Employee Survey
Readiness Guide
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MISSION

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**

You can print out and carry this handbook with you during the survey visit! It is highly recommended that you familiarize yourself with the information. 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
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.
CUSTOMER SERVICE

YOU ARE AU Medical Center:

- Break the ice – smile and introduce yourself

- Does someone look confused or lost? Stop and try to help.
  - IF YOU CAN’T HELP THEM, FIND SOMEONE WHO CAN

- Courtesy counts – kind gestures and polite words

- Explain what you are doing – be helpful

- Anticipate people’s needs and act on them

- Respond quickly

- Protect privacy and confidentiality

- Handle with care – imagine you are on the receiving end

- Protect the person’s dignity

- Take the initiative, even if it’s "not your job"

- Treat patients like adults

- Listen. If a person complains, don’t be defensive

- Keep it quiet! Patients are sick and need to rest

- Phone skills and courtesy – sound pleasant

- Look the part – maintain a professional appearance
  - Clean uniform and shoes
  - Well-groomed nails and hair
  - No excessive perfume, after-shave, etc.
A – I – D – E – T

Knowing that our patients will judge us by our actions, I will hold myself to the highest standards of behavior.

- **Acknowledge**: Acknowledge the patient (by the last name, if possible).
- **Introduce**: Introduce myself, my skill set, and my professional certification and training.
- **Duration**: Describe the duration of the test: how long it will take, how long the patient will be here and how long the patient will have to wait on the results.
- **Explanation**: Explain the tests and the pain involved, being very honest, and what happens next. Explain that I am looking at the patient’s wrist band because of patient safety and very good care.
- **Thank You**: Thank the patient for choosing AU Medical Center and always ask The patient before leaving: Is there anything else I can do for you?

**STANDARDS OF BEHAVIOR**

**Communication**: Exchanging thoughts or ideas effectively so that all parties involved Reach a common understanding. Actively listen to what others say and communicate your understanding and follow up as appropriate.

**Confidentiality**: Being sensitive to the personal nature of health care and protecting our customers’ confidentiality, privacy and modesty in all situations.

**Integrity**: By adhering to moral and ethical principles and by being honest, we keep our word and we are faithful to who we say we are. Be committed to the mission, vision, And values of AU Medical Center.

**Professionalism**: Knowing that our patients will judge us by our actions, I will hold myself to the highest standards of behavior.

**Service Excellence**: Service is the ability to anticipate, recognize, and provide for the needs of others by going above and beyond.
Teamwork: People working together – (building, linking, sharing, lifting, pulling, supporting, helping, encouraging) – can accomplish anything.

TEAM = Together Everyone Accomplishes More!!!
GENERAL SAFETY

Identification of Emergency Power Outlets

- Red in color
- Located in patient rooms and various other areas throughout the hospital

Problems with Patient Care Equipment

- Immediately remove the equipment from use. This is a patient safety requirement. Call Biomed Department (ext. 1-2228) between 8 AM and 5 PM to pick up the equipment or call 1-8400 after hours for the on-call Biomed. If the equipment is transportable, you can place it outside the Biomed office (BB 8521). If not transportable, Biomed will come and pick up.

Locations of Fire Alarms

- Located throughout the hallways and departments.
- Record the location of the nearest fire extinguisher to your regular workstation/area.

Electrical/Equipment

- New medical equipment must be safety inspected by the Biomedical Engineering Department before it is used in a clinical application.
- For existing medical equipment, check the Biomed preventative maintenance sticker and make sure that the month and year on the sticker has not expired before each use. If it has expired, immediately take the equipment out of service (do not use it!) and contact Biomed at ext. 1-2228.
- The use of extension cords and power strips is discouraged. If one must be used, obtain ordering information from Biomed for a hospital grade extension cord or relocatable power tap (“power strip” where there is a green dot on the cord’s outlet and has a UL rating of 1363A or 1363 for the in-patient care vicinity) and then purchase it.
- Do not use broken medical equipment or medical equipment with frayed cords or exposed wires.
  - TAG IT FOR REPAIR and notify Biomed or if possible, bring it to Biomed Office (BB 8521).
EMERGENCY CODES

CODE WHITE - PAGER OUTAGE
In case of a pager outage, the Paging Operator will announce “Code White until further notice” via overhead pager. Once announcement is made, please follow these procedures:

- All non-emergent contacts should be made by use of cell phone or land-line telephone. If emergency contact with an individual is necessary, call 706-721-3893:
  - Give the operator the name of the person to be contacted
  - Give the operator the extension you are calling from
  - Remain at the station you are calling from until contact is made.

When the Code White has ended, the Paging Operator will announce via overhead pager. All paging operations will then return to normal.

CODE TRIAGE – DISASTER/DISASTER DRILL
Disaster- any incident, natural or man-made that causes or poses widespread danger to occupants and property to the extent that normal services are disrupted.

Internal Disaster- occurs within AU Health (e.g. utility failure).

External Disaster- occurs at any other Health System site or elsewhere in the community (e.g. multi casualty- multi-vehicle accident, earthquake, flood, nuclear, biological, or chemical incident).

Depending on the circumstances surrounding a critical event or disaster the on duty or on call administrator will announce Code Triage Standby whereas all disaster response areas will be set up with a duty officer assigned.

At the announcement of Code Triage:
Contact your supervisor for the latest instruction or report to your assigned duty position:
Labor Pool Incident Command Media Center
Family Center Decon Area Work Area
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 PINK – INFANT / CHILD ABDUCTION

In case an Infant / Child abduction or pediatric elopements follow this procedure: Notify AU Health 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. Do not get into a physical confrontation. Please note that physical violence has not generally been used in abductions from health care facilities but violence is common in abductors from the home.
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.

Based on its analysis of cases of child abduction, the National Center for Missing and Exploited Children has listed the following characteristics of the “typical” abductor:

- Initially visits the nursery and the maternity units at more than one healthcare facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire stairwell for their escape and may also try to abduct from the home setting
- Usually plans the abduction but does not necessarily target a specific child; usually seizes best opportunity
- Frequently impersonates a nurse or other allied health professional – may obtain hospital scrubs or equipment
- Often becomes familiar with healthcare staff, staff work routines, and victim parents

**CODE BLUE – MEDICAL EMERGENCY**

(AU Health Location):

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
- Check breathing and initiate **FIRST AID** if trained to do so and if it is **SAFE** to do so, comfort them and reassure them that help is on the way. Do **NOT** touch ether person if you are not certified in first aid and / or do not have personal protection gear if there is danger of coming into contact with bodily fluids. If you are certified in first aid and it is **SAFE** to do so, provide care to the person to the extent you are capable.
- Keep bystanders from interfering with procedures and clear area for the Code Team when they arrive

(Augusta Campus):

- Remain calm and assess the situation. Do **NOT** put yourself in danger
- Call for HELP: University Police 706-721-2911 or 911
- Give University Police your location and as much information as possible: i.e., age/sex/ circumstances and other details concerning the emergency as necessary
- Send another person to bring the building AED to your location
- Do not move the injured/ill person unless they are in immediate danger of further injury
- Check breathing and initiate **FIRST AID** if trained to do so and if it is **SAFE** to do so, comfort them and reassure them that help is on the way. Do **NOT** touch the person if
you are not certified in first aid and/or do not have personal protection gear if there is
danger of coming into contact with bodily fluids. If you are certified in first aid and it is
SAFE to do so, provide care to the person to the extent you are capable.

Follow all directions given to you by University Police and/or other authorized
personnel.

**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 Health 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 Health 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. AU Health 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.

ALWAYS remain calm and never yell “Fire”. Encourage visitors and patients to also remain calm.

DO NOT use the elevators. ALWAYS use stairs during a fire emergency.

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 GOLD – ELOPEMENT 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 Health 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.

Patients fitting the above criteria may have an increased risk of elopement if the following are presented:

- Attempts or verbalizes a desire to leave the Hospital;
- If the patient vocalizes the desire to reach a specific destination;
- Cognition is moderate-to-severely impaired;
- Excellent ambulation skills or a steady gait;
- Those who are able to propel their own wheelchair.

If the risk of elopement is present a photograph of the resident should be taken and given to the Security Office.

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 resident 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 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 Health or AU 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 be 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, lock, wedge or barricade the door. 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 AUGUSTA 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.

**CODE GREY – BOMB THREAT**
Notify 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 on the attached Bomb Threat Check List. It is desirable, but not always practicable, to have more than one person listen in on the bomb threat call.
- Immediately, notify the AUGUSTA UNIVERSITY POLICE (706) 721-2911. They will initiate search procedures. Under no circumstances should an untrained faculty or staff member attempt to locate and move a suspicious device.

Ask questions and take notes:

<table>
<thead>
<tr>
<th>When will the bomb go off?</th>
<th>What does it look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What kind of bomb is it?</td>
<td>What will cause it to explode?</td>
</tr>
<tr>
<td>Did you place the bomb?</td>
<td>Why?</td>
</tr>
<tr>
<td>Who is calling?</td>
<td>Where is it located?</td>
</tr>
</tbody>
</table>

Keep talking to the caller as long as possible, listen carefully, and try to determine the following:

<table>
<thead>
<tr>
<th>Caller’s gender</th>
<th>Approximate age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the voice familiar</td>
<td>Accent or unique speech attribute</td>
</tr>
<tr>
<td>What is the emotional state of the caller</td>
<td>Describe any background noises during call</td>
</tr>
</tbody>
</table>
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.

Any individual receiving a bomb threat call should do the following:
**NOTIFY UNIVERSITY POLICE: (706) 721-2911 or call 911 IMMEDIATELY**

**BOMB THREAT AND OTHER THREAT CHECK LIST**

Questions to ask:
1. When is bomb going to explode? ________________________________
2. Where is it right now? _________________________________________
3. What does it look like? _________________________________________
4. What kind of bomb is it? _________________________________________
5. What will cause it to explode? _________________________________
6. Did you place the bomb? _______________________________________
7. Why? _______________________________________________________
8. What is your address? _________________________________________
9. What is your name? __________________________________________

<table>
<thead>
<tr>
<th>Threat Language</th>
<th>Exact Wording of the Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foul</td>
<td></td>
</tr>
<tr>
<td>Educated</td>
<td></td>
</tr>
<tr>
<td>Well Spoken</td>
<td></td>
</tr>
<tr>
<td>Irrational</td>
<td></td>
</tr>
<tr>
<td>Taped</td>
<td></td>
</tr>
<tr>
<td>Incoherent</td>
<td></td>
</tr>
</tbody>
</table>

Length of Call: ___________
Number at which call is received: ___________
Time: ___________ Date: ____________
Check all which apply:

<table>
<thead>
<tr>
<th>Caller’s Voice</th>
<th>Background Sounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Calm</td>
<td>Crying</td>
</tr>
<tr>
<td>Angry</td>
<td>Normal</td>
</tr>
<tr>
<td>Crackling Voice</td>
<td>Deep Breathing</td>
</tr>
<tr>
<td>Slow</td>
<td>Slurred</td>
</tr>
<tr>
<td>Rapid</td>
<td>Nasal</td>
</tr>
<tr>
<td>Soft</td>
<td>Stutter</td>
</tr>
<tr>
<td>Loud</td>
<td>Lisp</td>
</tr>
<tr>
<td>Laughter</td>
<td>Raspy</td>
</tr>
</tbody>
</table>

If voice is familiar, whom does it should like?

**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.

**RESPONSE, Severe Thunderstorm or Tornado Watch:**

- Be cautious of activities conducted outside buildings. No further action is required at this time *for a watch*. Moving patients from their rooms is a drastic procedure and will only be implemented if it has been established that a tornado has been sighted and moving toward the hospital.
RESPONSE, Severe Thunderstorm Warning:
- Curtail all movement outside of buildings until the warning if lifted.
- No further action is required of employees for a Section Thunderstorm Warning

RESPONSE, 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:
      a. Close drapes/blinds.
      b. 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
A. 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.
B. 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.
C. If no damage has occurred to the building, patients moved during a Tornado Warning may be returned to their rooms.
D. If operations and/or patient safety is affected, patients will be transferred to a safe haven which could mean evacuating to another hospital/facility.
E. All efforts will be made to protect the lives of patients, visitors,

SEVERE WINTER STORMS
Severe winter storms bring heavy snow, ice, strong winds, and freezing rains. Winter storms can delay or prevent employees and students from reaching the university or
hospital, leading to temporary disruption of administrative functions until roads and parking areas can be cleared. Heavy snow and ice can also cause structural damage or power outages.

During the winter storm season, all personnel should listen to local forecasts to determine any impact the weather may have on their schedule. The following terms are used to describe the predicted weather.

A Winter Storm Watch indicates that severe winter weather may affect the local area.

A Winter Storm Warning indicates that severe weather conditions are definitely on the way.

A Traveler’s Advisory indicates that severe winter conditions may make driving difficult or dangerous.

Personnel who must remain outdoors for considerable lengths of time should do the following:

- Dress warmly. Wear loose-fitting, layered, lightweight clothing. Layers can be removed to prevent perspiration and chill. Outer garments should be tightly woven and water repellant. Mittens are warmer than gloves because fingers generate warmth when they touch each other.
- Stretch before you go out. If you go out to shovel snow, do a few stretching exercises to warm up your body. Also, take frequent breaks.
- Cover your mouth. Protect your lungs from extremely cold air by covering your mouth when outdoors. Try not to speak unless absolutely necessary.
- Avoid overexertion. Cold weather puts an added strain on the heart. Be aware of symptoms of dehydration.
- Keep dry. Change wet clothing frequently to prevent loss of body heat. Wet clothing loses all of its insulation value and transmits heat rapidly.
- Be aware of Frostbite and Hypothermia.
  - Frostbite is a severe reaction to cold exposure that can permanently damage its victims. A loss of feeling and a white or pale appearance in fingers, toes, or nose and ear lobes are symptoms of frostbite.
  - Hypothermia is a condition brought on when the body temperature drops to less than 55 degrees Fahrenheit. Symptoms of hypothermia include uncontrollable. Shivering, slow speech, memory lapses, frequent stumbling, drowsiness, and exhaustion.
  - If frostbite or hypothermia is suspected, begin warming the person slowly and seek immediate medical assistance. Warm the person’s torso first. Use your
own body heat to help. Arms and legs should be warmed last because stimulation of the limbs can drive cold blood to the heart and lead to heart failure. Put the person in dry clothing and completely wrap them with a blanket.

- Never give a frostbite or hypothermia victim something with caffeine or alcohol in it. Caffeine, a stimulant, can cause the heart to beat faster and hasten the effects that the cold has on the body. Alcohol, a depressant, can slow the heart and hasten the ill effects of cold body temperatures.

SEVERE WEATHER / DISASTER INSTRUCTIONS
A disaster can occur at any time, at any place. Members of the AU Health and AU community should take precautions to alleviate the discomforts of possible primitive living during the period after a disaster by following these steps:

- Make plans to maintain family or group integrity, as much as possible.
- Learn basic first aid techniques.
- Have a small battery-operated radio and flashlight in case of electrical failures.
- Keep several large plastic or glass containers of drinking water on hand.

- If relocation to a shelter, the following items are suggested:
  - Blankets
  - Toilet articles
  - Warm clothing
  - Flash light
  - Prescribed medication
  - Pillow
  - Plastic bags
  - Water
  - Magazines and playing cards
  - Food
  - Portable radio
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 staffs. 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 staff, 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 AUMC staff member. Disaster privileges may be granted by one of the following criteria:
   a. A current picture hospital ID card;
   b. A current license with a valid driver’s license or other valid ID issued by a state, federal or regulatory agency;
   c. Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), or
   d. 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.
HAZARD COMMUNICATION

SDS/MSDS
SDS – Safety Data Sheets
MSDS - Material Safety Data Sheet.

“Right to Know”
Employees have the “right to know” what hazardous and potentially hazardous chemicals are in their work area.

Disposal of Infectious (Regulated/Biohazardous) Medical Waste
Infectious medical waste materials are placed in red bags at the point of waste generation and kept separately from ordinary waste. Infectious medical waste materials are disposed of at an appropriate off-site facility.

Disposal of Sharps
All sharps must be placed in the proper, designated and approved sharps disposal container for proper disposal at an appropriate off-site facility.
HUMAN RESOURCES

Assessment and validation of employee competency
- During the initial screening process
- General orientation
- Department orientation
- Implementation of new procedures, techniques, technology, equipment or skills
- Upon identification of specific deficiencies of an individual
- Annually for all mandatory competency validations

- Employee education is different from employee competency. Competency can be assessed by teach back method, use of written test, observation, return demonstration, etc.

For personnel files at the department/unit level, it is strongly recommended that the following items be tagged in the employee’s file in preparation of Survey.
- New hire orientation
- 90 day evaluation following hire
  - Education and competencies at 90 days
- Annual competencies (12-18 months)
- Annual education (12-18 months)
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, refer to:

- Policy # 405, Medical Staff Code of Professional Conduct
IMPROVING ORGANIZATIONAL PERFORMANCE
(Performance Improvement or PI)

- 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
• Safety rounds infection control surveillance
• Worker’s comp injury reports
• Outcomes data (i.e., wounds, blood use, autopsy reports, medication use, etc.)
• Sentinel Event Alerts (and Sentinel Events, should one occur)

**AU Medical Center Quality Control (QC) Activities**
• Crash cart checks – daily
• Defibrillator checks – weekly
• Refrigerator temperature checks – daily
• Glucose meter checks – daily when meter is in use
• Testing in the Laboratory, ABG Lab or as per procedure

**Performance Monitoring**
• Medication Management
• Surgical Case Reviews
• Blood Reviews
• Restraint Use
• Resuscitation and its Outcomes
• Risk Management
• Utilization 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
• Sepsis Core Measure
• Blood Culture Contamination
• Stroke Intervention
• VIP Patient Portal- Ambulatory
• Transfusion Ordering

**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
  o PC-01 Elective Delivery
  o PC-02 Cesarean Section
  o PC-03 Antenatal Steroids
  o PC-04 Health Care-Associated Bloodstream Infections in Newborns
  o PC-05 Exclusive Breast Milk Feeding
  o PC-05a Exclusive Breast Milk Feeding Considering Mother’s Choice

• Stroke
  o STK-1 Venous Thromboembolism (VTE) Prophylaxis
  o STK-2 Discharged on Antithrombotic Therapy
  o STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter
  o STK-4 Thrombolytic Therapy
  o STK-5 Antithrombotic Therapy By End of Hospital Day Two
  o STK-6 Discharged on Statin Medication
  o STK-8 Stroke Education
  o STK-10 Assessed for Rehabilitation

• CAC
  o CAC-3 Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver

• Venous Thromboembolism
  o VTE-1 Venous Thromboembolism Prophylaxis
  o VTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis
  o VTE-3 Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
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?
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, mucous 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

ABHR 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 infection by 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.

**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 CA-UTI:

- 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 patient 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
  o Cap (covering all hair)
  o Mask
  o Sterile gown
  o Sterile gloves
  o 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 airway 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.

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.
- AU Medical Center 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 medical 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:

- **Ref# 694, Infection Prevention and Control Annual Risk Assessment & Plan**
- **Policy# 1093, Hand Hygiene**
- **Policy# 1094, Catheter Associated Urinary Tract Infection Prevention**
- **Policy# 663, Central Line Associated Bloodstream Infection Prevention**
**INFECTION PRECAUTIONS**

**Standard Precautions**
Standard Precautions are measures taken to prevent the transmission of contagious diseases including blood borne pathogens, or germs that are spread by contact with infected blood or body fluids. Standard Precautions assume that certain areas of the body carry disease-causing germs, which, if spread to others, could cause disease. These areas include mucous membranes, moist areas of the body, broken skin, anything wet coming from the body, and any medical devices that drain fluids from the body. One very important method of protection is barrier protection or use of personal protective equipment (PPE). Barrier protection means that we cover and protect our non-intact skin and mucous membranes from potentially infectious material by wearing PPE. PPE includes disposable gloves, used whenever direct contact with blood and/or body fluids can be reasonably anticipated; and gowns, face shield masks and goggles, used whenever splashing or spraying of blood and/or body fluids is possible. In addition to barrier protection, practice proper hand hygiene before and after the removal of your gloves and other PPE.

**Transmission Based Precautions (TBP)**
Transmission based precautions are measures that are used for known or suspected organisms or diseases based on the method of transmission. These can be empirically applied early to prevent disease transmission and discontinued as organisms and diseases are ruled out. TBP signs are placed above the head of the bed, outside the door, and on the patient’s chart. The sign outside the door stays up until the room is cleaned by Environmental Services. If the patient is transferred to another room or unit, the sign above the bed should accompany the patient to their new room until additional signs can be obtained. TBP should be communicated during each shift and upon patient hand-offs.

**Airborne Precautions:** This guideline is aimed at preventing the transmission of disease that is spread primarily by the airborne route, such as tuberculosis. Requirements include use of a private, negative pressure room, and the use of a proper TB prevention mask (N-95) by all health care workers entering the room. When transporting a patient using airborne precautions, the patient should wear a surgical mask. Dealing with a patient in airborne precautions is the only time a health care worker should wear the N-95 mask.

These precautions require **negative pressure rooms**. Airflow for the negative pressure rooms is monitored by Facilities. Portable filters for patients requiring airborne precautions are used only when a negative pressure room is unavailable. Every effort should be made to move the airborne precautions patient to a negative pressure room as soon as possible; this may require making new bed assignments. All doors are to remain closed except to
enter and exit. Be sure both doors are closed. Bed Management Nursing Supervisors’ Office, Epidemiology and Facilities have a list of negative pressure rooms.

Use dedicated blood pressure cuff, stethoscope and thermometer found in the transmission based precautions cart to decrease the risk of transmission.

**Droplet Precautions:** This guideline is for use with other respiratory disease that can be transmitted through the air when an infected patient coughs or sneezes. This is for use with illnesses such as influenza, meningitis and pneumonia. Caregivers should wear a surgical mask if they will be within three feet of the patient.

**Contact Precautions:** Contact precautions protect the health care worker when they will come in contact with any surface in the patient’s room, including touching the patient themselves. Diseases transmitted in this manner include MRSA, VRE, herpes simplex and impetigo. Gloves and gowns should be worn by all caregivers, no mask needed. Gowns and gloves should be removed _BEFORE_ leaving the room. Hands should be washed immediately and should not retouch the patient or surfaces without washing hands again.

Patients with Clostridium difficile (C-Diff) are placed on contact precautions. Wash hands frequently with soap and water. Alcohol based hand rubs are not effective against spore-forming organisms and should not be used.

**Enteric Contact Precautions:** Patients with Norovirus, Clostridium difficile (C-Diff), or other spore-forming pathogens are placed on enteric contact precautions. Gloves and gowns should be worn by all caregivers, no mask needed. Wash hands frequently with soap and water. Alcohol based hand rubs are not effective against spore-forming organisms and should not be used. Gowns and gloves should be removed _BEFORE_ leaving the room. Hands should be washed immediately and should not retouch the patient or surfaces without washing hands again. Room surfaces and reusable medical equipment are cleaned with hypochlorite after use, between patients and upon discharge.

**Enhanced Contact Precautions:** Patients with carbapenemase resistant enterobacteraeiae (CRE) and other significant pathogens as identified by Hospital Epidemiology are placed on enhanced contact precautions protect the health care workers when they will come in contact with any surface in the patient’s room, including touching the patient themselves and to prevent horizontal spread to other patients. Staff is limited to key personnel only with the nurse performing as many ancillary duties as possible; students and volunteers are not allowed to enter. Tests and procedures are performed at the bedside when feasible. Gloves and gowns should be worn by all caregivers, no mask needed. Gowns and gloves should be removed _BEFORE_ leaving
the room. Hands should be washed immediately and should not retouch the patient or surfaces without washing hands again.
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: 630-792-5636
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
MEDICATION MANAGEMENT

Departmental Controlled Narcotics
- Narcotics are stored in automated dispensing machines and only removed by licensed staff upon pharmacist review of the physician’s order. Also a count is required before drug removal.
- First doses of certain medications can be obtained with a review override.
- Narcotic waste is witnessed by another licensed nurse.
- Any narcotic discrepancies are to be reconciled by the end of the shift.

Look-Alike/Sound-Alike Medications and Why It Is Important
Look-alike/Sound-alike drugs are medications that are easily confused with each other. Keep them stored in separate automated dispensing machines, cubicles or cabinets and separated in Pharmacy storage. AU Medical Center Pharmacy annually reviews and, as needed, revises its list of look-alike/sound-alike medications. This list is posted in all clinical areas.

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 without a specified sequence of administration), the pharmacist will contact the prescriber for clarification. For instance, if the prescriber orders
both ondansetron and promethazine as needed for nausea/vomiting, the pharmacist will contact the prescriber for clarification with regard to the sequence of administration.

**Patient Drug Education**
The nurse should review the purpose, dose, directions, and possible side effects of the medications – especially those new to the patient. Dietary provides information on certain food & drug interactions.

**Monitoring the Effects of Medication(s) on Patients**
AU Medical Center monitors the patient’s response to their medications to help assure appropriate medication therapy. The monitoring is individualized, based upon the clinical needs of the patient, but includes assessing the patient to determine if they are responding appropriately and that there are no medication-related problems. We monitor the patient’s own perceptions, relevant lab results, clinical response, and other problematic medications. This is particularly important for monitoring the patient’s first dose of a new medication. Problems are addressed with the patient’s physician for resolution.

*For more information please refer to:*
- Policy # 310, Safe Medication Practices
- Policy # 811 High Alert Medications and Safeguards
- Policy # 307, Medication Dose Standardization and Dose Rounding
NATIONAL PATIENT SAFETY GOALS (NPSG)

It is critical that EVERYONE be familiar with The Joint Commission National Patient Safety (NPSGs) and related patient safety standards, and include them into daily practice. An easy-to-read version is attached at the end of this document.

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

NPSG.01.03.01 Eliminate transfusion errors related to patient misidentification

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

NPSG.03.04.01 Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings

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

NPSG.03.06.01 Maintain and communicate accurate patient medication information

NPSG.06.01.01 Improve the safety of clinical alarm systems (NEW for 2016)

NPSG.07.01.01 Comply with either the current CDC hand hygiene guidelines or the current WHO hand hygiene guidelines

NPSG.07.03.01 Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms (MDROs) in acute care hospitals

NPSG.07.04.01 Implement evidence-based practices to prevent central-line associated bloodstream infections.

NPSG.07.05.01 Implement evidence-based practices for preventing surgical site infections
NPSG.07.06.01  Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI)

NPSG.15.01.01  Identify patients at risk for suicide

UP.01.01.01  Conduct a preprocedure verification process

UP.01.02.01  Mark the procedure site

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

**Patient Admission Packet**
We provide a patient admission packet to all patients admitted to our facility. It is provided at bedside by the nurse upon admission.

*For more information refer to:*
- *Policy # 224, Patient Family Education*
- *Policy # 384, Patient Rights and Responsibilities*
- *Policy # 375, Management of Patient Grievances*
Health Insurance Portability and Accountability Act (HIPAA)
- All staff members are trained on HIPAA.
- Patients are not discussed in public areas of the hospital or in town.
- Computer screens are not left open so that information can be read.
- Medical records are protected for privacy.
- Curtains, drapes and doors are used to provide privacy of speech as well as for care procedures.
- Patients are informed of their right to privacy and confidentiality.

Ethics
- AU Medical Center has an active Ethics Committee.
- **Ethical issues regarding patient care may be brought to the committee by any patient, family member (or other responsible party), physician or other member of the healthcare team or AU Medical Center employee. The first step is to contact your immediate supervisor to assist with a resolution.** Patients are involved, when possible, in resolving dilemmas about care decisions. The patient or resident, family members, medical staff or hospital staff may choose to request that the Ethics Committee be contacted for assistance in resolving ethical dilemmas. Members of the committee are on call 24 hours a day and may be contacted through Administration or the Administrator on call.

Advance Directives
All adult inpatients are asked if they have an Advance Directive. This information is documented in the patient’s medical record. **Advance Directive = document (witnessed) or oral statement in which a person expresses his/her desires concerning any aspect of his/her healthcare.** This includes, but is not limited to:
- Designation of a healthcare surrogate (the person who will make treatment choices if the patient should lose decision-making capabilities)
- A living will
- Durable Power of Attorney for Healthcare
- Order not to resuscitate (Do Not Resuscitate of DNR)

Advance Directives Process
- Patients are encouraged to bring a copy of their Advance Directive when they are admitted to the hospital.
- The Patient Access staff asks the patient for a copy of their Advance Directive upon admission.
- The Advance Directive and accompanying documentation are kept in the patient’s chart.
• If the patient has an Advance Directive but does not have it with them, it is recorded on the Notice of Advance Directives Section of the Hospital Consent form.
• If a patient does not have an Advance Directive but would like to make their wishes known, the case manager or director of patient care should be notified.

Do Not Resuscitate (DNR)
• “Do Not Resuscitate,” otherwise known as a No Code. DNR is NOT the same as comfort measures only!
• A physician order must be obtained for No Code status.
• Physicians must document any discussion with patient/family in establishing a change in code status.

For more information please refer to:
• Policy # 773, Advance Directive

Informed Consent
• Consent is obtained for any procedure involving risks, including invasive procedures, whenever sedation or anesthesia is used, for blood administration, and for research studies.
• Consent is also obtained at the time of admission with the Consent to Treat form.
• It is the responsibility of the physician to obtain Informed Consent – the nurse only witnesses the signature.

For more information please refer to:
• Policy # 388, Informed Consent

Viewing of Medical Records
• Only the patient, legal guardian or healthcare individual with healthcare Power of Attorney may request to see the patient’s medical records.
• A staff member must be present to answer questions, interpret information and prevent alteration of the medical record.
• If any other person wishes to view or obtain copies of the record, the patient or designee must sign the Release of Information Consent Form.
• The patient’s physician should be informed of the request to review records while a patient is still in the hospital.

Key Points Regarding Organ Donations
• AU Medical Center has cooperative working relationships with Georgia Eye Bank, Inc., and Lifelink of Georgia.
• All patients are screened as possible candidates for organ donation at the time of death.
• There is no additional charge to the donor family for any procedures or supplies related to the donation process.

For more information please refer to:
• Policy # 478, Organ Donation after Cardiac Death & Imminent Death Potential Organ Donation
• Policy # 355, Organ, Eye, Tissue Donation

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
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 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.

**Reporting Patient Safety Issues**
- Safety Intelligence (SI) Electronic Incident Reporting
- Suspected Adverse Drug Reaction Report
- Directly discuss issue with the Charge Nurse, Manager, Director, Safety Officer, or other management staff.
- Safety Hot Line at 1-800-

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

**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>Morse Fall Scale</th>
<th>Range</th>
<th>Risk Level</th>
<th>Fall Precautions</th>
<th>Visual Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-44</td>
<td>Low</td>
<td>Standard</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>&gt;45*</td>
<td>High</td>
<td>High Risk</td>
<td>Yellow Socks (nonskid)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Falling Star (door)</td>
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<td>High Fall Risk Sign (chart)</td>
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</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**
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*
# RESTRAINT UTILIZATION

<table>
<thead>
<tr>
<th>Topic</th>
<th>Non-Violent/Non-Self Destructive</th>
<th>Violent/Self Destructive</th>
</tr>
</thead>
</table>
| 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  
• Reason  
• Type of Restraint  
• Duration of Restraint  
• Release Criteria                                                                 | The physician/trained designee must evaluate (face-to-face) the patient within 1 hour of initiation of restraint. 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 |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Non-Violent/Non-Self Destructive</th>
<th>Violent/Self Destructive</th>
</tr>
</thead>
<tbody>
<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>• A qualified RN must examine and determine if the restraint continues to be clinically justified.</td>
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<tr>
<td></td>
<td>• The MD must see the patient by the next calendar day</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</td>
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<td></td>
<td></td>
<td>o 4 hours for patients ages 18 and older</td>
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<td>o 2 hours for children ages 9 to 17</td>
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<td></td>
<td>o 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>
</tr>
<tr>
<td>Nursing Monitoring/Care</td>
<td>Q 2 hours</td>
<td>Q 15 minutes</td>
</tr>
<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>
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<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>
</tr>
<tr>
<td>Removal</td>
<td>D/C at earliest possible time</td>
<td>D/C at earliest possible time</td>
</tr>
<tr>
<td></td>
<td>Document the released criteria met</td>
<td>Document the released criteria met</td>
</tr>
<tr>
<td></td>
<td>Document D/C in medical record and care plan</td>
<td>Document D/C in medical record and care plan</td>
</tr>
<tr>
<td></td>
<td>If patient again exhibits behavior requiring restraints, a NEW order must be obtained</td>
<td>If patient again exhibits behavior requiring restraints, a NEW order must be obtained</td>
</tr>
</tbody>
</table>

For more information please refer to:
- Policy # 942, Acute Care Restraints and Seclusion
## 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>NPSG.01.01.01</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. Make sure that the correct patient gets the correct blood when they get a blood transfusion.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NPSG.01.03.01</td>
<td></td>
</tr>
<tr>
<td>Improve staff communication</td>
<td>NPSG.02.03.01</td>
<td>Get important test results to the right staff person on time.</td>
</tr>
<tr>
<td>Use medicines safely</td>
<td>NPSG.03.04.01</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>NPSG.03.05.01</td>
<td>Take extra care with patients who take medicines to thin their blood.</td>
</tr>
<tr>
<td></td>
<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>
<td>Make improvements to ensure that alarms on medical equipment are heard and responded to on time.</td>
</tr>
<tr>
<td>Prevent infection</td>
<td>NPSG.07.01.01</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.03.01</td>
<td>Use proven guidelines to prevent infections that are difficult to treat.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.04.01</td>
<td>Use proven guidelines to prevent infection of the blood from central lines.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.05.01</td>
<td>Use proven guidelines to prevent infection after surgery.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.06.01</td>
<td>Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.</td>
</tr>
<tr>
<td>Identify patient safety risks</td>
<td>NPSG.15.01.01</td>
<td>Find out which patients are most likely to try to commit suicide.</td>
</tr>
<tr>
<td>Prevent mistakes in surgery</td>
<td>UP.01.01.01</td>
<td>Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body.</td>
</tr>
<tr>
<td></td>
<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></td>
<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>

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- Quick Fix

You will have approximately 1-2 hours to prepare for possible arrival on your unit - **Tracer Activity is scheduled to begin at 10:00 a.m. the first day and 9:00 a.m. on subsequent days and continues throughout each day. Plan to check the areas below periodically throughout out each day - EVERYDAY!**

<table>
<thead>
<tr>
<th>ASSIGNMENT</th>
<th>Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk all areas of department &amp; correct EOC or Safety Issues</td>
<td>√</td>
</tr>
<tr>
<td>No Corrugated Boxes</td>
<td></td>
</tr>
<tr>
<td>Doors are not propped open</td>
<td></td>
</tr>
<tr>
<td>Medication: Storage/dispensing areas secured/locked</td>
<td></td>
</tr>
<tr>
<td>Medication: No expired medications</td>
<td></td>
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<tr>
<td>Medication: Only meds in the Med Refrigerator…no foods/drink</td>
<td></td>
</tr>
<tr>
<td>Oxygen: Tanks are secured and labeled- call 1-4527 for labels</td>
<td></td>
</tr>
<tr>
<td>Oxygen: Tanks are segregated from Full/ Not Full- Empty</td>
<td></td>
</tr>
<tr>
<td>Hallways are clear clutter, equipment and trip hazards</td>
<td></td>
</tr>
<tr>
<td>No expired supplies (includes lab tubes)</td>
<td></td>
</tr>
<tr>
<td>Crash Cart: Log complete</td>
<td></td>
</tr>
<tr>
<td>Crash Cart: Plugged into Red Outlet</td>
<td></td>
</tr>
<tr>
<td>Refrigerator: Logs complete</td>
<td></td>
</tr>
<tr>
<td>Refrigerator: Food labeled with date, name &amp; expiration date</td>
<td></td>
</tr>
<tr>
<td>Refrigerator: Patient food is not expired</td>
<td></td>
</tr>
<tr>
<td>No Food/Drink in patient care areas</td>
<td></td>
</tr>
<tr>
<td>No unsecured power strips</td>
<td></td>
</tr>
<tr>
<td>Soap &amp; alcohol-based hand sanitizer dispensers are filled/ not expired</td>
<td></td>
</tr>
<tr>
<td>Fire pulls, extinguishers, oxygen shutoff valves not blocked</td>
<td></td>
</tr>
<tr>
<td>Fire exits not blocked</td>
<td></td>
</tr>
<tr>
<td>Evacuation route posted</td>
<td></td>
</tr>
<tr>
<td>Supply Room- nothing stored on the floor</td>
<td></td>
</tr>
<tr>
<td>Supply Room- Nothing stored closer than 18” from ceiling</td>
<td></td>
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<tr>
<td>Laundry is covered</td>
<td></td>
</tr>
<tr>
<td>Only clean items in the clean utility room</td>
<td></td>
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<tr>
<td>Only soiled items in soiled utility</td>
<td></td>
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<tr>
<td>PPE is readily available and appropriate</td>
<td></td>
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<tr>
<td>Sharps containers not over-filled and opening not obscured</td>
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</tr>
<tr>
<td>Only sharps in sharp containers</td>
<td></td>
</tr>
<tr>
<td>All monitor alarms on &amp; set</td>
<td></td>
</tr>
<tr>
<td>Stained tiles/ environment of care issues reported to 1-WORK</td>
<td></td>
</tr>
<tr>
<td>Splash zone (w/i 3 ft) surrounding sink is free from clean &amp; sterile items</td>
<td></td>
</tr>
<tr>
<td>Nursing stations and work areas are clean</td>
<td></td>
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<tr>
<td>Patient care microwaves are clean</td>
<td></td>
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<tr>
<td>No missing, broken, or stained ceiling tiles (Report to Facilities)</td>
<td></td>
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<tr>
<td>No holes in walls or ceilings (report to Facilities)</td>
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<tr>
<td>Unit specific tasks:</td>
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</tbody>
</table>
ATTACHMENT #3- 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
- **When to wash your hands?**
  - Before and after patient care
  - Before and after wearing gloves
  - When going from dirty to clean tasks/procedures
  - When visibly dirty
  - Don’t forget about your stethoscope
    - Foam 8-10 times before washing is required

- **Low level disinfection**
  - 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?**
  - Clinical Alarms Management
  - Patient Throughput
  - Patient satisfaction survey results

- **CLAS (interpreter) Information**
  - Call 1-6929
ATTACHMENT #4- 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
    - Safety Homepage
  - Nursing Portal

- **Human Resources**
  - 706-721-9365 (Main #)

- **Safety Intelligence (formerly known as PSN)**
  - Reporting Patient Safety Events
    - On PAWS
    - Citrix
• **Medical Records**
  - Forms
    - 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)
  - Informed Consents
  - Emergency Department Record
  - History & Physical
  - Intra-operative records
  - Practitioner progress notes
  - Rehabilitation Services (PT/OT/Speech) evaluations & Notes
  - Discharge Planning notes
  - Care Plans – navigate thru care plan to show changes made and issues addressed

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

• **Emergency Codes**
  - EOP manual – red notebook on your unit
  - Posters throughout the hospital
Sample questions (and possible answers!) that may be asked to staff by surveyors:

1) What special competencies are required to perform your job?
   - During the application process, credentials are reviewed to see if they match the job, in terms of education, licensure, certifications, etc. These are further matched during the interviewing process. During orientation, skills and competencies are observed. This observation is continued through the 90 day evaluation process. Each year, there are online studies related to training, as well as unit-based competencies to be completed. Also, a skills fair is held each year (Nurses) where competencies have to be achieved. (If there is some special task you do for your job, speak to that competency, ex. Chemotherapy administration).

2) How are patients informed of their rights?
   - A copy of the patients’ rights and responsibilities are included in the Admission Packet.

3) What have you worked on to improve patient outcomes in the past year? What are you most proud of?
   - Show the surveyor your unit’s bulletin board – it should tell the story of your performance improvement project(s)
   - Be sure to include any PFCC projects.

4) If a patient is admitted from one area to another or goes to another area for care, how do you communicate to the admitting unit/area?
   - For nurse-to-nurse communication, we use SBAR. Other methods of patient hand-off communication outside of nurse-to-nurse, we use the PAMPER acronym to communicate pertinent patient information to providers receiving patients.

5) What is your process regarding nutrition?
   - All patients are screened for malnutrition risk via the nutrition screen on the admit database. The criteria for nutritional screening include:
     o Unintentional weight loss > 5% in past month
     o Unintentional weight loss > 10% in past 6 months
     o Decubitus / Pressure Ulcer > Stage II
     o Diagnosis Malnutrition or Failure to Thrive (FTT)
     o Impaired Swallow / Suck / Gag Limits intake
     o Inborn Error of Metabolism
     o Nausea / Vomiting / Diarrhea >= 4 days
     o New Diagnosis or Poorly Controlled DM
     o Home Diet of TPN / Tube Feeding
Nutrition Nurse Referral

If a patient screens yes for any of these questions, a referral is sent to the dietitian.

6) Walk me through the process if the patient gets a referral sent to the dietitian.
   - Once a dietitian receives the referral from nursing, s/he will evaluate the patient for nutrition intervention(s).

7) Are there any prohibited abbreviations related to medications documented in the record on physician orders, progress notes, nursing documentation, etc.?
   - We have a list of prohibited medications and it is located on Policy Tech. Patient records are reviewed to determine if prohibited abbreviations have been used.

8) Why is it important to not use prohibited abbreviations?
   - Prohibited abbreviations can lead to confusion and potentially to medication errors.

9) What is your process for critical labs (if applicable)?
   - Only licensed personnel can accept these labs
   - Nurse records lab values on medical record
   - Nurse reads back to lab personnel and asks for verification that info is correct
   - Nurse documents “Read back/verified”
   - Nurse MUST contact MD and provide critical lab values
   - Nurse asks MD to read back labs to verify correct
   - Nurse documents names of MD notified with date/time/signature

10) How do you update Education plan(s) for patients?
   - There should be documentation of patient education on EVERY patient

11) What education resources are used to educate patients?
   - There are several links to printable patient education available on PAWS

12) How do you assess/reassess a patient’s pain?
   - We use several pain scales to include Numeric pain scale, the Faces pain scale, and the FLACC pain scale, depending on the patient’s ability to communicate their level of pain verbally or on observation of the patient. The pain scale, score, location and MD notification (for pain ≥ 4) are documented on the pain assessment form when vital signs/measurements are obtained.

   Pain is reassessed and interventions implemented based upon the patient’s pain score, acceptable pain goal, and reported perception of pain relief.

13) Surveyors will want to look at the documentation trail of pain medication in the medical record if given. They will look for:
• Initial pain score ≥ 4
• Description of pain complete?
  o Onset
  o Intensity
  o Frequency
  o Location
  o Duration
  o Character
  o Radiation
• Aggravating/alleviating factors
• Time medication administered
• Reassessment of pain within 1 hour

14) How did you involve the patient in their pain management?
• Patients are encouraged to be an active partner in managing their pain by using pain relief measures before pain becomes severe, tell staff when treatment doesn’t relieve pain, talk to doctor or nurses about questions/concerns about treatment.

15) Is there equipment with clinical alarms used in this area? How do you assure they are audible?
• We use_____. They are checked daily.

Surveyors will want to ask questions about procedures and observe them when possible. They will want to observe identification process, time out process (where applicable) and handwashing practices.

16) How do you assure you have the intended patient?
• Patients are identified using Active Communication. This means the patient/parent is asked to state his/her full name and date of birth. This is compared with the patient identification information on paperwork, labels, etc.

17) What if the patient is unable to communicate?

18) Describe the universal protocol process and when it is used?
• It is a three part process that is used anytime a surgical or nonsurgical invasive procedure is performed (anytime consent is obtained). The three processes are:
  1) Preoperative verification
2) Marking the procedure site
3) Time-Out

19) How are test results reported to the ordering physician?

21) Name ways that we protect a patient’s privacy.
   - Close the exam room doors
   - Log off/ close down computers when we are finished
   - Never talk about patients in public areas
   - Passwords needed to get into only the programs that we need - User roles defined based on job

22) What is our performance improvement model?
   - P-D-C-A. Plan- Do- Check- Act.

23) How would you know if a physician has privileges to perform a certain procedure?
   - We would look it up in the E-Priv system or we can call the Medical Staff Office.

24) Name ways that we help to ensure a patient’s safety.
   - Active Communication when possible: Verify patient’s full name and date of birth before medication administration and procedures
   - Bar code scanning of medications
   - Conducting Time-outs and having a patient initial site before procedures to prevent wrong patient, wrong site and wrong side surgeries.

25) Who obtains informed consent?
   - The physician performing the procedure/ surgery is responsible for obtaining informed consent.

26) Who can sign an informed consent?
   - An adult for themselves
   - Any person authorized to give consent pursuant to a Durable Power of Attorney for Healthcare
   - A parent for a minor child
   - A married person for themselves or his/her spouse
   - A person serving in place of the parents if the child is under their care
   - Anyone appointed as legal guardian for a child/minor
   - For an incompetent adult (without a Durable Power of Attorney for Healthcare) and does not have a spouse,
     - An adult child
     - The parent of an adult child
     - Any adult for his/her sibling
27) How do we work to prevent medication errors?
   - Active communication from patient or personal representative: full name and date of birth
   - Bar code scanning

28) What rights should be recognized when giving medications?
   - Right Patient
   - Right Medication
   - Right Dosage
   - Right Route
   - Right Time

29) How do you know that you are giving the right medications to the right patient?
   - Follow the Positive Patient Identification Policy

30) How do you know the patient does not have any allergy to the medication you will be giving?
   - Review Cerner Allergy Field in the Powerchart. Also, ask the patient and/or representative of any medication allergies.

Scenario #1
A patient slipped and fell in the exam room. The patient bruised their hand. Who would you notify and what would you do?

   - Notify the patient’s physician so that an assessment can be completed. Notify the Nurse Manager and complete a Safety Intelligence Report.

Scenario #2
A visitor slipped and fell in the hall. She is complaining of knee pain and cannot stand. Who would you notify and where would you take the visitor?

   - Notify Hospital Safety and Security at ext. 4787. Obtain a wheelchair and assist the visitor into it and take her to the Emergency Department.
Scenario #3
You find a person laying on the ground outside of the hospital. You asked the person what happened and he stated that he fell. You did not see the person fell and you are off-duty, what do you do?

- Notify Hospital Safety and Security at ext. 4787. Obtain a wheelchair and assist the visitor into it and take her to the Emergency Department.

Scenario #4
You are on your unit when the fire alarm is activated with notification that it is not a fire drill, what do you do?

- Follow the “Defend in Place” procedure utilizing the acronym R-A-C-E and contacting AU Health 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*-move 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 Health 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. AU Health 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.