implement the living will.
- Living Will is applicable in:
  - A terminal condition · an incurable condition in which death is imminent.
  - A persistent vegetative state · doctor has determined that there is no medically reasonable hope for recovery. Some people refer to it as a permanent coma.
- Signing a living will allows an individual to decide in advance whether he/she wants doctors to order what the law calls “life-prolonging procedures”.

**Review of Life-prolonging procedures:**

- Hydration (giving water by tube)
- Nutrition (giving food by tube)
- Ventilators
- Any other procedures that do not fall under the category of making one comfortable or reducing pain

**Durable Power of Attorney**

Person is named to make treatment decisions · to accept or refuse medical care for individual if at some point the individual cannot make them for himself/herself. This person cannot make decisions that he or she knows will go against the individual's religious beliefs, basic values, and stated preferences. It is implemented during a terminal illness, accident, and any condition that renders the person unconscious or mentally incompetent to make health care decisions.
Do Not Resuscitate (DNR) Orders

- DNRs are legal and valid, and must be a written order by the attending physician or their designee.
- Failure of the attending physician to countersign a DNR order within 24 hours does NOT invalidate or terminate the order. If the attending physician has not countersigned or discontinued the DNR order within 24 hours, the order remains in force while increased efforts are made to have the attending physician complete this requirement.
- A DNR order should be mutually discussed and arrived upon by the physician and patient or patient's family, if indicated.
- In the absence of a DNR order, resuscitation is initiated.

Informed Consent

Informed consent is required prior to performing any operative procedure or administering anesthesia, performing an invasive diagnostic or therapeutic procedure, administering blood products, engaging in any investigational process, or removing organs or tissue from a living or dead person for any purpose. It is the physician's responsibility to obtain informed consent. Telegraphic consents and consent sent by FAX are acceptable.

The nurse's responsibilities regarding informed consent are as follows:

- Witness the patient's signature on the consent form. Nursing students may not serve as a witness for informed consent.
- Contact the physician if the patient is uncertain of or expresses ambivalence about undergoing the procedure.
- Write out the entire procedure that the patient is signing the consent for. Do not use abbreviations. Please check spelling if unsure of the correct spelling of a procedure type.
- Verify that a properly completed consent is in the patient's chart prior to a procedure.

- A designated family member should sign consents for patients who do not have the cognitive ability to do so.
- The informed consent should not be signed by a patient who is not alert and oriented or unable to understand the entire procedure.

Pre-medication should not be administered before the informed consent is obtained.

- Complete the pre-op/pre-procedure checklist.
- Do not send the patient to the OR unless consent is completed.
- Review the consent form for completeness including making certain that the surgical site is identified.
Questions for Review

45. An occurrence is any event that involves an unusual situation with a patient, visitor, employee, or volunteer that results in injury or potential injury. The following are examples of occurrences: medication errors, procedures not performed as ordered, a fall, accident or injury to a patient visitor, employee or volunteer, patient leaving against medical advice, wrong diagnostic or surgical procedure, missing or damaged property, unexpected adverse results of professional care and treatment. True or False

46. The goal of the fall prevention program is to identify the patient who is at risk to fall, institute proactive efforts to reduce the occurrence of fall-related incidents, and provide a safe environment for patients, visitors and staff. True or False

47. Risk Management activities contribute to the quality of care and help to promote a safer environment for patients, visitors, volunteers and employees, as well as reduce the cost of the risk to the facility. In order to accomplish these goals, all employees and volunteers must participate in the system that provides a reporting mechanism for those occurrences that may cause a risk. Through identification of the risk, we can take steps to correct, reduce, modify, or eliminate risk situations. Everyone at RMCBP must be aware and involved in the process to eliminate risk events. True or False

48. Documents that patients use to communicate their wishes about medical care they want to receive are called Advance Directives. True or False

49. It is not necessary prior to performing any operative procedure or administering anesthesia, performing an invasive diagnostic or therapeutic procedure, administering blood products, engaging in any investigation process or removing organs or tissue from a living or dead person for any purpose for the physician to obtain informed consent. True or False

Hospital Volunteers

RMCBP volunteers provide a great deal of services to the hospital and community.

Permitted Activities:
- Providing patient with food or drink (if permitted)
- Acting as a messenger to other areas of the hospital when asked to do so (Delivering mail, running errands, etc.)
• Visiting with patients; providing reading material when requested.
• Transporting a stable (as approved by the RN) patient via a wheelchair at the time of admission or discharge
• Compiling admission forms or packets
• Delivering water and ice to patients
• Assembling and copying documents

Activities not permitted:
• Lifting or transferring a patient
• Giving or selling a patient any food or drink without first obtaining the permission of the RN
• Entering a room with an isolation or precaution sign on the door
• Transporting medication from the Pharmacy unless 18 years of age
• Walking with an ambulatory patient
• Feeding patients
• Making patient beds
• Sitting with a violent, suicidal or Baker Act patient
• Discharging a patient with a rolling oxygen (O₂) tank without assistance

Human Resources (HR)

Regional Medical Center Bayonet Point ensures employees are not only provided good pay and benefits, but are treated fairly, given opportunity to make a substantial contribution to RMCBP through your work and are valued and appreciated for your efforts. We believe that nothing is better than a sincere “thank you – job well done.” Peer recognition is a significant part of our programs and they especially add meaning because it often comes from the heart.

Our recognition strategies are designed to thank employees for a variety of achievements and team work, including:
• Making time in staff meetings and huddles to thank employees for outstanding efforts
• Above-and-Beyond performance and spot recognition
• Service Awards
• Retirement Gifts
• Social functions, i.e., family picnic, Birthday luncheons, Parade floats, Celebration of Lights
• Employee of the Month
• Team recognition, i.e., PEARLS, pumpkin carving, decorating contests
• Perfect Attendance
• Innovators Awards
• Peer-to-Peer Intranet Recognition
• Employee Advisory Group (EAG)

Another aspect of Human Resources (HR) is to insure hospital staff is appropriately educated and are competent to fulfill their job duties in a safe manner.
Each staff member is given a copy of his/her job description upon employment and at annual evaluations, and the original is kept in the Human Resources Department. Employees are validated annually on their job specific competencies. Staff competencies are age-specific as well as demonstrating the provision of culturally competent care. General and department specific orientation process provides initial job training and assesses the staff’s ability to fulfill job duties. The cultural values or religious beliefs of patient care givers may be considered an aspect of patient care assignment and may be taken into account when there is a communicated and direct conflict between the employee’s values or beliefs and the patient’s care and treatment. The Staff Request Policy provides a mechanism for addressing any staff member’s request not to participate in an aspect of patient care, while ensuring that patient care will not be negatively affected (Reference Policy/Procedure # HR409.916 – Staff Request Mechanisms)

**Staff Support**

A confidential Employee Assistance Program (E.A.P.) is available to all RMCBP employees seeking resolution with personal problems (Reference Policy/Procedure # HR.OP.010 – Employee Assistance Program) All HCA-affiliated employees and their families have access to an Employee Assistance Program (EAP), a confidential counseling and referral service providing personal, legal and financial services. These services can help individuals deal with a wide variety of life’s challenges that could affect their health, relationships and/or job effectiveness. Whether the issue is large or small, you can contact the Employee Assistance Program for assistance 24 hours a day, 365 days a year. **Call 800-434-5100**

**Licensure and Certifications**

(Reference Policy/Procedure # HR.JC.005  - Licensure, Certification and Registration Verification) Licenses issued through the Florida Department of Health must be verified ONLINE at the DOH as valid and renewed. HR cannot accept a confirmation receipt of payment as proof of renewal. A clean, legible, and signed copy of your license and/or certification must be provided to HR for your personnel file. It is the responsibility of the employee to renew their license and/or certification on time; staff will not be allowed to work with an expired license or certification. You must submit proof of renewal to HR in order for the certification to be considered valid and renewed. If your position requires a BLS /PALS /NRP/ ACLS certification, it must be from an American Heart Association approved provider.

**Smoking – Tobacco Free Campus**

**We are a Smoke Free Facility.** In keeping with our mission to improve the health of our communities, we are committed to providing a safe, clean and healthy environment for our
patients, employees, visitors, and customers. To support this commitment and in response to studies that indicate that the use of tobacco is a leading cause of preventable illness and premature death, this policy outlines our approach to the use of tobacco/electronic smoking devices in buildings, property, and vehicles brought onto the property (Reference Policy / Procedure PC 553.600 – Smoking- Tobacco Free Campus)

**Attendance**

Staff is required to notify the Department Director or Administrative Coordinator a minimum of 2 hours prior to the start of shift when calling off duty. The reason for the call-in must be given when calling-in. Absences that exceed (6) occurrences in a rolling calendar year are considered excessive. An “Occurrence” is defined as an absence of one or more continuous days for a specific illness or reason (Reference Policy/Procedure # HR.OP.001 – Attendance and Tardiness)

**Dress Code**

(Reference Policy / Procedure (HR.OP.026) - Professional Dress Standards)

**Clothing not to be worn into or out of the Medical Center**

Clothing considered inappropriate to wear while working includes, but is not limited to:
- Tight or revealing clothing
- No visible tattoos
- Facial piercing must be removed or covered
- Ear piercing are limited to 2 sets per ear: small hoops
- Leggings/Stirrups, Cropped pants
- Sweatpants/sweat suits
- Shorts and skort
- Mini or extremely short skirts
- Denim (unless specifically allowed during employee activities/events)
- Hats (non-uniform)
- Casual T-shirts including those with inappropriate logos
- Flip-flops

<table>
<thead>
<tr>
<th>Position/Department</th>
<th>Uniform Type</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN/LPN (OR and Cath Lab will remain in existing colors)</td>
<td>Scrubs</td>
<td>All White or All Royal, or any combination of White and Royal</td>
</tr>
<tr>
<td>Sitter</td>
<td>Scrubs</td>
<td>Red</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>Scrubs</td>
<td>Black</td>
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<tr>
<td>Respiratory Therapy</td>
<td>Scrubs</td>
<td>Caribbean Blue</td>
</tr>
<tr>
<td>PT/OT/Speech Therapy</td>
<td>Scrubs</td>
<td>Olive</td>
</tr>
<tr>
<td>Transport</td>
<td>Scrubs</td>
<td>Pewter</td>
</tr>
</tbody>
</table>
An impaired healthcare provider is one who is unable to meet the requirements of the code of ethics or standards of practice as a result of alcohol, drugs, or psychiatric illness that interferes with their cognitive, interpersonal, or psychomotor skills. *(Reference Policy/Procedure # CSG.MM.002 – Substance Use in the Workplace)*

**Impairment Warning Signs**

- Deteriorating appearance
- Weight loss
- Decline in personal hygiene
- Frequent use of mints or mouthwash
- Unexplained bruises
- Slurred speech
- Tremors, unsteady gait
- Lethargy
- Smell of alcohol on the breath
- Mood swings
- Lying
- Isolation from coworkers
- Forgetfulness or poor concentration
- Becoming uncharacteristically quiet or excessively talkative
- High rates of absenteeism for implausible reasons
- Deteriorating performance
- Inability to meet deadlines or achieve goals that others can easily accomplish
- Actions that reflect poor judgment
- Lack of previously demonstrated enthusiasm
- Noncompliance with accepted policies and procedures
- Sloppy, illegible, incorrect, or incomplete documentation

Isolated behaviors do not always provide hard evidence of substance abuse. In fact, even though a pattern of clues suggests that something is amiss, caution must be exercised in drawing conclusions.
If you suspect impairment, do NOT
- Ignore or deny the problem
- Enable the person by covering up mistakes, making excuses, or performing his/her duties to protect his/her job.
- Assume the “counselor” role for the individual.

If you suspect a healthcare professional/coworker is impaired, DO:
- Intervene immediately to protect the safety of any patients in danger of physical or emotional harm due to the healthcare provider’s actions.
- Immediately report observations of unsafe practices or impaired behavior to your nurse manager/supervisor.
- Document accurately and completely any suspicious behaviors or incidents that have occurred.

Social Media Guidelines

Blogs, Twitter, Facebook, wikis, text messages: Thanks to social media, we can share our lives with family, friends, coworkers, and communities more easily and dynamically than ever before. Because technology has changed the way we are “connected”, it is important that we rethink exactly how this affects our utmost responsibility – caring for our patients.

That’s why we’ve developed guidelines to clearly state how we can work together to honor our patients’ right to privacy and uphold our facility’s reputation while enjoying social media. To be successful, it’s going to take all of us actively monitoring ourselves both at work and home. RMCBP’s sites and systems are also routinely monitored to prevent any avoidable releases of sensitive information.

Please remember that we genuinely appreciate and encourage you to express yourself. For everyone’s sake, please continue to do so responsibly.

Protect our patients Protected Health Information (PHI) is by nature not social, so it doesn’t belong on any blog or social site under any circumstances. Period.

Identify yourself as an employee when posting on our facility’s blog or social site. Never present yourself as speaking on behalf of our facility and always direct questions from the media to our Marketing or Public Affairs Department.

Add a disclaimer somewhere on each account (Facebook, Twitter, etc.), explaining your views are your own. You can keep it simple, like: “The opinions expressed here are my own views and not those of RMCBP.”
**Don’t assume privacy anywhere** on the Internet, no matter what your settings are or who you think has access. If it’s negative, keep it offline. You can be held personally liable for any post considered defamatory, obscene, or libelous by any offended party regardless of the site or context.

**Follow the photo / video policy,** which you can find along with our other privacy policies. *(Reference Policy/Procedure # HIM.PRI.001 – Photo Video Model RMCBP)*

**Get written permission** before posting anything online that doesn’t belong to you such as Copyrighted photos.

**Privacy settings** and the use of strong passwords help protect you. And beware of suspicious links; these could load spyware or malicious programs on your computer or steal your personal information.

**Ask a question** if you need help deciding what is okay to post or if you see a possible violation. Contact your supervisor or Facility Privacy Official (FPO), or report a violation by calling the Ethics Line at 1-800-455-1996.

Any questions or issues concerning Patient Privacy, please contact your Facility Privacy Officer (FPO)

Any questions or issues concerning Information Security, please contact your Facility Information Security Officer (FISO)

**Questions for Review**

50. HCA and / or its affiliates investigate and respond to reports of violations of the social media guidelines, which may result in disciplinary action.  
   True or False

51. Social media guidelines, which define appropriate actions for utilization of social media such as Facebook and Twitter, apply for both Company-authorized uses of social media and HCA-affiliated employees’ personal use of social media.  
   True or False

52. It is the responsibility of the employee to renew their license and/or certification on time; staff will not be allowed to work with an expired license or certification.  
   True or False

53. The cultural values or religious beliefs of patient care givers may be considered an aspect of patient care assignment and may be taken into account when there is a communicated and direct conflict between the employee’s values or beliefs and the patient’s care and treatment.  
   True or False
Infection Prevention and Control Program

Each member of the health care team plays an integral part in preventing the spread of infection. Special procedures and precautions are followed in order to prevent the spread of communicable diseases and pathogenic microorganisms within the Hospital.

The Infection Control Manual including the Blood borne Pathogen Exposure Control Plan and TB Exposure Control Plan are located on the hospital intranet at http://bpmc.atlas.medcity.net/Policies/Infection%20Control/Forms/AllItems.aspx These plans detail the policies and procedures approved by the Infection Control Committee and Medical Executive Committee.

Personal protective equipment (PPE)

PPE is worn to create a barrier of protection between you and the infectious or potentially infectious material. PPE examples include protective gowns, gloves, goggles/eye protection, and masks or respirators. These items are worn to protect the employee from exposure to Blood borne Pathogens such as HIV, Hep B, Hep C, or other potentially infectious material (OPIM), and communicable diseases. All PPE must be removed prior to leaving the work area and properly disposed of. Hand washing MUST be done immediately after removing PPE.

Gloves
Wear gloves (clean, non-sterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items. Remove gloves promptly after use and before going to another patient.

Wash hands after removing your gloves to avoid transfer of germs to other patients and other environment surfaces.

Masks and Protective Eyewear
Wear masks and protective eyewear covering the nose, eyes and mouth when splashing and spraying is anticipated. Also, wear masks and protective eyewear as indicated by Transmission Based Precautions.

Gowns
Wear a gown when splashing, spraying, or contact with blood or other potentially infectious material. Also, wear a gown as indicated by Transmission Based Precautions.

Surgical Caps and Shoe Coverings
Wear when engaged in procedures likely to produce gross contamination.
The following HAND HYGIENE products are used at RMCBP:

- Alcohol based hand rub – An alternative to washing with soap and water unless there is visible soil on the hands. The alcohol in the hand rub effectively destroys organisms.....but will not work appropriately if you use it and your hands are visibly soiled. The alcohol based hand rub also contains emollients and is less drying than soap and water.

- Soap and water – Take 20 seconds to vigorously rub together all surfaces of lathered hands and rinse under running water. The friction loosens the germs and the running water washes the germs away. Dry with a paper towel. Use the paper towel to turn the faucet off.

- If caring for a patient with C.difficile or other spore type infection, you must wash with soap and water because alcohol based hand rub is not as effective at killing these spores.

**Standard & Transmission Based Isolation Precautions**

We follow CDC Guidelines for Standard and Transmission Based Precautions.

Standard Precautions are used for all patients at all times and include using PPE when performing a procedure that you anticipate the possibility of being exposed to blood or other potentially infectious material. It is recommended that all health care workers should treat all blood and body fluids and tissues as if they are infected.

Transmission Based Precautions are used when we know that the patient has an infection with certain communicable diseases or a pathogen of concern such as MRSA, VRE, ESBL, or C.difficile. There are different types of Transmission Based Precautions which are put into place depending on the type and location of the infection.

An Isolation Sign will be posted on the patient room door. Read the sign to see the precautions you must take to prevent exposure to the known or suspected disease. They include:

- Airborne Precautions – This requires the Isolation Room with ante room
- Contact Precautions - Can be done in any room
- Droplet Precautions – Can be done in any room
- High Risk Precautions - Sometimes patients are placed in a protective environment due to certain diseases or if their body can’t fend off infections like a healthy person is able to do.

**ALWAYS notify the nurse if you have questions or concerns**

**Exposure Control Plan**

The hospital has an Exposure Control Plan in place to protect Healthcare Workers from exposures to blood or other potentially infective materials. There are Engineering Controls in place including needleless IV systems, sharps disposal containers, and safety medical devices. There also are Work Practice Controls in place including policy, procedures, including Best
Practices that reduce the likelihood of exposure by the manner in which a task is performed e.g. prohibiting recapping of needles.

Sharps containers:
- Must be readily accessible, closeable, and puncture and leak resistant.
- Be securely closed immediately prior to removal or replacement.
- Have an international “Biohazards Symbol” label.
- Sharps shall be segregated from all other waste and discarded directly into single use sharps containers meeting standards that are puncture and leak resistant.
- Sharp containers must be replaced when 3/4 full or at 30-day point.
- Avoid needle sticks: handle sharps carefully.
- Use safety devices when available.
- Discard all used sharps in needle box as soon as possible, be sure needle drops into container.
- DO NOT RECAP needles!!
- If an employee has an exposure to blood and/or body fluids or a needle stick, clean the exposed area immediately, report this occurrence to your supervisor, go to Employee Health and complete an occurrence report.

**Tuberculosis Control Plan**

CDC recommends mandatory skin testing on all new hires and employees. Routine Follow up testing/screening is based on the facility TB Risk Assessment. TB Exposure follow up testing is done in conjunction with Employee Health and the Florida State TB Division recommendations.

Patient follow up with suspected TB will also be in conjunction with the Florida State TB Division.

In addition to routine healthcare worker TB screening, patients admitted to the hospital will be screened for symptoms of Active Tuberculosis and include:

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough &gt; 3 weeks</td>
<td>HIV Infections</td>
</tr>
<tr>
<td>Bloody Sputum</td>
<td>Homelessness</td>
</tr>
<tr>
<td>Night Sweats</td>
<td>Alcoholism</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Anorexia</td>
<td>History of (+) PPD test result</td>
</tr>
</tbody>
</table>

If the patient has 2 symptoms and 1 risk factor, a diagnosis of TB should be considered. Place a surgery/procedure mask on the patient and move them into an Airborne Isolation (Negative Pressure) room. When the patient has been placed in the Airborne Isolation room, the employee must don an N95 particulate respirator mask. Then the patient can remove their surgery mask. The doors to the Ante Room and the patient’s room must remain closed at all times. Enter the patient room via the Ante Room. PPE is donned and doffed in the Ante Room.
Aerosol generating procedures must be performed in a Negative Pressure room. Elective surgery should be scheduled at the end of the day.

**HIV / AIDS Facts**

**Cause**: The agent that causes AIDS is the Human Immunodeficiency Virus (HIV).

**Transmission**: HIV can be transmitted by any type of sexual contact (rectal, vaginal or oral), by blood-to-blood contact (most often by shooting drugs and sharing needles), or by a woman to her unborn or newborn baby perinatally or through breastfeeding. HIV is not transmitted through any type of casual contact, by insects, or by animals.

**Infection**: A person can be exposed to HIV and not become infected. It is possible to have sex with an infected individual and not get infected. It is also possible that infection can occur from one single contact with an infected person. Everyone is different. Enough viruses must get into the bloodstream in order for infection to occur, and this happens most often through sexual and blood-to-blood contact.

**Disease Process**: When HIV enters the body and the bloodstream, it attacks certain cells. Its favorite target is the T-4 helper lymphocyte (also known as T-cells or CD4+). T-cells are a critical part of the immune system. Without T-cells, the body cannot effectively fight off most diseases and infections.

**Opportunistic Diseases and infections**: At about the time an HIV-infected person is diagnosed with AIDS, one or more opportunistic diseases or infections will appear. This is because the immune system can no longer protect the body from these diseases. An individual with a healthy immune system does not usually get opportunistic diseases.

**Time**: The time from infection with HIV until opportunistic diseases and infections appear is, on average, about ten years. Since each individual is different and people get infected with varying amounts of virus during exposure, this "incubation" period may be as short as about two and as long as fifteen years.

**Testing**: Anyone can get a blood test for antibodies to HIV. The body produces antibodies that attempt to destroy a foreign invader - in this case, HIV. Antibody blood tests are done confidentially at any County Health Department in Florida, or can be done anonymously at many of them. An individual can also be tested at their doctor's office and at other testing sites.

**Prevention**:  

**Abstinence**: No drugs and no sex virtually guarantees no infection.

**Mutual Monogamy**: Having sex with only one person who is not infected means no infection.
**Drugs:** If needles are not shared during drug use, no infection will occur. If needles must be shared, ordinary bleach will disinfect them before sharing. Bleach should be drawn into the needle and syringe three times & shaken each time, and then water should be drawn in three times to rinse the bleach.

**Condoms:** Since abstinence and mutual monogamy are not prevention options for some people, latex condoms must be used correctly, consistently, and responsibly. Condoms can only be used once. They must be used from start to finish. They must be used during every sexual encounter. Only water-based lubricants must be used with latex condoms.

**Treatment:** Many new advances in the treatment of HIV/AIDS have been developed in recent years. It is extremely important that treatment begin as soon as possible if one suspects exposure to infected blood/body fluids.

**Multi-Drug Resistant Organisms (MDRO)**

Contributing Factors:
- Overuse and misuse of antibiotics
- Human demographics and behavior
- Technology and industry
- International travel and commerce
- Microbial adaptation and change

**Methicillin Resistant Staphylococcus aureus (MRSA)**

First recognized in the US in 1961, MRSA was a hospital acquired infection. That is no longer the case. The overwhelming majority of MRSA infections and colonization is now acquired in the community. We know community acquired MRSA did not leak out of the hospitals as it has qualities that differ from hospital acquired. Community acquired MRSA is more contagious, but more antibiotics will work on it than hospital acquired. Community acquired MRSA is also the result of overuse and misuse of antibiotics.

**Transmission**
- Person to person contact with an infected or colonized individual
- Patient to healthcare worker contact
- Contact with a contaminated inanimate object

**Vancomycin Resistant Enterococci (VRE) Transmission**
- Colonizer of the gastrointestinal tract
- Survives well in environment and on hands of caregivers

Regional Medical Center Bayonet Point 2016 Orientation/Reorientation Program
Transmission occurs largely by way of healthcare workers’ hands. Bacteria may be ingested or introduced directly into the blood stream, urine, or wound by way of IV catheters, urinary catheters, and contact with open wounds.

**Ebola virus**

- Spread through direct contact with the blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, and semen) of a person who is sick with Ebola.
- Standard, Contact, and Airborne* Precautions

**Clostridium difficile (c-diff)**

- Forms spores which are able to exist in the environment for months.
- Spores are killed with sodium hypochlorite (bleach).
- C-Diff patients are placed on Contact precautions. These isolation rooms are to be cleaned with bleach.
- Hand sanitizers are not effective. Wash hands with soap and water to wash the spores away. Infects via fecal-oral route.
- Spores resist stomach acid and become vegetative in the colon.
- Transmitted on the healthcare worker’s hands and contaminated inanimate objects.
- Association made with antibiotic therapy disrupts normal flora of colon allowing Clostridium difficile to flourish.
- Asymptomatic carriage (20% hospitalized adults).
- Use dedicated equipment as much as possible. If unable to dispose of equipment, disinfect using manufacturer’s recommendations prior to using it on the next patient.
- **EVERYONE MUST WASH THEIR HANDS WITH SOAP AND WATER PRIOR TO LEAVING THE ROOM.**

**Questions for Review**

54. It is necessary that RMCBP follow the Centers for Disease Control (CDC) recommendation for mandatory PPD skin testing on all new hires and employees and skin testing or assessment on current employees and volunteers on an annual basis.  
True or False

55. It is not important to use Personal Protective Equipment (PPE) to clean up a biomedical waste spill to prevent exposure from blood borne pathogens. True or False

56. A person can be exposed to HIV and not become infected. True or False

57. The three transmission-based precautions are contact, strict contact, and neutropenic. True or False
58. The use of gloves almost always eliminates the need to wash your hands.  

   True or False

59. Standard precautions are not to be used on all hospital patients, regardless of their diagnosis or presumed infectious status.  

   True or False

60. Policy and Procedures may be found on the hospital intranet > Policy and Procedures.  

   True or False

**Catheter Associated Urinary Tract Infections (CAUTI)**

These are infections of the urinary tract (kidneys, ureters, bladder, and urethra) that are associated with the use of a urinary catheter, with signs and symptoms that go along with it. These account for 30 percent of all hospital acquired infections each year, with a cost of 340 million dollars, not to mention the personal cost on our patients (NHSN, n.d.). At RMCBP we strive for zero, meaning no CAUTIs (Catheter Associated Urinary Tract Infections) each year (CDC, 2010). To that end, multiple interventions have been implemented to reduce the chance of our patients developing this condition:

- Tracers to ensure all CAUTI prevention strategies are being utilized on each unit
- Removing urinary catheters that are no longer needed by a nurse driven protocol
- Utilizing securement devices for each catheter
- Ensuring the urinary catheter is maintained as a closed system
- Regular education and reeducation
- Many more interventions you may receive training on as you progress depending on job title

In the end, it is up to everyone to prevent infection in our patients, and assist as we aim for zero with hospital infections at RMCBP

Source:


**Central Line Associated Blood Stream Infections (CLABSI)**

These are infections of the blood stream that are associated with a central line catheter in the person. A Central line is a tube placed in a large vein of the body by a doctor or specially trained nurse. These lines are used to give medication or fluid for a short period of time. These infections result in thousands of deaths, and cost billions of dollars each year (CDC, 2011). To that end, multiple interventions are in place to prevent these from happening as we aim for zero with hospital acquired infections:

- Tracking device utilization across the hospital
• Tracking hand washing practices of healthcare workers in the facility
• Utilizing latest evidence of dressing change materials and techniques
• Ensure sterile insertion of the tube when possible
• Implementing all components of a CLABSI bundle to prevent infections.

In the end, it is up to everyone to prevent infections in our patients, and assist as we aim for zero with hospital infections at RMCBP.

Source:

Joint Commission Contact Information

Email: compliant@jcaho.org
Fax: Office of Quality Monitoring 630-792-5636
Mail: Office of Quality Monitoring, The Joint Commission
       One Renaissance Blvd., Oakbrook Terrace, IL. 60181
A copy of the Quality Incident Report Form can be found at: www.jointcommission.org
Questions concerning how to file your Complaint: 800-994-6610
Complaints can be filed anonymously. Joint Commission forbids any accredited organization from taking retaliatory actions against employees for having reported quality care concerns to the Joint Commission.

Centers for Medicare and Medicaid Services (CMS)

• Medicare Service Center: 800-MEDICARE (800-633-4227)
• Medicare Service Center TTY: 877-486-2048
• Report Medicare Fraud & Abuse: 800-HHS-TIPS (1-800-447-8477)

To report fraud: Office of Inspector General Hotline

To further assist you, the Office of the Inspector General maintains a hotline which offers a confidential means for reporting vital information. The Hotline can be contacted:
By Phone: 1-800-HHS-TIPS (1-800-447-8477)
By Fax: 1-800-223-2164 (no more than 10 pages please)
By E-Mail: HHSTips@oig.hhs.gov

By Mail: Office of the Inspector General
HHS TIPS Hotline
P.O. Box 23489
Washington, DC 20026

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The Occupational Safety and Health Administration aims to ensure employee safety and health in the United States by working with employers and employees to create better working environments. Since its inception in 1971, OSHA has helped to cut workplace fatalities by more than 60 percent and occupational injury and illness rates by 40 percent.

**Tampa Area Office**

5807 Breckenridge Parkway, Suite A  
Tampa, Florida 33610-4249  
Phone: (813) 626-1177  Fax: (813) 626-7015

**Agency for Health Care Administration**  
**Consumer Complaint, Publication and Information Call Center**

The agency provides a toll-free telephone system for consumers to call in order to file complaints, receive publications, information and referral numbers. This system can be accessed by calling the number below between the hours of 8:00 A.M. and 6:00 P.M. Eastern Time Monday through Friday.

Complaints about health care facilities are taken during regular business hours, 8:00 A.M. to 5:00 P.M., Eastern Standard Time (EST).  
(888) 419-3456

**Resource List**

<table>
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<tr>
<th>Department</th>
<th>Extension</th>
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<tbody>
<tr>
<td>Quality Assurance / Management</td>
<td>*95584</td>
</tr>
<tr>
<td>Linda Budzilek</td>
<td></td>
</tr>
<tr>
<td>Educational Services Director</td>
<td>*35811</td>
</tr>
<tr>
<td>Jill Corriveau</td>
<td></td>
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<tr>
<td>Employee Health Office</td>
<td>*95246</td>
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<tr>
<td>Company Care</td>
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<tr>
<td>Ethics and Compliance Officer (ECO)</td>
<td>*95533</td>
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<tr>
<td>Dajana Yoakley</td>
<td>*35623</td>
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<tr>
<td>Co - Ethics and Compliance Officer</td>
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<tr>
<td>Ralph Uzzi</td>
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<tr>
<td>Hazardous Material Coordinator / Co- Safety Officer</td>
<td>*95413</td>
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<tr>
<td>Joe Menard</td>
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<tr>
<td>Infection Control</td>
<td>*35630</td>
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<tr>
<td>Aaron Preston</td>
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<td>Workers’ Compensation Case Manager</td>
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<td>Company Care</td>
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<tr>
<td>Plant Operations &amp; Security Director / Co-Safety Officer</td>
<td>Joe Menard</td>
</tr>
<tr>
<td>Radiation Safety Officer</td>
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<tr>
<td>Florida Poison Information Center</td>
<td></td>
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<tr>
<td>Florida Abuse Registry</td>
<td></td>
</tr>
<tr>
<td>Facility Privacy Official</td>
<td>Julie Sivyer</td>
</tr>
<tr>
<td>Information Security Official</td>
<td>Mike Willms</td>
</tr>
</tbody>
</table>
Post test

1. According to our Mission & Values statement, we are to act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.

2. The Board of Trustees is the governing body of the hospital that establishes policy and approves medical staff credentialing.

3. Patients want us to show them courtesy and respect and listen carefully when they speak with us.

4. Empathy is the ability to see the world as another person, to share and understand another person’s feelings, needs, concerns and/or emotional state.

5. The Plan for Provision of Patient Care is the document that outlines RMCBP’s plan for providing nursing care.

6. Our Code of Conduct Orientation program entitled “A Tradition of Caring” provides guidance to ensure that our work is done in an ethical and legal manner.

7. If you are hired prior to September 1st, you have to complete the annual Code of Conduct Refresher training in addition to Code of Conduct Orientation.

8. RMCBP provides various ways to assist with communication with any patient or visitor. Some of these ways include: a) translator, b) Crycom Language Line Service, and c) Telecommunications Device for the Deaf -TDD.

9. Patients have a fundamental right to considerate care that safeguards their personal dignity, and respects their cultural, psychosocial, and spiritual values.

10. A Medical Center’s behavior toward its patients and its business practices has a significant impact on the patient’s experience and response to care. All patients/surrogates receive a copy of the Patient’s Rights Responsibilities upon admission.

11. The hospital provides care that optimizes the dying patient’s comfort and dignity and addresses the patient’s and his or her family’s psychosocial and spiritual needs.

12. The attending physician and the hospital determine medical suitability for organ or tissue donation.

13. When communicating with a toddler (1-5 years of age) the following techniques should be used: Introduce yourself, do not rush patient, allow them to touch equipment, exclude parents from explanation to establish a relationship with the child.
14. Family members, including children should be used for interpreting medical information when necessary.

15. The goals of RMCBP Plan for Performance Improvement are to: Maintain and improve the quality of patient care, enhance appropriate utilization of resources, design efficient processes of care/services, measure, assess and improve performance, reduce or eliminate unnecessary risk and hazards within the facility.

16. Prodromal symptoms such as mild chest pain, intermittent or stuttering chest pain can be indicative of a heart attack.

17. If you found a patient in cardiac arrest, you should call for help: have someone dial *31999; initiate CPR (if BLS certified) unless there is a Do Not Resuscitate order then stay with the patient and call for help.

18. Heart attack warning signs can include: chest pain or pressure, discomfort in arms, back, neck, jaw or stomach; lightheadedness, sweating, nausea or indigestion; shortness of breath and fatigue.

19. For the 50% of people experiencing symptoms, the heart attack can be prevented with early treatment before any damage to the heart can occur.

20. An allergy band is only placed on patients who have an identified food or medication allergy.

21. Allergies to latex are treated as any other allergy and simply need to have the allergy identified on their allergy band.

22. If you witness a fall or find patient who has fallen, immediately post fall - be sure the patient is cared for and the environment is safe.

23. Patients’ self-report of their pain level is the most reliable indicator.

24. To report an emergency or “emergency code” within the hospital dial *31999 if accessible to the medical center operator or 911 if not accessible to the medical center operator.

25. It is important that you always wear your RMCBP ID badge at all times. If someone is in your area and they do not have an ID badge you have the right to ask them who they are.

26. Empty cylinders are defined as open down to 0 PSI. Do not use any cylinder less than PSI on the gauge.

27. Some electrical safety guidelines are: a) don’t touch anything electric with wet hands either water or alcohol based sanitizers, b) don’t place cords near heat or water, and c) check electrical equipment for inspection stickers.

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28. Those in a patient care area should know the location of your medical gas shut off valves and what rooms they affect, however; only Nursing Management, Plant Operations, Respiratory, Security, and Fire Department personnel have the authority to shut them off.

29. Florida Right-to-Know Law requires that employees are given information regarding the nature of toxic substances with which they are working.

30. Biomedical equipment failures, user errors and preventative maintenance are not reported to the Environment of Care Committee.

31. The basic principle of oxygen safety are: a) identify when oxygen is in use, b) stabilize oxygen cylinders in an approved stand or rack to prevent tipping, and c) smoking is permitted campus wide.

32. The intent of the Safe Medical Devices Act (SMDA) is to track medical devices and report incidents that result in patient illness/injury or death. It is the responsibility of the equipment company to keep track of their own equipment, so employees do not need to report any incidents.

33. Safety Data Sheet (SDS) provides information concerning the nature of toxic substances and a complete listing of all the SDS in the facility is kept in the Emergency Department.

34. R-A-C-E is the fire response acronym that is on your I.D. badge and stands for Rescue, Activate alarm, Confine/contain the fire, and Extinguish.

35. The Definition of Biomedical Waste is any solid or liquid waste that may present threat of infection to humans including: liquids (secretions and excretions), non-liquid tissue and body parts from humans, laboratory waste which contains disease causing agents, discarded sharps (new and used).

36. Sharps containers do not need to be emptied until they are 100% full.

37. It is not important to use Personal Protective Equipment (PPE) to clean up a biomedical waste spill to prevent exposure from blood borne pathogens.

38. In any crisis development situation there are four distinct and identifiable behavior levels. The purpose of defining each level is to attempt to meet each level with the appropriate staff response to defuse or de-escalate the crisis development. These levels include: anxiety, defensive, acting-out and tension reduction.
39. By following our policies and procedures, on average our staff receives more exposure from naturally occurring background radiation outside of work than they do on the job.

40. Never allow individuals to access storage areas where medications are stored unless you are sure the individual is authorized to be there.

41. The following abbreviations are approved for use at Regional Medical Center Bayonet Point: ‘U’ for (unit) and ‘QD’ for (every day).

42. Black Hazardous Waste Buckets should be used to waste narcotics.

43. Blue Pharmaceutical Waste Buckets should be used for non-hazardous drug waste.

44. Insulin and MDI should be returned to pharmacy for waste.

45. An occurrence is any event that involves an unusual situation with a patient, visitor, employee, or volunteer that results in injury or potential injury. The following are examples of occurrences: medication errors, procedures not performed as ordered, a fall, accident or injury to a patient visitor, employee or volunteer, patient leaving against medical advice, wrong diagnostic or surgical procedure, missing or damaged property, unexpected adverse results of professional care and treatment.

46. The goal of the fall prevention program is to identify the patient who is at risk to fall, institute proactive efforts to reduce the occurrence of fall-related incidents, and provide a safe environment for patients, visitors and staff.

47. Risk Management activities contribute to the quality of care and help to promote a safer environment for patients, visitors, volunteers and employees, as well as reduce the cost of the risk to the facility. In order to accomplish these goals, all employees and volunteers must participate in the system that provides a reporting mechanism for those occurrences that may cause a risk. Through identification of the risk, we can take steps to correct, reduce, modify, or eliminate risk situations. Everyone at RMCBP must be aware and involved in the process to eliminate risk events.

48. Documents that patients use to communicate their wishes about medical care they want to receive are called Advance Directives.

49. It is not necessary prior to performing any operative procedure or administering anesthesia, performing an invasive diagnostic or therapeutic procedure, administering blood products, engaging in any investigation process or removing organs or tissue from a living or dead person for any purpose for the physician to obtain informed consent.
50. HCA and / or its affiliates investigate and respond to reports of violations of the social media guidelines, which may result in disciplinary action.

51. Social media guidelines, which define appropriate actions for utilization of social media such as Facebook and Twitter, apply for both Company- authorized uses of social media and HCA – affiliated employees’ personal use of social media.

52. It is the responsibility of the employee to renew their license and / or certification on time; staff will not be allowed to work with an expired license or certification.

53. The cultural values or religious beliefs of patient caregivers may be considered an aspect of patient care assignment and may be taken into account when there is a communicated and direct conflict between the employee’s values or beliefs and the patient’s care and treatment.

54. It is necessary that RMCBP follow the Centers for Disease Control (CDC) recommendation for mandatory PPD skin testing on all new hires and employees and skin testing or assessment on current employees and volunteers on an annual basis.

55. It is not important to use Personal Protective Equipment (PPE) to clean up a biomedical waste spill to prevent exposure from blood borne pathogens.

56. A person can be exposed to HIV and not become infected.

57. The three transmission-based precautions are contact, strict contact, and neutropenic.

58. The use of gloves almost always eliminates the need to wash your hands.

59. Standard precautions are not to be used on all hospital patients, regardless of their diagnosis or presumed infectious status.

60. Policy and Procedures may be found on the hospital intranet > Policy and Procedures.
# | True/False | # | True/False | # | True/False
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3 |            | 23 |            | 43 |            
4 |            | 24 |            | 44 |            
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6 |            | 26 |            | 46 |            
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NAME: ________________________________________________
DATE:_________________________SCHOOL/Traveler:_____________________

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