Provider Survey
Readiness Guide
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ORGANIZATION

Mission
Our mission is to provide leadership and excellence in teaching, discovery, clinical care, and service as a student-centered comprehensive research university and academic health center with a wide range of programs from learning assistance through postdoctoral studies.

Vision
Our vision is to be a top-tier university that is a destination of choice for education, health care, discovery, creativity, and innovation.

Our Values
- **Collegiality** - reflected in collaboration, partnership, sense of community, and teamwork
- **Compassion** - reflected in caring, empathy, and social responsibility
- **Excellence** - reflected in distinction, effectiveness, efficiency, enthusiasm, passion, and quality
- **Inclusivity** - reflected in diversity, equality, fairness, impartiality, and respect
- **Integrity** - reflected in accountability, ethical behavior, honesty, and reliability
- **Leadership** - reflected in courage, honor, professionalism, transparency, and vision
INTRODUCTION

AU Medical Center is accredited by The Joint Commission (TJC) under the “Hospital” Accredited Program as well as certified under the Advanced Certification for Comprehensive Stroke Center.

TJC is an independent, not-for-profit organization that sets standards for patient safety and quality healthcare and then inspects healthcare organizations to see if they are in compliance with these standards.

In 2002, TJC announced changes in its accreditation process: Shared Vision-New Pathways. This initiative has drastically changed how our facility is surveyed. First, the survey will be unannounced. Because we will not know when they are arriving, our goal is Continuous Readiness for "our very next patient". The Survey team will use Patient/System Tracers to conduct its review. This format allows the surveyors to follow a selected number of patients, known as tracers, through the healthcare process from the patient’s arrival until his/her discharge. This means that the majority of the survey process will focus on patient charts and direct caregivers. This patient/system tracer method focuses on how services are perceived from the patient’s point of view and on how well we work together to coordinate his/her care.

When TJC surveyors come to visit, they will be touring all areas of our organization and asking staff, as well as physicians, questions about how the hospital works. The tour and questions they ask will be a big part of their inspection of the hospital. Chances are that you will be asked some questions by one of the surveyors. The information in this booklet is provided to help you prepare for some of the questions they may ask.
TIPS

It is highly recommended that you familiarize yourself with the information and the policies listed within this handbook. This book will be a valuable resource even when the Joint Commission is not coming to survey.

If a surveyor asks you a question during the visit:
- Be friendly, professional and helpful
- Answer each question as completely as you can
- Never guess if you don’t know the answer
- Keep your answers related to the question being asked
- Do not monopolize the conversation
- Do not volunteer additional or unnecessary information
- Ask for the question to be repeated or stated differently if you do not understand it
- Never argue with the surveyor

Here are some general guidelines in responding to the questions:
- Use some common sense in your answer. The surveyors are not trying to trick you. They will only ask questions which you should be able to answer.
- If you are asked a question and do not know the answer, you are allowed to look up the answer in any printed material or computerized resource.
- Words to avoid during an interview
  - Usually
  - Attempt
  - Try
  - Sometimes

What Will The Surveyors Observe?
- **Hand Hygiene**
  - Equipment correctly cleaned and disinfected between patients with hospital approved disinfectant (i.e. your stethoscope, mobile equipment)
    - Know that the CONTACT TIME for the purple top wipes is 2 minutes!
    - If in doubt, refer to the label!
  - No gowns or gloves in hallways
  - No expired supplies
  - Clean and dirty utility room doors are closed
  - Oxygen tanks are labeled, secured, and stored appropriately
  - Response to clinical alarms and call lights
  - Access to exits not blocked
  - Corridors are clear and uncluttered- no trash on floors
# RESTRAINT UTILIZATION

<table>
<thead>
<tr>
<th>Topic</th>
<th>Non-Violent/Non-Self Destructive</th>
<th>Violent/Self Destructive</th>
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| Order reason               | • Pulling at lines   
                          • Pulling at tubes   
                          • Pulling at dressing  
                          • Unable to follow commands  
                          • Confused  
                          • Sedated  | • Imminent risk of harm to self  
                          • Imminent risk of harm to others  
                          **Seclusion** can only be used for violent or self-destructive behaviors |
| Alternatives Attempted     | Alternatives to restraints are attempted and documented in EMR prior to application of restraints |                                                                                  |
| Provider evaluation/Order | A written order must include                                        | The physician/trained designee must evaluate *(face-to-face)* the patient **within 1 hour of initiation** of restraint.  
                          • Reason  
                          • Type of Restraint  
                          • Duration of Restraint  
                          • Release Criteria  
                          Documentation of this must include:  
                          • evaluation of the patient’s immediate situation;  
                          • evaluation of the patient’s reaction to the intervention;  
                          • evaluation of the patient’s medical and behavioral condition;  
                          • Determine whether restraint should be continued; and  
                          • The order for the restraint. |
| Order exception            | In EMERGENCIES, a qualified RN may apply restraints prior to MD order. The order must be obtained and entered by the provider within *a few minutes* |                                                                                  |
| Order restrictions         | PRN orders for restraints are not allowed                              |                                                                                  |
| Attending notification     | **If you are not the attending MD for the patient and you order the restraints**, you MUST notify the attending MD by the next calendar day and document this notification in the Medical Record |                                                                                  |
| Time duration              | Valid for one calendar day                                              | Valid for 24 hours ALSO must be periodically renewed depending on patient’s age  
                          Orders are time limited based on age:  
                          • 4 hours for patients ages 18 and older  
                          • 2 hours for children ages 9 to 17  
                          • 1 hour for children age 8 and under |
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<th>Non-Violent/Non-Self Destructive</th>
<th>Violent/Self Destructive</th>
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<tr>
<td>Re-evaluation and continued use</td>
<td>• A qualified RN must examine and determine if the restraint continues to be clinically justified.</td>
<td></td>
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<tr>
<td></td>
<td>• The MD must see the patient by the next calendar day</td>
<td>• A qualified RN must examine and determine if the restraint continues to be clinically justified.</td>
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<td></td>
<td></td>
<td>• The RN must notify the provider if continued use is required</td>
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<td></td>
<td></td>
<td>• The RN must obtain an order renewal based on age every</td>
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<td>• 4 hours for patients ages 18 and older</td>
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<td>• 2 hours for children ages 9 to 17</td>
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<td></td>
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<td>• 1 hour for children age 8 and under</td>
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<td>• The physician/provider must conduct a face to face evaluation every 24 hours prior to re-ordering violent restraints.</td>
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<tr>
<td>Nursing Monitoring/Care</td>
<td>Q 2 hours</td>
<td>Q 15 minutes</td>
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<tr>
<td>Nursing Documentation</td>
<td>• Verification of restraint order</td>
<td>• Verification of restraint order</td>
</tr>
<tr>
<td></td>
<td>• Attending Notification (if applicable)</td>
<td>• Attending Notification (if applicable)</td>
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<tr>
<td></td>
<td>• Modification of the care plan</td>
<td>• Modification of the care plan</td>
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<td></td>
<td>• Individual patient assessments and reassessments</td>
<td>• Individual patient assessments and reassessments</td>
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<td></td>
<td>• Clinical Justification</td>
<td>• Clinical Justification</td>
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<tr>
<td></td>
<td>• Restraint Type</td>
<td>• Restraint Type</td>
</tr>
<tr>
<td></td>
<td>• Alternative used</td>
<td>• Alternative used</td>
</tr>
<tr>
<td></td>
<td>• Patient/Family Education</td>
<td>• Patient/Family Education</td>
</tr>
<tr>
<td></td>
<td>• Monitoring results</td>
<td>• Monitoring results</td>
</tr>
<tr>
<td></td>
<td>• Any injuries to the patient (if applicable)</td>
<td>• Any injuries to the patient (if applicable)</td>
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<tr>
<td>Removal</td>
<td>• D/C at earliest possible time</td>
<td></td>
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<tr>
<td></td>
<td>• Document the released criteria met</td>
<td></td>
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<tr>
<td></td>
<td>• Document D/C in medical record and care plan</td>
<td></td>
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<tr>
<td></td>
<td>• If patient again exhibits behavior requiring restraints, a NEW order must be obtained</td>
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*For more information, please refer to: Policy #942, Acute Care Restraints and Seclusion*
IMPROVING ORGANIZATIONAL PERFORMANCE

- What is Quality Improvement/ Process Improvement?
  - A systematic approach to improving outcomes of our work processes including clinical care, support services, and administration
  - Uses intentional changes to improve outcomes
  - Measurements and metrics are used to measure changes in outcomes and to determine if the changes made work

- The process we use is called the PDCA cycle:

  P- Plan for Improvements

  D- Do the Improvements

  C- Check. (What did we learn? Are improvements working?)

  A- Act to hold the gain and to continue to improve the process.

We use this organized process to make improvements at the hospital regarding care for our patients and how we get work done.

Processes for Improvement
- Projects correlate with Mission, Vision and Values
- Select high-risk, low-volume, or problem-prone processes
- Variance reports
- Satisfaction surveys – patient, staff, physician
- Employee suggestions
- Strategic Quality Initiatives
- National Patient Safety Goals (NPSGs)
- Monthly chart and billing audits
• Environment of Care Rounds
• Outcomes data (i.e., wounds, blood use, autopsy reports, medication use, etc.)
• Sentinel Event Alerts (and Sentinel Events, should one occur)

Performance Monitoring
• Medication Management
• Surgical Case Reviews
• Restraint Use
• Resuscitation and its Outcomes
• Risk Management
• Infection Control Surveillance and Reporting
• Autopsies
• Organ Procurement

Education in Quality Improvement and Performance Program (EQIP)-
Facilitated learning sessions aligned with PI projects that were chosen by leadership and Medical Executive Committee. These are conducted annually and include several disciplines across the organization. Examples are
• Sepsis Core Measure
• Blood Culture Contamination
• Stroke Intervention
• VIP Patient Portal- Ambulatory

Examples of Hospital-wide PI Projects (List not all inclusive)
• Alarm Management Project:
  A PI project since January 2014 after TJC published a new NPSG pertaining to clinical alarm fatigue. A multidisciplinary workgroup identified the important alarm signals- Cardio-respiratory alarms. A clinical alarm policy was approved that details
  o Where to find individual patient parameters
  o Who can order and change parameters
  o Response in ICU, ED, procedure areas
  o Response in Med-Surg areas

• Reducing Post-Operative Pneumonia:
  A PI project since November 2015 after National Surgery Quality Improvement Program (NSQIP) data showed increase in post-op pulmonary occurrences. The project focused on
  o Revised pre-operative patient education
  o Standardization of pre and postoperative pulmonary measures
    ▪ Incentive spirometry
    ▪ Early mobility protocol
    ▪ CHG mouthwash with ventilator protocols

• Patient Throughput
Examples of Changes Instituted from PI Projects in FY 15:

- Discharge Nurses supporting Adult nursing units
- New patient management software
- Discharge Lounge
- PICU stepdown unit
- Sepsis Treatment Guidelines

Core Measures (2015-Q3)

- Perinatal Care
  - PC-01 Elective Delivery
  - PC-02 Cesarean Section
  - PC-03 Antenatal Steroids
  - PC-04 Health Care-Associated Bloodstream Infections in Newborns
  - PC-05 Exclusive Breast Milk Feeding
  - PC-05a Exclusive Breast Milk Feeding Considering Mother’s Choice
- Stroke
  - STK-1 Venous Thromboembolism (VTE) Prophylaxis
  - STK-2 Discharged on Antithrombotic Therapy
  - STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter
  - STK-4 Thrombolytic Therapy
  - STK-5 Antithrombotic Therapy By End of Hospital Day Two
  - STK-6 Discharged on Statin Medication
  - STK-8 Stroke Education
  - STK-10 Assessed for Rehabilitation
- CAC
  - CAC-3 Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
- Venous Thromboembolism
  - VTE-1 Venous Thromboembolism Prophylaxis
  - VTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis
  - VTE-3 Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
  - VTE-5 Venous Thromboembolism Warfarin Therapy Discharge Instructions VTE-6 Incidence of Potentially-Preventable venous Thromboembolism
- Immunization
  - IMM-2 Influenza Immunization Seasonal

Core Measures (Value Based Purchasing (VBP))

What is VBP?

Established by the Affordable Care Act of 2011, beginning October 2012, Medicare began withholding one percent of all diagnosis related group payments to U.S. hospitals so the
program is funded by hospital “contributions.” Hospitals can “earn back” some or all of those funds based on their performance in core measures and patient satisfaction.

Medicare payment incentives/penalties are designed to promote achievement of high quality care and improvement in care quality. They began adjusting Medicare inpatient prospective payment system (IPPS) payments on October 1, 2012 (FFY 2013) based on quality performance. Program details were left to the Centers for Medicare/Medicaid Services (CMS).

VBP performance determines Pay for Performance amount. It is budget-neutral in that it is redistributive. **Best performers win, others break even or lose.** VBP payments are netted against contributions.

Included are hospital acquired conditions and mortality rates as well as outcome measures which includes readmission measures for AMI, HF, and PN.

National performance in core measures has increased. The benchmark to achieve full payment reimbursement will require **consistent performance near the 100 percent level in each core measure.** Patient satisfaction scores will also need to be higher.

You can help by being familiar with core measures and the Physician-focused patient satisfaction questions; using pre-printed order sets or computerized physician order entry (CPOE); **documenting reasons when you choose a patient-care intervention that varies from core measures;** and participating in assigned committees related to core measures, patient satisfaction and performance improvement.

**Resources**

If you have questions regarding a core measure, the following resources are available: **Core Measure Specification Manual**, available at [www.qualitynet.org](http://www.qualitynet.org).

**Call the Quality Management Core Measure Team at for any core measure you may have questions about.**

**Patient Safety Event Reporting**

AU Medical Center is committed to identifying and eliminating conditions that are conducive to error, and designing processes to protect people from these occurrences. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes.
All staff have the right to report patient safety events directly to the Joint Commission (TJC). If a patient safety event is reported to TJC, it is preferred that a Safety Intelligence (SI) Report be filed as well. This will ensure the organization has an opportunity to review and improve systems. You can enter a Safety Intelligence Report anonymously if you do not wish to disclose your contact information. Reporting concerns about safety or quality of care is non-punitive.

All patient safety events including adverse events, sentinel events, good catches / close calls, critical incidents, and hazardous conditions will be reported utilizing Safety Intelligence (SI), our electronic reporting system, and should be evaluated to determine the associated harm. For all patient safety events reaching a harm score of 6 (temporary harm) or higher, or if the patient treatment plan is altered as an outcome of the event, Risk Management shall be immediately contacted. Risk Management is available Monday – Friday 8 a.m. – 5 p.m. at 706-721-7475 (706-721-RISK). After hours, weekends, and holidays, Risk Management may be reached by paging 7475.

As part of our insurance coverage, it is expected that any patient safety event that falls into any of the following eight (8) categories will be reported immediately to Risk Management at 1-7475:

1. Loss of sensory capacity (sight or hearing)
2. Amputation
3. Brain damage or brain injury
4. Birth injury to an infant / child
5. Paralysis or serious neurological impairment
6. Burns
7. Serious cosmetic deformity
8. Unexpected death

Failure to report events that could be classified, after review, as critical incidents or sentinel events in a timely manner has the potential to result in disciplinary action.

For more information, please refer to:
Policy #379, Patient Safety Event Reporting.
Failure Mode and Effects Analysis (FMEA)
A FMEA is a systematic way of examining a process before implementation looking for possible ways in which failure can occur. It assumes that no matter how knowledgeable or careful people are, errors will, or are likely, to occur. This is proactive, trying to determine what factors might contribute to an event before an event occurs.

FMEA Examples:
- PICU Step Down Unit

Root Cause Analysis (RCA)
The goal of a RCA investigation is to identify the underlying factors and prevent recurrences of the problem. This is reactive, after an event has occurred.

Components of a RCA include:
- Outline the specific sequence of events leading up to the event, and the departments/services/personnel involved.
- Uncover “why” the errors occurred and what systems contribute to vulnerabilities in the areas of proximate cause.
- Attempts to identify what needs to be done, what systemic improvements are needed to reduce the risk of another Sentinel Event.
AU Health Quality Structure
How does PI information flow up and down?

For more information, please refer to:
Policy #693 Performance Improvement and Patient Safety Plan
Policy # 815 Quality Plan
ONGOING PROFESSIONAL PRACTICE EVALUATION

Each clinical service is responsible for monitoring the professional practice of their privileged staff. This is to be done through review of provider practice patterns as well as through peer review activity that assesses a practitioner’s practice behavior and his/her ability to perform requested privileges. Results of this ongoing professional review will be used to facilitate improvements in the quality of care offered to patients and to ensure a practitioner's continued privilege-specific competency.

On an ongoing basis (at least every 6 months), performance data will be collected on all members of the staff. The Clinical Service Chief, or designated departmental peer review group, shall evaluate staff based on a pre-determined set of criteria submitted and approved by the MEC annually.

Each Clinical Service Chief or designee shall stipulate the criteria by which ongoing professional practice evaluation shall trigger a focused professional practice evaluation. Variances from established practice expectations will be referred for a focused professional practice evaluation by the Clinical Service Chief or designee as stated in Focused Professional Practice Evaluation Policy.

For more information, please refer to:
Policy # 1095 Ongoing Professional Practice Evaluation
FOCUSED PROFESSIONAL PRACTICE EVALUATION

In addition to the OPPE, a period of appropriate focused professional practice evaluation (FPPE) will occur in the following circumstances:

- An applicant requests initial privileges, or a provider reenters practice after a clinical absence of more than 12 months (365 days);
- If a member of the medical staff voluntarily surrenders his/her privileges as provided by the Medical Staff Bylaws (Article V, Section 6.5, Paragraph A. 5.), he/she must be subject to an FPPE as a condition of reinstatement to the medical staff.
- An issue arises during the ongoing evaluation of a practitioner's performance that raises concern about his/her ability to provide safe, high quality patient care;
- **An applicant requests privileges for care or procedures that he/she has not previously performed at this facility**
- A provider's performance on a measure in OPPE is outside the defined threshold;
- A sentinel event, a complication, a provider specific tort settlement, a substantiated practitioner-specific complaint, a safety violation, or a behavior occurs, which raises concern about the ability of the provider to provide safe, high quality care and is felt by the Clinical Service Chief or designee to merit focused professional practice evaluation;
- A disturbing trend of less severe, unrelated clinical practice patterns or events is noted which is felt by the Clinical Service Chief or designee to merit focused professional practice evaluation.

Upon completion of the focused evaluation period, the Clinical Service Chief will submit a Focused Professional Practice Evaluation Summary to the Credentials Committee (CC) indicating satisfactory completion of the focused period of evaluation or the reasons to extend the period of focused professional practice evaluation.

Departmental findings that indicate an adverse deviance from expected performance during focused professional practice evaluation will be presented in a written report to the CC to assist in their privileging decisions.

External review may be sought when adequate clinical expertise does not exist within the facility, when concerns about conflict of interest suggest an external review would be beneficial, and/or when a new technology or procedure, not previously provided, is requested.

For more information, please refer to:
Policy # 1088 Focused Professional Practice Evaluation
MEDICAL STAFF CODE OF PROFESSIONAL CONDUCT

Professional behavior, ethics and integrity are expected of each individual member of the Medical Staff at AU Medical Center. This Code is a statement of the ideals and guidelines for professional and personal behavior of the Medical Staff in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, and among themselves, in order to promote a culture of safety and the highest quality of patient care.

Each Medical Staff Member has a responsibility for the welfare, well-being, and betterment of the patient being served.

Unacceptable and Disruptive Behaviors are behaviors which may be intentional or unintentional, but they undermine a culture of safety. The practitioner:

- Disrupts the operation of the hospital and clinics;
- Adversely affects the ability of others to perform their jobs or responsibilities effectively;
- Creates an unprofessional or hostile work environment for AUMC employees and staff members;
- Interferes with an individual’s ability to practice competently; and
- Undermines the culture of safety at AU Medical Center.

Examples include, but are not limited to:

- Using profane, offensive, demeaning or abusive language in addressing AU Medical Center employees, other staff members, patients, visitors, students, residents, or fellows; or who uses such language within earshot of staff, patients, visitors, students, residents or fellows even if such language is not directed at these individuals;
- Displaying behavior that is offensive, threatening or intimidating;
- Inappropriate physical contact with another individual; including but not limited to unwanted touching and lack of respect for personal space;
- Refusal to accept medical staff assignments or to participate in departmental affairs in a professional and appropriate manner.

For more information, please refer to:
Policy #405 - Medical Staff Code of Professional Conduct
**EMERGENCY OPERATIONS DISASTER RESPONSE PLAN**

Disaster Privileging Plan for Licensed Independent Practitioners:

When the Emergency Operation Plan (EOP) has been activated for a local, state, or national disaster, and the Chief Executive Officer of Chief Operating Officer has declared, in writing, that AU Medical Center is operating in disaster mode (not emergency mode), disaster privileging can be authorized by the Medical Director or designee when AU Medical Center or Children’s Hospital of Georgia is unable to handle the immediate patient care needs. Disaster privileges must be granted on a case-by-case basis at the discretion of the Medical Director. The practitioner will be assigned to an appropriate service on the AU Medical Center staffs in which he/she is granted disaster privileges and the Clinical Service Chief or designee will be responsible for managing the activities of the practitioner. Disaster privileges do not confer any status on the medical staff to which the practitioner is assigned. The authorization to practice will be documented on the Disaster Privileging Plan Document.

The Medical Directors may grant disaster privileges by one of the following three categories:

1. Granting disaster privileges to a practitioner that is currently on one of the AUMC staff. If the practitioner is currently a member of one Medical Staff, the appropriate Medical Director (or designees) may grant disaster privileges based on the current credentials file. The practitioner must appropriately wear the AUMC badge at all times.

2. Granting disaster privileges to a practitioner that is not currently on one of the AUMC staffs, but is a known local community physician whose practice, ethics, and character can be vouched for by one or more active AUMC staff members.

3. Granting disaster privileges to a practitioner that is not currently on one of the AUMC staffs and the practitioner is not known by an active AU member. Disaster privileges may be granted by one of the following criteria:
   - A current picture hospital ID card;
   - A current license with a valid driver’s license or other valid ID issued by a state, federal or regulatory agency;
   - Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), or
   - Identification indicating that the practitioner has been granted authority to render patient care in emergency circumstances. Such authority having been granted by a federal, state, or municipal entity.

Once the immediate situation is under control, Medical Staff Office personnel, and others as assigned, will initiate temporary privileges for all practitioners granted disaster
privileges according to the guidelines with the Bylaws and Medical Staff Credentialing Policy. This process will be deemed as high priority.

For a non-AU Medical Center practitioner, a temporary badge will be issued by the Medical Directors with assistance from the Medical Staff Office, if needed. The temporary badge will contain the AU Medical Center logo, name of the practitioner and signature of the Chief Medical Officer or designee. If the practitioner is currently an AU Medical Staff member, a copy of the Disaster Privileging Plan Document will be placed in the credential files. If the practitioner is not a member of any AU Medical Staff, the information will be maintained in a temporary privilege file within the Medical Staff Office.

REPORTING OF ABUSE, RAPE, ASSAULT AND VIOLENCE

All healthcare providers are responsible for recognizing and reporting the signs of possible abuse. All healthcare providers are responsible for following the guidelines for reporting any suspicion of possible abuse as outlined in policy, and for following the mandatory reporting of suspected child abuse under Georgia law.

Annually, health care providers are provided education through the computerized learning system on what to look for and how to report.

For more information, please refer to:
Policy # – Reporting of Abuse, Rape, Sexual Assault, and Domestic Violence
RAPID RESPONSE TEAM ACTIVATION

The Rapid Response Team (RRT) will respond when beeped, for a patient who has potentially life threatening changes in status, and falls under the Rapid Response (RR) criteria. The RR team will not be called for patients in the ED, ICU, Surgery, PACU, or Cath Lab. The goal of the RRT is to limit the number of codes outside the ICU.

Any member of the hospital staff, visitors or family members can call the RRT. To activate the RRT, notify the hospital operator who will beep all members of the team. The staff member should say, “Activate the RRT to room #__.”

It is the responsibility of the Critical Care Charge Nurse, the Charge Respiratory Therapist, and the House Supervisor to respond to a RR call. After stabilization if the patient is to be moved to another level of care, the Critical Care Nurse and Respiratory Therapist will assist with the transfer.

Chain of command – Communication of Patient Care Concerns

**Should issues occur with communication between services, the goal is to have attending MD speak to attending MD.**

For EMERGENT issues that require practitioner notification (contact made no later than 5 minutes):

- Any licensed individual (who is permitted to take verbal orders) should immediately place a call to the practitioner while other team members continue to manage the needs of the patient.

- If unable to immediately reach the practitioner or unable to resolve the concern(s), the Nursing Supervisor should be contacted and may escalate the issue to the next higher level if needed. The process should be repeated until practitioner contact is made and notification of patient’s status or need is communicated and resolved.

- Order of escalation:
  - Resident (no response within one (1) minute)
  - Attending Physician or designated call coverage physician
  - Clinical Service Chief
  - Chief Medical Officer (CMO) and Risk Manager (as directed by CMO) and Administrator-on-call (as directed by CMO)
For **URGENT** issues that require practitioner notification (contact made within 10 minutes):

- Any licensed individual (who is permitted to take verbal orders) should contact the appropriate practitioner.
- If unable to reach the practitioner after two attempts, the Nursing Supervisor should be contacted and may escalate the issue to the next higher level if needed. The process should be repeated until practitioner contact is made and notification of patient’s status or need is communicated and resolved.
- Order of escalation:
  - Resident (repeat one (1) attempt within five (5) minutes)
  - Attending Physician or designated call coverage physician
  - Clinical Service Chief
  - Chief Medical Officer (CMO) and Risk Manager (as directed by CMO) and Administrator-on-call (as directed by CMO)

*For more information, please refer to:*
*Policy #714, Escalation Chain of Authority Involving Patient Care Issues of Concern*
FALLS

1) AU Medical Center inpatient units will utilize the Morse Fall Scale (MFS) assessment instrument.
2) Children’s Hospital of Georgia (CHOG) inpatient areas will utilize the Humpty Dumpty Fall Prevention Program (HDFPP).
3) The Ambulatory Care, Emergency Department, and Hospital-Based Services will use the fall prevention program as outlined in Attachment to Falls Prevention and Management Policy: Ambulatory Care, Emergency Department and Hospital-Based Services Fall Prevention Guidelines.

<table>
<thead>
<tr>
<th>Range</th>
<th>Risk Level</th>
<th>Fall Precautions</th>
<th>Visual Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-44</td>
<td>Low</td>
<td>Standard</td>
<td>none</td>
</tr>
<tr>
<td>&gt;45*</td>
<td>High</td>
<td>High Risk</td>
<td>Yellow Socks (nonskid)</td>
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<td></td>
<td></td>
<td></td>
<td>Falling Star (door)</td>
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<tr>
<td></td>
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<td>High Fall Risk Sign (chart)</td>
</tr>
</tbody>
</table>
Prevention Intervention – high risk for falls:

1) Identifying the patient visual cues listed above.
2) Conducting hourly bedside rounds and checking patient for pain management, elimination, positioning, patient comfort, availability of personal possessions, and environmental hazards;
3) Transporting off unit with assistance of staff or caregivers and notifying receiving area of high fall risk;
4) Encouraging family/caregiver to stay with the patient;
5) Providing diversion therapy as appropriate;
6) Supervising and/or assisting the patient in bedside sitting, personal hygiene, and toileting as appropriate;
7) Establishing an elimination schedule when appropriate and ensuring the bedside commode or urinal is readily accessible and empty;
8) Reorienting confused patients as necessary;
9) Notifying the physician to order a Physical Therapy consult for those patients at high risk for falls or who have impaired mobility;
10) Utilizing the bed alarm as available for all patients scoring 45 on the MFS assessment tool; and
11) Ensuring the alarm is audible at the time of initiation and at each shift and responding rapidly when activated.

For more information, please refer to:
Policy #170, Falls Prevention and Management
MEDICATION MANAGEMENT

Communication of Medication Shortages, Outages, or Substitution Protocols
When a medication shortage is identified, pharmacy staff will perform an assessment of current stock, consider anticipated length of the shortage, determine current usage patterns, and brainstorm potential actions. If necessary, pharmacy staff will coordinate with departments impacted to discuss practice changes across medical disciplines including the approval of using alternative products (i.e., development of therapeutic interchanges or substituting protocols), prioritizing patients, and rationing product. Any immediate action plans developed will be communicated to the medical staff and clinical hospital associates. Communication may include, but not be limited to, emails, computer alerts, flyers, and individual verbal communication. At the next Pharmacy and Therapeutics Committee meeting, the Committee will review immediate actions put in place and recommend an ongoing plan.

- Can anyone access meds when pharmacy is not available?
  - The central pharmacy is available and staffed by pharmacists and pharmacy technicians 24/7/365.

High Alert Medications
High-alert medications are drugs that bear a heightened risk of causing significant patient harm when used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients. High alert medications are not the same as Look Alike – Sound Alike Medications.

A full list of high alert medications can be found in the High Alert Medications and Safeguards Policy. Examples are chemotherapeutic agents, moderate sedation agents, neuromuscular blocking agents and oral anticoagulants.

Efforts To Reduce Medication Errors
Use of non-punitive error reporting designed to identify errors and fix system issues
Routine review of all medication-related events
Implementation of software and technology (e.g., including barcode scanning, dose error reduction software in epidural, general infusion and PCA pumps, etc.)
Medication Use Evaluation (MUE) and Improvement Program

Therapeutic duplication
If a pharmacist notes therapeutic duplication (i.e., defined as the use of multiple medications for the same indication), the pharmacist will contact the prescriber for clarification. The nurse and/or other qualified healthcare professionals authorized to administer medications will review orders promptly with the prescriber whenever there is a question about the appropriateness of the medication order or need for other clarification.

For more information on therapeutic duplication or a complete medication order, refer to policy #310, Safe Medication Practices.

For more information, please refer to:
Policy #310, Safe Medication Practices
Policy #1052 Formulary Management, Drug Selection, Drug Procurement and Drug Storage Policy
Policy #811 High Alert Medications and Safeguards

INFECTION PREVENTION AND CONTROL

EDUCATION
All new employees are introduced to the importance of infection prevention and control, personnel hygiene, the OSHA Bloodborne Pathogens Standard, the Medical Center’s Tuberculosis Exposure Control Plan, Bloodborne Pathogen Exposure Control Plan and their responsibilities in each of these are part of new employee orientation.

Annually, all employees are required to renew their safety training, including a basic review of how infections are transmitted as well as the OSHA Bloodborne Pathogens Standard through a computer based training module.

Annually, in June and July, all new medical residents and fellows attend an orientation to the Infection Control Program at AU Medical Center.

Education is driven by findings during surveillance, data analysis, Environment of Care (EOC) rounds, procedure observations and input from frontline staff.

HANDWASHING
The single most important factor in reducing Healthcare-Associated Infections (HAIs) is HANDWASHING. Please follow the guidelines below:

- WASH visibly soiled hands with soap and water
- Use an alcohol based hand rub (ABHR) to decontaminate hands not visibly soiled
- Decontaminate hands after each contact with patients and after contact with body fluids or excretions, mucus membranes, non-intact skin, and wound dressings.
- Decontaminate hands before and after donning gloves
- Decontaminate hands before inserting a sterile catheter (urinary or vascular)
- WASH hands with soap and water before eating and after using the restroom
- WASH hands with soap and water after possible exposure to enteric and spore forming pathogens such as Norovirus, Clostridium difficile or Bacillus anthracis

AHBR dispensers are located in each patient’s room or right outside the patient’s door on patient units and in other strategic locations throughout the hospital.

**HEALTHCARE-ASSOCIATED INFECTIONS (HAIs) and MULTIPLE DRUG RESISTANT ORGANISMS (MDROs)**

Healthcare-associated infections (HAIs) — especially infections caused by multidrug-resistant organisms (MDROs) — pose a serious global health care threat. MDROs are most commonly associated via horizontal transmission (i.e., caregiver-to-patient, environment-to-patient or patient-to-patient) in the health care setting. They cause serious, difficult to treat infections that are often related to substantial morbidity, mortality and excess cost.

There is an urgent need for better strategies to prevent transmission of HAIs. The critical need for health care institutions to reduce infections through compliance with basic prevention measures has been recognized at many levels, including The Joint Commission’s recent decision to add prevention of healthcare-associated infections as a National Patient Safety Goal.

AU Medical Center has been successful in minimizing infections caused by methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C-Diff) and Vancomycin-resistant Enterococci (VRE), by implementing a combination of interventions, such as hand hygiene, active surveillance cultures, contact precautions and robust decontamination rather than relying on a single approach.

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)**

Despite their use in less intensive general medical and surgical wards, indwelling catheters pose significant infection risks to patients. Four components of care are recommended for all patients to prevent or reduce the risk of CAUTI:

- Avoid unnecessary urinary catheters
- Use alternative measures for bladder elimination
Bladder training, which consists of placing the patient on the bedpan or commode every two hours
- Intermittent catheterization for patients requiring chronic urinary drainage due to neurogenic bladder and postoperative patients with urinary retention
- External condom catheterization in cooperative males without urinary retention or obstruction.
- Ultrasonic bladder scanning device utilization in conjunction with intermittent catheterization for suspected urinary retention

- Insert urinary catheters using aseptic technique
- Maintain urinary catheters based on recommended guidelines
- Review urinary catheter necessity daily and remove promptly

The following are appropriate indications for placement of urinary catheters:
- Acute urinary retention or bladder outlet obstruction
- Accurate measurement of urinary output in critically ill patients
- Perioperative use in selected procedures
  - Urological surgery or other surgery on contiguous structures of the genitourinary tract
  - Anticipated prolonged duration of surgery (remove catheter in PACU)
  - Anticipated receipt of large volume infusions or diuretics during surgery
  - Need for intraoperative monitoring of urinary output
- Assisted healing of perineal and sacral wounds in incontinent patients
- Prolonged immobilization for trauma or surgery
- Comfort care of the terminally ill patient if needed

THE NEED FOR A URINARY CATHETER NEEDS TO BE DOCUMENTED

CENTRAL LINES
The key components of the central line bundle are:
- Hand hygiene (surgical hand scrub)
- Maximal barrier precautions upon insertion
  - Cap (covering all hair)
  - Mask
  - Sterile gown
  - Sterile gloves
  - Large sterile drape (covering the patient from head to toe)
- Chlorhexidine skin antisepsis
- Optimal catheter site selection, with avoidance of the femoral vein for central venous access in adult patients
- Daily review of line necessity with prompt removal of unnecessary lines
- Complete central line checklist at the time of insertion
- Remove noncertified central lines (those inserted without a qualified inserter or observer or when the bundle is not met) within 24 hours

**SURGICAL SITE INFECTION (SSI) PROPHYLAXIS**

In addition to the proper use of prophylactic antibiotics and good surgical technique, other factors under the control of the operative team have been demonstrated to affect significantly the risk of SSI. These other factors include:

- Avoid shaving the operative site
- Maintain post-operative glucose control for major cardiac surgery patients
- Maintain post-operative normothermia for surgery patients
- Remove urinary catheter within 48 hours of surgery
- Use appropriate VTE prophylaxis

The Infection Prevention and Control department in conjunction with Surgical Services developed a patient education tool related to decreasing surgical site infections. The end product is the patient education brochure which is given to surgical patients during their preoperative appointment and reviewed prior to discharge.

**VENTILATOR-ASSOCIATED PNEUMONIA (VAP)**

By definition, ventilator-associated pneumonia (VAP) is a lower airways infection that must have developed more than 48 hours after the patient was intubated. Preventing pneumonia of any variety seems at first blush to be a laudable goal. However, there are some reasons to be particularly concerned about the impact of pneumonia associated with ventilator use.

Perhaps the most concerning aspect of VAP is the high associated mortality. Hospital mortality of ventilated patients who develop VAP is 46% compared to 32% for ventilated patients who do not develop VAP.

In addition, VAP prolongs time spent on the ventilator, length of ICU stay and length of hospital stay after discharge from the ICU.

Reducing mortality due to VAP requires an organized process that guarantees early recognition of pneumonia and consistent application of the best evidence-based practices.
The ventilator bundle is a series of interventions related to ventilator care that, when implemented together, will achieve significantly better outcomes than when implemented individually.

The key components of the ventilator bundle are:
- Elevation of the head of the bed 30-45° unless contraindicated
- Daily "sedation vacations" and assessment of readiness to extubate
- Peptic ulcer disease prophylaxis
- Deep venous thrombosis prophylaxis
- Daily oral care with chlorhexidine

INFLUENZA
- Influenza is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness, and at times can lead to death. Each year in the United States on average, 5% to 20% of the population gets the flu; on average, more than 200,000 people are hospitalized from flu-related complications, and; about 36,000 people die from flu-related causes.
- Proactively minimize exposure to patients and co-workers if you become ill with typical symptoms of influenza, which include but are not limited to: cough, congestion, sore throat and a temperature of 100.4 degrees or higher. Influenza vaccination remains the single most effective means of protecting patients and employees from influenza.
- AUMC is committed to the health and wellbeing of employees, employee’s families, and our patients, and considers annual seasonal influenza vaccination for all patients and employees, physicians, other LIP, students and volunteers a high PATIENT SAFETY priority. Influenza vaccination is provided at no cost.

OTHER STRATEGIES TO AVOID HAI
Prevention of infection in an acute care setting requires adherence to best practice guidelines. These guidelines are outlined briefly below.

Handling of medical wastes
- Items saturated/dripping with blood or body fluids are placed in red bags at the point of waste generation.
- Red bags are removed from patients’ rooms and placed in the appropriate biohazardous waste container in the soiled utility room.
- Waste items with small amounts of blood or body fluids that will dry quickly (IV dressings, band-aids, etc.) can be disposed of with regular waste.
• All sharps must have the safety device engaged (when available) and be placed in a sharps disposal container; Sharps without safety devices are never recapped.
• Sharps containers must be below the fill line without obstructed inlets.
• All laboratory/pathology waste goes into red bags or biohazard disposal containers.
• Non-hazardous waste items (disposable dishes, packing, etc.) are disposed of with regular waste.
• Chemotherapy and radioactive waste must be disposed of separately from medical waste.

Handling and storage of linen
• Clean linen must be covered at all times on all sides.
• Soiled linen is placed in linen hampers or blue linen bags. Linen hampers must not be overfilled.
• Soiled linen bags are taken to the soiled utility room and placed down the linen chute or in a cart.
• Linen bags should never be laid down or dragged in the hallway as this may cause the spread of infection. Launderable yellow gowns are placed in the linen hampers.
• All linen hampers remain in the hallway during use except in the case of an isolation patient. The linen hamper for an isolation patient must remain in the patient's room.
• If a linen hamper is rolled to the soiled utility room to dispense soiled linen, it must be disinfected upon leaving the soiled utility room.

For more information, please refer to:
Policy # 694 Infection Prevention and Control Risk Assessment and Plan
Policy #1093 Hand Hygiene Policy
Policy # 1094 CAUTI Prevention Policy
Policy # 663 CLABSI Prevention Policy
PATIENT SAFETY

AU Medical Center promotes safety to our patients, staff, and our environment. Some examples include:

- Our policies and procedures comply with the National Patient Safety Goals.
- Wash your hands before and after each patient encounter and wear gloves when in contact with body fluids.
- Follow transmission-based precautions when indicated.
- Identify the patient by using two patient identifiers before giving medication, treatment or working with a patient. (This includes all staff: nurses, therapists, technologists, phlebotomists, CNAs, transporters, etc.)
- High-risk medications are marked differently. Warnings are communicated through the Medication Administration System.
- Look-alike/sound-alike drug list is posted and medications are located separately in the automated dispensing machines in the medication areas.
- The crash cart, defibrillator, glucose meter controls and refrigerator temperatures are checked every 24 hours or per policy.
- You educate patients and families about infection and fall prevention.
- All staff have an opportunity to participate on performance improvement (PI) teams (i.e., Clinical Initiative teams, Root Cause Analysis (RCA), Failure Modes & Effects Analyses (FMEA)).
- You help maintain a clean and clutter free, safe environment.
- ALWAYS wear your ID badge.
- Never use unapproved abbreviations.
- Check that the alarm is in working order when setting up new equipment.
- Conduct and document a "time out" immediately before any invasive procedure.

**Sentinel Event**

An unanticipated occurrence, involving unexpected death or serious injury (i.e. loss of limb, loss of function or death). This is a very serious situation for the hospital and all staff involved. If an incident occurs that may become a Sentinel Event, immediately notify your supervisor/ department director. He/she will notify the administrator on call and Risk Management.

- Complete an Incident Report in Safety Intelligence System stating the facts of the occurrence.
- The hospital will promptly begin a root cause analysis (RCA) following our Sentinel Event Policy. The RCA will help pinpoint what specifically went wrong and how we can prevent it in the future.
- Staff involved in the incident will be asked to participate in the root cause analysis.
Management will follow-up with staff involved in the sentinel event to focus on preventing future similar occurrences.

For more information, please refer to:
Policy #379, Patient Safety Event Reporting

JOINT COMMISSION /CMS/CLIA NOTIFICATION

We encourage all staff and independent practitioners to report safety and quality of care concerns to the area manager or director for resolution. Reports of unresolved patient safety or quality of care issues may be made, without fear of retaliatory disciplinary action, directly to:

Linda Henderson, RHIA, CPHQ  
Director, Quality Management  
Phone: 706-721-6221  
Email: lhenderson@gru.edu

OR

Patient safety or quality of care issues may also be reported directly to:

Office of Quality Monitoring  
The Joint Commission  
One Renaissance Blvd.  
Oakbrook Terrace, IL 60181  
Compliance Hotline: 877-436-6195  
Fax: 630792-5636  
E-mail: complaint@jointcommission.org

If you have any concerns, questions or complaints about care, treatment, or any issues related to laboratory services, please let the care provider know. You can also contact:

• Centers for Medicare and Medicaid Services (CMS) Division of Laboratory Services/Clinical Laboratory Improvement Amendments (CLIA) 877-267-2323, ext. 63531

Environmental or Public Safety opportunities can be reported to:

• AU Medical Center Safety Office: 706-721-4527
PATIENT AND FAMILY CENTERED CARE

AU Medical Center is a pioneer in the concept of Patient and Family Centered Care, an approach that removes the barriers to having collaborative partnerships between healthcare providers, patients, and families. This means that we put patients and families first. We believe that families are extensions of the patient, not an imposition. The more involved a family is, the more our quality and safety improve along with the patient’s satisfaction. Not only do we have visitors in our hospitals, we have healthcare partners and they are an integral part of the healthcare team.

Because we are an academic medical center with three missions: Patient Care, Medical Education, and Research, we take a team approach to medicine, with the patient being the most important member of the team. Our team approach means that the patient receives better care and better outcomes because of the number of individuals bringing their skills. In addition to your attending physician and nurses, the team might also include a resident, who is getting hands-on experience in a given medical specialty, or, in some cases, a medical or nursing student.

Patient and Family Education
Patients/family members can find information regarding active participation in their plan of care in all admission packets and they can ask staff members.

Educating the Family and Patient of Their Plan of Care
- Brochure on admission
- Review after each intervention that is ordered

Pain Management
Patients at AU Medical Center are educated about pain, the risk for pain, the importance of effective pain management, the pain assessment process and methods for pain management by nursing staff at every point in the hospital system. You, as the provider, should be aware that AU Medical Center assesses and reassesses pain using the appropriate scale for the patient. The 0-10 Numeric Scale (Visual Analog), the Faces Scale (Wong-Baker Scale), the non-verbal scale (FLACC non-Verbal scale) and non-English scales are all used for pain assessment according to the patient situation. As their
physician, the patient and family will be looking to you for diagnosis, management and treatment of the patient’s pain.

**Medication Reconciliation**
Patients should receive a comprehensive list of all medications they are to continue upon discharge. This list should be written clearly, and in terms that are understood by the patient. This list is to be reviewed with the patient and/or family by the nurse before discharge. Patients and family (and staff) also need to know that our reconciliation of medications in all areas of the hospital stay assures that we are reducing the chance that medication errors occur.

**Language Barriers**
AU Medical Center recognizes and supports the needs of Limited English Proficient (LEP), deaf and hard-of-hearing patients who may require assistance in communicating with hospital and clinic staff. Interpreter and Translational Services is dedicated to help healthcare providers bridge the gap with LEP and hearing impaired patients through an accurate interpretation.

Culturally and Linguistically Appropriate Service (CLAS) has an array of services to support our mission:
- Trained Spanish Medical interpreters available 24/7.
- For languages other than Spanish, contracted CyraCom International, a transparent language service that specializes on medical interpretations in over 150 different languages via telephone interpretation.
- Coordinated access to licensed American Sign Language (ASL) interpreters for the hearing impaired.

Please reference the following web page for further information on Interpreter and Translational Services: https://paws.gru.edu/pub/patient-family-engagement/interpreter/Pages/services.aspx

For more information, please refer to:
*Policy #224, Patient Family Education*
*Policy # 384, Patient Rights and Responsibilities*
*Policy # 375, Management of Patient Grievances*
COMPLIANCE & ENTERPRISE RISK MANAGEMENT

The Augusta University and AU Health System enterprise is committed to providing instruction, research, healthcare, and other activities in compliance with applicable federal, state, and local law and regulations. The Compliance & Enterprise Risk Management office supports this commitment and promotes an organizational culture that encourages ethical conduct, and serves as a resource in providing guidance in compliance, privacy, and risk management oversight.

"Compliance is everyone's responsibility." This is a statement you have probably heard before. What does that really mean? It means:

Being aware of our surroundings and expected standards to help maintain our compliance. Generally everyone participates in compliance by completing the assigned ongoing compliance education, reviewing the rules of conduct and/or code of ethics, and remaining aware of the policies and procedures. Managers can provide additional awareness opportunities for their program staff. This can be done by routinely including compliance topics on the staff meeting agenda, by reviewing and discussing the most current policies and procedures, or by inviting the in-house experts from different departments to discuss specific areas. Awareness creates knowledge, and this is key to successfully creating an environment of accountability.

Reporting concerns so they are properly addressed is everyone's responsibility, regardless of position. If a concern is identified but is not reported, there is the potential for that concern to remain "undetected" and this can place employees, customers, and/or the organization at risk in any number of ways. Anyone can encounter an issue during day-to-day job activities. How we respond is important. Any identified actual or potential concern needs to be reported to those who can help ensure that the issues are properly investigated, evaluated, and corrected. Augusta University and AU Health System has personnel designated to respond and address different types of issues. For this reason, it is important that the appropriate personnel are notified. These experts can carefully assess all facts without bias and evaluate the process or system to determine the necessary response, thus ensuring that the regulations and standards are met and that matters are handled consistently and fairly. This assists in creating a safe reporting environment and a just and ethical culture.
Being accountable for compliance is different depending on our roles. Sometimes it's about making sure we regain compliance in an area where an issue has been identified (corrective actions). Sometimes it's about revising or drafting a policy or procedure to make sure we comply with a new or revised regulation, law, or standard. For others it's about being aware and maintaining licensing requirements and renewals, or being aware and accountable for addressing changes to professional practice standards or financial requirements. When it comes down to it, we are all accountable to do the jobs we were hired to do and that means we need to remain informed about relevant standards to properly carry out our duties. It also means we need to ensure that concerns are properly reported and addressed. This helps contribute to creating a just and ethical culture throughout the Augusta University and AU Health System enterprise.

Compliance Hotline
The Augusta University and AU Health System provide a 24-hour hotline number that you may call to report any complaints or concerns you may have relating to compliance issues. The toll free number to call is:

(800) 576-6623

This confidential phone line can be used for concerns you may have about any kind of activities that may be suspect or that you have questions about. This could include, but not limited to: conflicts of interest, patient health information, receiving something of value in exchange for purchasing a service or product, time and expense abuses, research misconduct, and student and/or employee privacy issues. The Hotline provides you the opportunity to communicate your concerns with Augusta University and AU Health System. You will be protected from retaliatory actions and if you prefer, you can remain anonymous.

In order to research your concern, some basic information is needed.
- A description of the concern
- Who is involved
- Where and when the incident took place
- Your name and contact number (if you are willing to share this information)

If you prefer, you may report your concern using the following email address, compliance@augusta.edu. When using the email service you will need to provide the basic information listed above. Please be aware that when using the email address your concern may not remain anonymous. However, the confidentiality of the individual
reporting the issue will be maintained to the best of our ability. Or you can also file a report online.

EMERGENCY MANAGEMENT PLANS

CODE RED - FIRE

If a fire emergency occurs within the hospital, please follow the “Defend in Place” procedure utilizing the acronym R-A-C-E and contacting AU Medical Center Security, 706-721-4787. “Defend in Place” means to attempt to extinguish or to contain the fire in a room and only move the necessary patients while awaiting further instructions.

R-A-C-E

R-emove persons in immediate danger of the fire. (Only do so if you are not putting yourself in immediate danger).

A-ctivate the nearest fire alarm pull station, calmly notify other personnel in the area, and call AU Medical Center Security, 706-721-4787. Fire alarm pull stations are located near exits and stairwell doors. Activating the pull station will notify the Fire Department of the fire emergency and emergency responders will be en route. The phone call to Facilities Dispatch is required to establish the exact location of the fire, the severity of the situation, and if any additional help may be needed. Identify yourself and remain on the phone as long as possible or until you are released. Hospital Security will be relaying pertinent information to emergency responders. AUMC Security is staffed 24 hours a day, seven days a week.

C-onfine/ C-ontain fire by closing all doors to the affected area.

E-xtinguish the fire with the proper extinguisher provided in your area. If the room door was closed, do not re-open it, wait for the Fire Department. Do NOT attempt to fight a fire if you are alone, if the fire is large, spreading, or could block your exit.

ONLY qualified nursing and/or respiratory personnel are authorized to shut off oxygen. If oxygen to a particular room needs to be shut off, the employee doing so MUST know the procedure and understand the implications of turning off oxygen to certain rooms and zones. Replacement oxygen may be needed or patients may need to be moved to different rooms.

ENSURE corridors are clear of obstruction.

IF the Code Red activation is not in your immediate area, standby, practice procedures, await instructions and be ready to give assistance if needed.
REMEMBER!

CODE BLUE – MEDICAL EMERGENCY

In case of Cardiac Arrest, or a Medical Emergency, follow this procedure:

- Contact paging operator at 706-721-2222
- Give location and as much information as possible: i.e., age/sex/circumstances
- Stand by to assist until Code Team arrives

CODE GREEN – SEvere WEATHER

Severe Thunderstorm Watch- Indicates that conditions are favorable for tornadoes, large hail, heavy rain, high winds and thunderstorms. Be alert for changing conditions.

Severe Thunderstorm Warning- Issued by the National Weather Service when storms with strong winds, rain and hail are expected in the area. A severe thunderstorm warning may last for up to one hour.

Tornado Watch- Issued when weather conditions exist that could produce a tornado. A tornado watch may last for several hours.
Tornado Warning- Issued when a tornado has actually been sighted and is threatening the community. Emergency messages broadcast by the media, NOAA radios or notification from external agencies such as Augusta Richmond County Emergency Management Agency (ARCEMA), Columbia County EMA, Richmond County Sheriff's Department, i.e., are reliable sources of weather information. A tornado warning usually last for thirty minutes of less.

**Tornado Warning:**

A. Once the message is announced, all patients who condition permits shall be moved to interior corridors away from windows.
   1) If the patient is bedridden, move them in the bed.
   2) If the patient is ambulatory, pull a chair into the corridor for them to sit.
   3) Patients who cannot be transferred from their rooms:
      - Close drapes/blinds.
      - Move the patient’s bed near the inner wall, away from windows as much as possible.

B. Employees should:
   1) Remove all articles off window sills.
   2) Close all drapes/blinds over windows.
   3) Close door to patient’s rooms.
   4) Direct visitors, volunteers, students, and medical staff to interior corridors and to stay away from exterior windows.

C. Safety/Security will secure external doors as much as possible.

D. Facilities/Environmental Services will assist with moving patients and securing the building.

**NOTE:** It is safer to remain inside a building/shelter rather than attempt to flee from the storm.

**Termination/Recovery**

- Once the weather has cleared the area, an overhead announcement of “Severe Thunderstorm/Tornado Warning, All Clear” will be made. The announcement will be made at least three times.
- Facilities will assure that the facility is assessed for damage. Evaluation of the situation for its effect on operations and/or patient safety will be conducted.
- If no damage has occurred to the building, patients moved during a Tornado Warning may be returned to their rooms.
- If operations and/or patient safety is affected, patients will be transferred to a safe haven which could mean evacuating to another hospital/facility.
- All efforts will be made to protect the lives of patients, visitors,
CODE PINK – INFANT / CHILD ABDUCTION

In case an Infant / Child abduction or pediatric elopements follow this procedure:

Notify AU Medical Center Security 706-721-4787, University Police 706-721-2911, 706-721-2222 or call 911 as soon as possible.

- Look for suspicious persons walking through or exiting the hospital. Be aware of persons in laboratories or other non-public areas without ID badges
- Pay close attention to exits
- Watch for persons that are hand-carrying an infant or accompanying a child. Abductors may carry infants in plain view or in large containers such as gym bags or tote bags
- If you observe a suspicious person, attempt to engage in conversation to slow them down while having a co-worker call the police or security. If it is possible and safe to do so, follow the person and note their direction of travel
- If the suspect has already left the building get a good physical description, direction of flight and other information such as vehicle make and registration and contact University Police immediately.

CODE ORANGE – DECONTAMINATION

- Presentation of a patient to the Emergency Department who is believed to have been exposed/contaminated with a hazardous, or potentially hazardous substance
- Upon notification of Emergency Department by a credible source that patient(s) believed to have been exposed to a hazardous substance are en route to the hospital
- Upon request from a Regional hospital or agency for the Community Decon Center to be opened

In all cases where the source or the release is brought to the hospital:

- Persons contaminated are not to enter any part of the hospital until decontaminated, unless they are in a life-threatening medical condition
- DIAL 911 and give all information available
- Initiate Lockdown Procedures
- Shut Down Air Handling Systems
- No hospital personnel should enter the vehicle
- Liaison Officer will make contact with responding Fire Department on Scene Commander
- All Personnel should shelter in place*
- Establish containment areas at all entrances within 300 meters of source
*Activation of Code Triage or Code Orange should be discouraged until Fire Department contains the source. Any action which would force personnel to move between buildings may endanger their lives.

CODE GOLD – ELOPMENT RESPONSE PLAN

**Elopement:** When a patient wanders, runs, escapes, or otherwise leaves the care giving environment (Hospital) and grounds unsupervised or unnoticed prior to their scheduled discharge.

Notify: AU Medical Center Security (706) 721-4787 and Paging Operator (706) 721-2222

Focus is towards persons who have a history of dementia, Alzheimer’s or altered mental status, and persons who may have their health and safety compromised by leaving the grounds unaccompanied prior to their scheduled discharge.

If at any time a patient with risk for elopement cannot be accounted for, the Elopement Response Plan should be implemented. A thorough search of the Unit will be completed.

The Hospital Operator should be notified and advised that an elopement has occurred: The Announcement Code is “**Code Gold**” and the last known location and description of the patient announced, repeat the announcement two (2) times.

If the patient is not located in the Hospital, the following persons should be notified:

- Security Department
- Administrator of Unit
- Nursing Supervisor
- Risk Management
- Family/ Next of Kin
- Physician Treating Patient

When a patient is located, the announcement “Code Gold, All Clear” is made. Repeat Announcement two (2) times. Security should document the incident.

**CODE GREY – BOMB THREAT**

Notify **AUGUSTA UNIVERSITY POLICE:** (706) 721-2911 or call 911 IMMEDIATELY

**Phone Bomb Threat:**

If you receive a bomb threat phone call:
• Remain calm and keep the caller on the line as long as possible. Ask the caller to repeat the message and record every word.
• If the caller does not indicate the location of the bomb or the time of detonation, ask for this information.
• Advise caller that the building is occupied and detonation could result in death or serious injury to innocent people.
• Pay particular attention to background noises, such as motors running, music, or any other noises, which may indicate the location from which the call is being made.
• Listen closely to the voice to determine voice quality, accents, speech impediments, sex, or unusual characteristics, and complete threat data form.
• If the caller can be kept talking, ask specific questions as indicated below. It is desirable, but not always practicable, to have more than one person listen in on the bomb threat call.
• Immediately, notify the UNIVERSITY POLICE (706) 721-2911. They will initiate search procedures.

Written Bomb Threat

If you receive a bomb threat via a letter or note:
• Make a note of all persons that you know who handled the note.
• Avoid excessive handling of the note. The police will want to check for fingerprints.
• Follow all instructions from responding emergency personnel. Evacuate if ordered to do so.

CODE BLACK- ACTIVE SHOOTER

When a hostile person(s) is actively causing death or serious physical injury or the threat of imminent death or serious physical injury to person(s) on AU or AU Medical Center property, we recommend the following procedures be implemented:

• NOTIFY AUGUSTA UNIVERSITY POLICE: (706) 721-2911, Paging Operator (706) 721-2222 or call 911 as soon as possible.
• Run away from the threat if you can, as fast as you can.
• Do not run in a straight line.
• Distance yourself from the perpetrator. Put something between you and the shooter!
• While you are running, use vehicles, bushes, trees and anything else that could possibly block your view from the hostile person(s).
• If you can get away from the immediate area of danger, summon help and warn others.
• If you decide to hide, take into consideration the area in which you are hiding. Will I be found here? Is this really a good spot to remain hidden? Do I have an escape route if necessary?
• If the person(s) are causing death or serious physical injury to others and you are unable to run or hide, it may be safer to choose to play dead if other victims are around you.
• The last option you have if caught in an open area outside may be to fight back. This is dangerous, but depending on your situation, this could be your last option.
• If you are caught by the intruder and you are not going to fight back, obey all commands and do not look the intruder in the eyes.
• In the event of an active shoot, RUN, HIDE, or FIGHT!
• PLAN, and PREPARE, on how you will REACT!
• Once the police arrive, obey all commands. This may involve your being handcuffed or made to put your hands in the air. This is done for safety reasons and once circumstances are evaluated by the police, they will give you further directions to follow.

If you are in a classroom: STAY THERE, secure the door, Notify AUGUSTA UNIVERSITY POLICE: (706) 721-2911 or call 911. Consider quietly exiting a ground floor window, if safe. If you can’t exit a window, stay away from the door, stay low and be quiet. The shooter may bang on the door and yell for help to entice you to open the door. If police are not on the scene yet, move well away from the incident, find a safe cover position, and wait for police to arrive. When instructed to exit, proceed to the safest exit to leave the building and then move toward any police vehicle. Keep your hands on your head and follow the exact directions from the police.

Bottom Line: Seek cover. Notify UNIVERSITY POLICE: (706) 721-2911 or call 911. Move away from the immediate path of danger. Distance yourself from the shooter. Put something between you and the shooter! Thinking and planning about a shooter on campus NOW, will help you make better decisions during a critical incident.

Staff Identification During Emergency Operations
AU Health System uses the regular staff identification badge and colored vests to identify caregivers and other employees during mass casualty or major environmental disasters. Staff coming into the facility needs to have a visible Georgia Regents Health System ID visible in order to enter.

Key members of the Incident Command Center are issued a colored vest with the ICC Command Title across the back or on the fore arm to identify their role in the response. These vests move with the job title as more senior staff become available, and during longer incidents, as jobs are handed from staff to staff. The Liaison Officer from the Incident Command Center is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the media, and volunteer responders to issue AU Health System emergency identification.

Alternate Roles for Staff During Emergencies
During emergencies the Incident Commander and department managers implement the Emergency Operations Plan, which defines the Disaster Command Staff that supersedes normal hospital management. Senior staff, as available, will be assigned responsibilities
from the Incident Command Center. Most staff performs the usual tasks they are trained for, however in a differing context. Incident Command Staff receive training and participate in drills which define their roles in the ICC.

You can refer to our organization’s Emergency Operation Plan located on Policy Tech for more detailed information. There is also a RED notebook located on the patient units that contains a hard copy of the Emergency Operation Plan.

**Attachment #1 - 2016 NPSGs**
**Attachment #2 – Survey Hit List- Things to Remember**
**Attachment #3 – Survey Hit List – Know Where to Find It**
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.

**Identify patients correctly**

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment. Make sure that the correct patient gets the correct blood when they get a blood transfusion.

NPSG.01.03.01

**Improve staff communication**

NPSG.02.03.01

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

**Use medicines safely**

NPSG.03.04.01

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

NPSG.03.05.01

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

NPSG.03.06.01

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

**Use alarms safely**

NPSG.06.01.01

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

**Prevent infection**

NPSG.07.01.01

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

NPSG.07.03.01

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

NPSG.07.04.01

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

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01

Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

**Identify patient safety risks**

NPSG.15.01.01

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

**Prevent mistakes in surgery**

UP.01.01.01

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

UP.01.02.01

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

UP.01.03.01

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

The Joint Commission Accreditation Hospital

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.
Attachment #2

Survey Hit List- Things to Remember!

- The method used for verifying physician privileges/ resident competencies
  - E-Priv – for physician privileges
    - Located on Citrix and Nursing Portal
    - All areas of hospital now combined
    - The log-in/password information is:
      - Log in: CVO
      - Password: CVO123
      - Choose CVO from dropdown
  - Resident – Resident Competency
    - Located on Citrix and Nursing Portal-  
    - No log-in. Password is “nursing”
      - Status
        - A=Approved/deemed to be competent for the unsupervised performance of the designated procedure
        - S=Always supervised by either upper level resident who is deemed to be competent to perform the same procedure, or a privileged faculty member
        - X=Not approved to perform the procedures/must always be supervised by a privileged faculty member
  - Call Medical Staff Office at 1-3928

- Where are the Clinical System Downtime procedures located?
  - On PAWS
  - Know where your downtime forms are kept in your units
Attachment #2 – Survey Hit List- Things to Remember!

- When to wash your hands?
  o Before and after patient care
  o Before and after wearing gloves
  o When going from dirty to clean tasks/procedures
  o When visibly dirty
  o Don’t forget about your stethoscope
    ➢ Foam 8-10 times before washing is required

- Low level disinfection
  o Wet time for purple top Super Sani-wipes is 2 MINUTES

- What PI projects are performed on your unit? Point to your displayed bulletin boards to tell the story.

- What are some examples of the Organization’s PI Initiatives?
  o Clinical Alarms Management
  o Patient Throughput
  o Patient satisfaction survey results

- CLAS (interpreter) Information
  o Call 1-6929
Attachment #3

Survey Hit List- Know Where to Find It!

- **Policies & Procedures**
  - Policy Tech (organizational policies)
    - On PAWS
  - Mosbys on Nursing Portal
  - Departmental policies (Know where hard copy is)

- **Formulary/Medication Information**
  - High Alert Medications list
    - Policy Tech Policy # 811 – High Alert Medications and Safeguards Policy
  - On Pharmacy Intranet Homepage

- **MSDS**
  - Safety Homepage
  - Nursing Portal

- **Human Resources**
  - 706-721-9365 (Main #)
Attachment #3- Survey Hit List- Know Where to Find It!

- **Safety Intelligence (formerly known as PSN)**
  - Reporting Patient Safety Events
    - On PAWS
    - Citrix

- **Medical Records**
  - Forms on Demand
    - On Citrix
  - Advance Directive
    - If new, in patient paper chart on unit AND/OR
    - In Powerchart
      - Clinical Notes
        - Admission/Registration
        - Advance Dir Checklist (Copy of Advance Directive)
      - Clinical Notes
        - Nursing Documentation
        - Admission Database (Documentation of Advance Directive)

- **HIPAA Regulatory Compliance**
  - Compliance Hotline 1-800-576-6623

- **Emergency Codes**
  - EOP manual – red notebook on your unit
  - Posters throughout the hospital