CALIFORNIA HOSPITAL MEDICAL CENTER
ORIENTATION INFORMATION ACKNOWLEDGEMENT

I understand that I can ask my assigned department resource (nursing supervisor, charge nurse, shift manager/supervisor, lead technician/therapist, department manager, or designee) for clarification of any of the material contained within this packet.

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I will observe HIPAA & Information Security policies.

I understand that full text copies of the references policies and procedures followed may be found in the California Hospital policy and procedure manuals as well as published references available in each work area. I, __________________________ have reviewed the contents of the orientation packet and understand it is my responsibility to read California Hospital policies, procedures and protocols and implement them as written as they pertain to my area and scope of responsibility. If I do not comprehend any policy, procedure or protocol, it is my responsibility to immediately acquire understanding or clarification from my department resource.

Signature: ___________________________ Date: ___________________________

Print Name: ___________________________ Agency Name: ___________________________
California Hospital

Non-Employee
GENERAL ORIENTATION
(Clinical)

PLEASE COMPLETE THE SIGNATURE PAGE AND RETURN TO:

Nursing Students/ Instructors: Education

Medical Students / Residents: Medical Education Director

Nursing: Staffing Office

Non-Nursing: Department Manager
I. Welcome to California Hospital Medical Center

II. Our Mission and Vision
   Our Mission: We are committed to furthering the healing ministry of Jesus.
   We dedicate our resources to:
   - Delivering compassionate high quality affordable healthcare services
   - Servicing and advocating to for our sisters and brothers who are poor and disfranchised.
   - Partnering with others in the community to improve the quality of life

   Our Values:
   - Dignity
   - Collaboration
   - Justice
   - Stewardship
   - Excellence

III. Parking Policy:

   Parking is available at the parking lot (corner of Grand & Venice) and non employees are required to pay the parking fee.

IV. Dress Code

   - All employees/students are required to wear identification badges at all times while on duty.
   - All employees/students are expected to be professional in appearance.
   - Attire shall be modest, safe, and clean while on duty.
   - Employee/Student appropriate attire is defined as, but not limited to the following:
     1. Artificial nails nail extenders, silk wraps or other nail overlays, or nail jewelry are not allowed for staff with direct patient contact or contact with patient care supplies and equipment.
     2. Fingernails must be kept neatly trimmed, ¼ inch maximum length, and clean.
     3. If worn, polish will be light in color and in good repair (i.e. no chips or cracks).
     4. As appropriate, hose or socks are required.
     5. Closed toe shoes are required. Extreme colors, style, heel height, sandals, beach flip-flops are not acceptable.
     6. Department specific dress code may be required. Sportswear such as jeans, denim pants of any colors, stretch pants, legging, shorts, walking shorts, skirts, T-shirts, sweatshirts, sleeveless shirts, bare shoulder or spaghetti strapped blouses, tank tops or sun dresses are not permitted.
     7. Clothing must be modest and professional. Sheer, low cut, spandex, clinging, bare or revealing clothing must not be worn. Proper undergarments must be worn at all times.
8. Long hair will be pinned up or tied back.
9. For safety reasons, it is requested that if jewelry is worn, it be conservative. Items such as earrings worn in areas other than the earlobe are considered unprofessional and not allowed.
10. Mustache and/or beards are required to be neatly trimmed.

V. Smoking Policy:

California Hospital is "smoke free" campus. Smoking is totally banned inside the hospital. Smoking is only permitted outside in designated smoking areas.

VI. Breaks and Lunches

- You are allowed a fifteen (15) minute paid rest period for every 4 hours that you work.
- You are allowed thirty (30) minutes unpaid meal period per 8 hour shift.
- 12 hour shifts are required in certain clinical areas. Please ask your department resource for break and lunch period information.
- Rest period and meal breaks may not be combined.

VII. Body Mechanics

- All staff is expected to practice safe body mechanics. Use of lift and position assistive equipment is required. If you need equipment orientation, please ask your staff resource.

Key Points to remember:

- To maintain a safe and healthy working environment California Hospital attempts to prevent injury to employees who perform lifting as a part of their job duties. Therefore, it is crucial that all employees demonstrate safe lifting, transporting and proper back care techniques at all times.
- California Hospital is firmly committed to maintaining a safe and healthful working environment. To achieve this goal, we have implemented the comprehensive Injury & Illness Prevention Program. This program is designed to prevent workplace accidents, injuries, and illnesses wherever possible.
- Good housekeeping is an integral part of any effective Safety Program. Keeping workplace areas neat and clean reduces the chance of accidents and injuries. Well-organized areas also increase the ability of employees to perform their jobs effectively. Each employee is responsible for keeping his or her work area neat and orderly.
- All direct care employees shall function as a "lift team" by providing patient handling assistance to colleagues when needed. If an urgent or emergent
need has been identified by the nurse, Physical Therapy (PT) or Occupational Therapy (OT) may provide support to nursing. Employees are encouraged to actively be involved in maintaining a safe environment by reporting any unsafe conditions to the unit supervisor.

- Be familiar with the general proper body mechanics and ergonomics techniques

VIII. Hazardous Materials

- Under the "Right to Know" requirements employees working in a healthcare environment have a "Right to Know":
  
  1. What chemical hazards exist in the facility?
  2. What their exposure potential may be?
  3. What precautions have been taken to protect the employee?
  4. What "work practice controls" are in place to protect workers?
  5. What systems are in place (engineering controls) to limit exposure?
  6. What personal protective equipment has been provided?

- The leadership within the organization is required to:
  
  1. Establish policies and procedures for the safe use, handling and storage of hazardous substances.
  2. Orient and train staff on the potential exposure hazards and hospital policy.
  3. Provide work policies & procedures for safe work practices.
  4. Provide engineering controls and personal protective equipment to protect employees.
  5. Monitor the compliance with use of the above.
  6. Monitor the environment. Provide material safety data sheets.
  7. Monitor accidents and incidents.

- Employees and Non Employees are responsible to:
  
  1. Understand and comply with hospital policies and procedures related to hazardous material safety.
  2. Use the Hazmat spill kits when handling hazardous substances.
  3. Use the Personal protective equipment provided when handling hazardous substances.
  4. Report unsafe or hazardous situations.
  5. Report and document accidents, incidents, exposures and spills.
  6. Understand where to find and how to read Material Safety Data Sheets (MSDS) or Safety Data Sheets (SDS).

- How to Find and Use a Material Safety Data Sheet (MSDS) or Safety Data Sheets (SDS): The MSDS or SDS for each hazardous substance in your work area tells you how to use, handle and store the substance safely. Each MSDS may look a little different, but they all contain the same basic
information. Manufacturers are required to convert to SDS format by June 2015. SDS sheets will follow the new OSHA standard and will all look the same. We are in the process of changing the way we get MSDS/SDS sheets. MSDS/SDS information is available from Dignity Health MSDS/SDS database on the “My Dignity Health” website. There is a CHMC shortcut for this on every desktop.

**Minor Incident**

Definition: A spill or release of a chemical substance where there is no danger to any personnel, patient, or visitor.

- Notify the department supervisor.
- Obtain the SDS for the specific substance and contain the substance according to the SDS.
- Clean-up will be completed by department staff under the direction of the department supervisor.
- If an employee becomes ill from exposure to the substance, he/she should:
  a) Report to Employee Health. After-hours staff is to report directly to the Emergency Department.
  b) Complete an incident report and submit it to the Safety Officer and Risk Management.

**Major Incident**

Definition: A hazardous chemical spill where the spill is so severe that the department cannot handle it with its own personal protective equipment or spill kit.

- Initiate “**Code Orange**” (dial 6666)
- If possible, contain spill. If not possible, evacuate the immediate area, especially if anyone exhibits any of the following symptoms:
  - Eye irritation
  - Nausea
  - Headache
  - Choking/coughing
  - Dizziness
  - Chemical burn
  - Unconsciousness

Safety First
Isolate and deny entry to the area
Notify Proper personnel – ext 6666,
Disaster Planner @ 213-342-7184
IMMEDIATELY!!!

- **DO NOT** approach the area if a person seems unconscious.
- Assign a staff member to secure the area from unnecessary traffic.
• Use the Dignity Health MSDS/SDS database to obtain a copy of the Material Safety Data Sheet (MSDS) or SDS for the specific product that was involved in the spill. If the system is down, a hard copy of the MSDS/SDS is available in the Emergency Department’s MSDS/SDS binder. If it is unknown, the Disaster Planner has a chemical detection kit that can be used to determine the chemical.
• Have the MSDS available for the Safety Officer (or designee) when that person arrives.
• Report to Employee Health (or after-hours to the Emergency Department) if you become ill from exposure to the spilled substance. (Make sure if you have been contaminated with the substance that you are fully decontaminated before you do so.)
• Complete an event report for major spills.

IX Electrical Safety

• Personnel are responsible for knowing how to operate each piece of electrical equipment before using it.
• All equipment in patient care areas must be approved by the Engineering Department of the hospital.
• Check power plugs and cords before turning on equipment. Any damaged equipment should not be used, tagged with the facility form, and sent for repair.
• If any electrical equipment “looks, smells, or sounds strange”, disconnect the plug from power source, tag with facility form and notify engineering.
• Patients are not allowed to use their own electrical appliances unless battery operated.
• The first step to take in the event of an electrical fire or electrical shock is to disconnect the power to the equipment.
• Never handle electrical equipment while in contact with potential grounds water faucets, sinks, or wet areas.

X. Fires

FIRE RESPONSE PLAN: CODE RED
It is the responsibility of every employee, physician, student, volunteer or contractor in the hospital to be constantly alert for conditions that cause fire. If a fire does start, the actions taken during the first few minutes can make the difference between containment and catastrophe.

If You Are in the Vicinity of Fire or Smoke

If you smell smoke or discover a fire - DO NOT WAIT FOR AUTHORIZATION –Activate the manual pull station immediately!
This one action will sound the alarm throughout the hospital; it will close all the smoke and fire barrier doors; it will notify PBX so they can page the location; and perhaps most significantly, it will automatically notify the fire department so they can mobilize and respond within minutes.

Meanwhile, you and your co-workers should work as a team to execute other critical response actions as quickly and as simultaneously as possible:

- Team up to remove all persons from immediate danger of the fire, especially patients who cannot help themselves. **Safety of life is most important!**
- Someone dial 6666 to report the exact location of the fire;
- If the fire is small, someone should grab an extinguisher and put it out. Otherwise, let the Fire Department handle it. They will arrive very quickly;
- Close all the doors in your unit to contain the fire. Do not re-open any doors that are hot to the touch!
- Shut the oxygen valve that feeds the room where the fire is. Check to make sure no patients in that zone will be affected.
- Clear the corridors of any obstacles to fire fighters or evacuation.
- Prepare for horizontal evacuation to the next fire compartment. Ambulatory patients first, bed-ridden patients last.
- Have someone guard the elevators and the fire doors. Keep them closed to all but Fire Response personnel.

**Fire Response Team Members** In addition to staff from the immediate area, the following departments have responsibilities and experience that make them key members of our fire response team:

| a. All available Security Officers |
| b. All available Engineering staff |
| c. Nursing Supervisor |
| d. 2 members from departments above, below and adjacent to the fire compartment. |

These Fire Response Team members should come ready to help with containment and preparation for evacuation.
For use of the fire extinguisher use the acronym PASS:

- **P**– Pull the Pin
- **A**– Aim
- **S**– Squeeze
- **S**– Sweep

- Do not use elevators in the event of fire.
- Keep hallways clear (place equipment only on one side of the hallway)
- Do not block exits, fire alarms or prop doors open
- Do not store supplies or boxes on the floor
- Keep items on top shelves at least 18 inches from the ceiling.
- Fires are classified according to the material that is burning. Fire extinguishers are coded to reflect the type of fire they can put out. The classifications are:
  - Class A: Ordinary combustible material, such as paper, cloth, wood and some plastics.
  - Class B: Liquids, oil and gases.
  - Class C: Electrical, such as live energized electrical equipment.
  - Class ABC: Extinguishes all types of fires

*It is required to know the location of the closest fire extinguisher, fire alarm pull, and exits in your work area.

**XI. Life Safety Measures**

- In the event you are directed to conduct a partial or total building evacuation know where your designated evacuation location is on the exterior of the building. The priority of patient evacuation is as follows:
  1. Any in immediate danger.
  2. Ambulatory patients.
  4. Non-ambulatory patients.

**XII. Emergency Codes**

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<th>Emergency Codes &amp; Basic Staff Response</th>
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<td>CODES</td>
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<tr>
<td>Fire</td>
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<td>Medical Emergency</td>
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<tr>
<td>Category</td>
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</tbody>
</table>
| Infant Medical Emergency | Infant Medical Emergency such as respiratory and/or cardiac arrest | - Dial 6666  
- Give location and description of call |
| Combative Person | Patient/visitor/staff member presenting a safety risk to the facility, other staff, and visitors. | - Dial 6666  
- Clear the area of non-essential personnel to keep out of reach of perpetrator. |
| Person with Weapon/Hostage Situation | Anyone encountering a person brandishing a weapon or a person who has taken hostages in the medical facility | - Dial 6666  
- Keep clear of the area; close/lock your doors  
- Clear the area of non-essential personnel. |
| Infant Abduction | Removal/kidnapping of an infant, under one year of age, from the medical facility by an unauthorized person. | - Dial 6666  
- Go to the nearest exit and prevent all visitors/staff with a baby from leaving. Search all visitors/staff that are carrying packages/bags or wearing clothing that might conceal a baby. |
| Child Abduction | Removal/kidnapping of a child, one year of age and older, from the medical facility by an unauthorized person. | - Dial 6666  
- Go to the nearest exit and prevent all visitors/staff with a child from leaving. Search all visitors/staff that are carrying packages/bags or wearing clothing that might conceal a small child. |
| Bomb Threat | Notification of a bomb on campus, usually by an outside caller. | - Obtain as much information as possible (Where is the bomb, when will it go off, what does it look like, why was it placed, etc.)  
- Dial 6666  
- Have staff and visitors turn off all 2-way radios, cell phones, pagers and other type of handheld phones.  
- Do not touch or move any suspicious objects. Immediately report any suspicious items to security.  
- Evacuate area/building if directed. |
| Hazardous Material Spill | Any major spill that may present a hazard to people, the environment, | - Isolate spill area  
- Deny entry to others  
- Dial 6666 |
<table>
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<tr>
<th>Patient Elopement</th>
<th>Patient Elopement CODE GREEN</th>
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<tr>
<td>or that may have effects that are unknown.</td>
<td>When any patient is missing or has eloped</td>
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<td>Contact your supervisor/Nursing Administrative Supervisor/Safety Officer</td>
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<tr>
<td>Dial 6666</td>
<td>All personnel shall monitor all points of exit and surrounding area in their vicinity as assigned</td>
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<tr>
<td>Communicate any suspicious activity to security immediately</td>
<td>Communicate any suspicious activity to security immediately</td>
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<tr>
<th>Changes in Patient Condition</th>
<th>Changes in Patient Condition CODE H</th>
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<tbody>
<tr>
<td>Any Family member can Initiate (CODE H Dial 6666) at any time for clinically significant changes in patient condition</td>
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<tr>
<td>Any family member or patient can activate Code H</td>
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<tr>
<th>Changes in Patient Condition</th>
<th>Changes in Patient Condition Rapid Response (RRT)</th>
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<tr>
<td>Any concerned staff member or patient/family can initiate their sites rapid response process</td>
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<tr>
<td>Any employee Dial 6666 for the Rapid Response Team to assess patient</td>
<td>Any employee Dial 6666 for the Rapid Response Team to assess patient</td>
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<tr>
<th>TRIAGE INTERNAL</th>
<th>TRIAGE INTERNAL Internal Disaster</th>
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<td>Report to your department for further instructions.</td>
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<tr>
<th>TRIAGE EXTERNAL</th>
<th>TRIAGE EXTERNAL External Disaster</th>
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<td>Report to your department for further instructions.</td>
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</table>

**Other Medical Emergency Codes**

**Code OB**

Any staff member in L&D or Couplet Care may initiate the code

Dial x6666

State “code OB L&D room ----“

**Why:**

To quickly mobilize the key members of the OB Team for OB related emergencies:

- Eclamptic seizure
- Abruption
- Cord prolapse
- Change in maternal status (SOB, LOC)
- Uterine rupture
- Prolonged deceleration
- Shoulder dystocia

**Code OB Hemorrhage**
Any staff member in L&D may initiate the code
- Dial x6666
- State “Code OB Hemorrhage L&D room ----“

**Why:**
For cumulative blood loss of >/= 1500 ml

**Code Trauma**
- Trauma Activation depends on activation as a level 1 or 2 trauma. Criteria for activation of either is set out in the Trauma Activation Policy in the Trauma Policies
- Activation is performed by the Mobile Intensive Care Nurse (MICN) who will call the Hospital Operator on the Emergency Line and ask him/her to activate Level I or Level II Trauma Team. The MICN must document the level of activation and time of activation on the Trauma Activation Log. These times will be recorded and given to the bedside scribe RN.

- **Trauma Teams**
  - **Level 1** Trauma Team Include:
    - Trauma Surgeon - Team Leader
    - Emergency Department Physician
    - Anesthesiology
    - Respiratory Therapist
    - Trauma PA or NP
    - Trauma Program Director (while on duty)
    - Trauma Nurse Coordinator (while on duty)
    - Radiology Technician
    - Three RN’s competent in Trauma Resuscitation
    - OR Scrub Technician
    - One Emergency Department EMT
    - Security Officer
    - Blood Bank
  - (CT scan technician will also be paged and notified of the trauma patient and begin to prepare their respective areas.)

- **Level 2** Trauma Team Includes Level 1 team and the following:
  - Emergency Department Physician
  - Respiratory Therapist
  - Radiology Technician
  - Two Emergency Department RN’s
  - One Emergency Department EMT
  - (Blood Bank and CT Scan technician will also be paged and notified of the trauma patient and begin to prepare their respective areas.)
  - Security
Patients who fall into either category are to be transported directly to the Emergency Department’s Trauma Resuscitation area.

- Follow the Massive Transfusion Protocol per policy
- Specific Trauma Policies exist for managing the following:
  - Vital Signs
  - VTE prophylaxis
  - Pelvic fractures
  - Hand injuries
  - Near amputations
  - Spinal Injuries
  - Pregnant trauma patients
  - Traumatic Brain injury
  - Determination of death

XIII. General Safety and Access Control

- Always wear your California Hospital issued I.D. badge or agency/school ID while working/training at the hospital. New badges are obtained from Security after your sponsoring Director or Designee fills out the correct paperwork. Security department is located on 1401 S. Grand Ave., main hospital building, first floor, Rm. 179 (near Chapel/Nursing Office). Hours to obtain badges are Monday and Thursday from 1:00pm – 3:00pm and Tuesday, Wednesday and Friday from 7:30am – 10:00am.

- Your badge must be worn on the front upper half of your body, above your waistline, with your name and photograph clearly visible and without alterations or obstructions by pins, stickers etc. If your badge is lost, stolen, has become unreadable or your photograph is no longer recognizable, you may contact the Security Department for new badge.

- Please report to security ext. 5565 any suspicious persons claiming to be an employee, student, associate, or contracted employee that is not wearing a hospital issued badge/valid badge.

- Help to maintain a more secure environment by politely contacting and escorting any persons found in unauthorized or restricted areas, who are not wearing a proper colored hospital issued visitor’s pass and/or that do not belong in the area, to the nearest badge issuing location (Main Lobby or D&T Security Desks.) Do not engage aggressive, hostile, or combative persons. Notify the security department at ext. 5565 for assistance when necessary.

- Be aware of persons piggybacking and tailgating (entering secure areas when doors open as authorized persons are entering and exiting.) Politely direct and assist persons tailgating and piggybacking to the proper staff for authorization.
into secure areas. If you are unsure where to direct unauthorized persons, escort the person to the Main Lobby or D&T Security Desks. Do not engage aggressive, hostile, or combative persons. Call security at ext. 5565 for assistance when necessary.

**Summary of Guidelines for Visiting Dignity Health California Hospital Medical Center**

**Here is a summary of our visiting policy:**

- Patients have a right to decide whether someone will visit them and who will visit them, regardless of whether any guest is related or married to the patient or not.
- Patients’ spouses or partners are welcome whether they are of the same sex as the patient or not.
- Same-sex parents or guardians of patients or those who act or have acted in a parental relationship to a patient, are welcome to visit their minor or adult child regardless of whether they are biologically related to the child.
- We refer to family and others who visit patients at our hospital as guests.
- On many units patients may have a support person stay overnight with them, but this is not usually the case in critical care units. We have only a limited number of cots or sleeping chairs for guests; not always enough for everyone who stays overnight.
- While recommended visiting hours are from 9:00 AM to 9:00 PM, patients may have family and others visit at any time.
- From 9:00 PM until 7:00 AM is quiet time, when everyone is expected to make a special effort to be quiet so patients can sleep.
- Guests must follow the guidelines in the visiting policy, which are stated in the Visiting Guide for Patients and Families. The Visiting Guide is included in the Admissions booklet and is also available as a separate booklet.
- It is especially important that no one visit the hospital while feeling ill or after being exposed to a contagious illness.
- Everyone must wash their hands before and after visiting a hospital patient.
- Generally children may visit, but some units such as critical care and the NICU only allow guests over a certain age, determined by the nursing unit.
- The policy contains guidelines about how many guests can comfortably fit in a room at one time.

The Center for Medicare Services enacted a new regulation in 2010 to prevent hospitals from discriminating against visitation by a patient’s unmarried partner, whether same sex or opposite sex. **Here is a summary of the new regulation:**

- We must have written policies and procedures that state our visitation rules.
- We must give written notice to patients and their support person(s) about the rules and their rights.
Patients have a right to choose their visitors.
Patients have the right to refuse visitors.
Patients may change their mind about whether to have visitors and who they want to visit them.
Hospitals may not restrict, limit or deny visitation privileges based on race, color, sex, religion, ethnicity, gender, gender identity or expression, sexual orientation, socioeconomic status, marital status or physical or mental disability, or based on whether or not a visitor is a legal relative of a patient.
Patients who lack capacity may receive visits from family, friends and other individuals, consistent with the non-discrimination provisions of the preceding paragraph.
Hospitals must ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.
A hospital may only restrict or limit visitation if there is a reasonable clinical basis to do so.

Underlying Principles

The underlying premise of the policy and guidelines is that decisions about visitation should be for the benefit of patients and never primarily for our own benefit or convenience. Additionally, we have established the guidelines for the majority of our patients and guests, not based on the behavior of a minority of our patients and families with whom we have difficulties. This premise is consistent with our mission, vision and values, and with Humankindness.

Ensuring that a patient’s environment is conducive to healing and establishing relationships with guests is a clinical responsibility. Nurses have the expertise and the training to make judgments about what will benefit patients, and to communicate boundaries diplomatically, firmly and courteously. Therefore, we expect clinical staff to be responsible for communicating the visiting guidelines, and to request a guest to leave when necessary, not the security department. Supervisors, social workers and chaplains are available to help when someone is expressing strong emotions, which does not by itself indicate that there is a security threat. Security has the expertise and training to communicate and enforce boundaries when there is an imminent risk to safety.

VISITOR BADGE COLORS
(Remember all visitor badges indicate the permitted floors on the front of the badges).

<table>
<thead>
<tr>
<th>Lower level</th>
<th>Grey</th>
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<tbody>
<tr>
<td>1st and 2nd floors</td>
<td>White</td>
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</table>

3rd floor: Blue
4th floor: Purple
XIV. Guidelines for Infection Prevention

- These guidelines are intended to protect patients and healthcare providers from potential exposure to communicable disease. The Infection Control Manual provides extensive additional information.

1. **Standard Precautions**
   - **Time**: Hands must be washed for at least 10-15 seconds
   - **Technique**: Remove jewelry, wash hands vigorously under running water using anti-microbial soap and friction; wash between fingers and under fingernails, keep hands lower than the elbow; nails must be short (not longer than 1/4 inch) and well maintained. Nail polish must be free from chips. Artificial nails and nail tips are prohibited for all health care workers who provide direct, "hands on" patient care, those who prepare products or process patient care products.
   - **C. difficile**: Use soap and water for hand hygiene when caring for any patient incontinent of stool or suspect or known to have *C. difficile*.
Note: When using alcohol-based hand rub allow the solution to dry completely to prevent electrostatic discharge (ESD) that can cause skin burn. These rubs can be used if hands are not soiled with proteinaceous material. Wash hands with soap and water to remove organic material… alcohol hand rub can be used after soil has been mechanically removed with hand washing.

2. **Practice good hygiene**: Do not eat or drink in areas where there is a chance you may be exposed to blood or body fluids. Minimize splashing or spattering when performing procedures involving blood or other potentially infectious materials (OPIM).

3. **Personal Protective Equipment (PPE)**: protects you from infectious hazards when worn properly. PPE includes impervious gowns, gloves, face shields, protective eyewear and mask, caps, shoe covers, resuscitation masks or other ventilation devices. General rules for PPE:

   a) Use the appropriate personal protective equipment based by the symptoms that the patient demonstrates and not only if the patient is in Transmission-Based Precautions. Practicing Standard Precautions in this manner, will reduce transmission of infection all the time and not just when you are aware of a
      1. If the patient has a draining wound – add gloves and gown when caring for the patient
      2. If the patient coughs and sneezes – add a mask with a face shield
      3. If the patient is incontinent of stool – wear gloves and a gown
   b) Replace soon as possible if it becomes contaminated by blood or other OPIM.
   c) Always remove PPE before leaving the work area and place in a designated receptacle for disposal.
   d) Remove in the proper order:
      1. Gloves
      2. Gown
      3. Hand hygiene
      4. Face mask/shield
      5. Hand hygiene

4. **Protective Housekeeping**: good housekeeping is everyone’s responsibility.
   a) Handle used patient equipment soiled with blood or OPIM with care. Avoid touching skin, mucous membrane, clothing, other patients, or items in the environment.
   b) Discard single-use items.
   c) Medical equipment that is shared by patients must be cleaned appropriately and disinfected before using for another patient.
   d) Empty sharps container when 2/3 full.
   e) Handle linens as little as possible, with minimal agitation.
f) Transport specimens in closed containers; wear gloves and handle container carefully.
g) Clean all blood and body fluid spills promptly.

5. **Exposure Control Plans:** Mandated by the Occupational Safety and Health Administration, CHMC developed the Blood borne Pathogen Control Plan and Tuberculosis Prevention standards, based on Standard Precautions.

- **The Blood borne Pathogen Control Plan** reduces occupational exposure to hepatitis B virus (HIV), human immunodeficiency virus (HIV) and other pathogens carried by the blood. There is a list of job classifications, tasks and procedures in which occupational exposure can occur.

  Blood borne pathogens can be transmitted by bodily fluids of all kinds. Contaminated sharps must be disposed of immediately in puncture-resistant containers located in the patient's room. Employees must report incidents to their immediate supervisor, complete an incident report, and see Employee Health Services or the ER when Employee Health is closed.

- **The Aerosol Transmissible Diseases Respiratory Protection Program Plan** identifies employees at risk for exposure to TB and other transmissible diseases (ATD). It provides training methods to protect them from exposure and getting treatment when indicated. The plan includes TB surveillance and employee notification, medical evaluation and preventive therapy, methods of compliance, training, record keeping, and evaluation.

  **TB infection vs. active TB disease:** a person may become infected by the TB germ, but never develop active disease. A healthy immune system prevents the development of active disease. However, the germs remain in the lungs and must be destroyed by using a TB drug for approximately six months and when symptoms improve. CHMC is a high risk hospital for exposure to TB as defined by the CDC (more than six cases a year diagnosed here) and has a plan in place for early identification, and proper isolation of suspect or know TB patients.

  **PPD skin test:** The skin test for TB is the best way to determine if a person has become infected with TB. This is why six monthly or annual TB screening is required of employees.

  **State law** requires that the hospital does not discharge, release or transfer a patient with suspected or active TB without a written plan and discharge approval from Los Angeles County Department of Health Services TB Control Unit. This is the Gotch Bill.

- **The Ebola Exposure Control Plan** identifies patients with suspect Ebola disease and provides for immediate isolation and use of PPE of healthcare
workers with potential exposure. All healthcare workers who will potentially have contact with an Ebola case are identified and training provided to ensure proper control measures are understood and practiced. These healthcare workers will be deemed competent to care for the patient prior to contact. No patients with Ebola will be admitted to the facility, but cases could be seen in the Emergency Department.

TRANSMISSION BASED PRECAUTIONS: Patients with the following types of infection must be handled with particular care, called "isolation." These precautions are used in addition to the Standard Precautions above. Transmission precautions apply to:

- Airborne
- Droplet
- Contact

### OVERVIEW OF ISOLATION GUIDELINES

<table>
<thead>
<tr>
<th>Precautions</th>
<th>When Used</th>
<th>Some Examples of Disease</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>All patients</td>
<td>All blood, body fluids, secretions, excretions (except sweat) and contaminated items. Non-intact skin mucous membranes</td>
<td>Use barrier precautions as needed to prevent contact with blood, body fluids, excretions, secretions, and contaminated items. Wash hands before and after contact or glove use. Wash hands and change gloves between patients. Take care to prevent injuries when using sharps. Dispose of properly.</td>
</tr>
</tbody>
</table>

#### Transmission Based Precautions In Addition To Standard Precautions

<table>
<thead>
<tr>
<th>Precautions</th>
<th>When Used</th>
<th>Some Examples of Disease</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airborne</td>
<td>Spread by droplet nuclei particle</td>
<td>Measles, Chickenpox, \textbf{Tuberculosis}</td>
<td>Private room, negative air pressure, door closed. N95 Respirator for HCW, procedural mask on patient during transport.</td>
</tr>
<tr>
<td>Droplet</td>
<td>Spread by droplets</td>
<td>Meningitis, Diphtheria, Mycoplasma, Pneumonia, Influenza, Mumps, Rubella</td>
<td>Private room if possible, wear mask, within 3 feet of patient, limit transport, surgical mask on patient during transport.</td>
</tr>
</tbody>
</table>
Spread by contact with intact skin or surfaces
Resistant bacteria like CRE and ESBL, highly contagious skin infections, lice or scabies infestation, C. difficile (infectious diarrhea)

XV. Core Measures

The Joint Commission (TJC) requires accredited hospitals to collect and submit performance data. This requirement was established to improve the safety and quality of care and to support performance improvement in hospitals. The Core Measure initiative allows TJC to review data trends and to work with hospitals as they use the information to improve patient care. At CALIFORNIA HOSPITAL we are complying with following Core Measures:

1. Venous Thromboembolism
2. Influenza Immunization
3. Stroke

Patients with a “core measure” diagnosis have clinical pathways and protocols. Your department resource will provide you with specific information and criteria.

**AMI: Acute Myocardial Infarction**
- Primary PCI within 90 minutes of arrival

**VTE: Venous Thromboembolism**
- Hospital Acquired VTE

**IMM: Influenza** (October-March)

**Stroke**
- Venous Thromboembolism (VTE) Prophylaxis
- Discharged on Antithrombotic Therapy
- Anticoagulation Therapy for Atrial Fibrillation/Flutter
- Thrombolytic Therapy
- Antithrombotic Therapy By End of Hospital Day 2
- Discharged on Statin Medication
- Stroke Education
• Assessed for Rehabilitation

**Perinatal Care Core Measures**: To be discussed during unit orientation

- Elective Delivery
- Cesarean Section
- Antenatal Steroids
- Health Care-Associated Bloodstream Infections in Newborns
- Exclusive Breast Milk Feeding

**XVI. National Patient Safety Goals 2016**

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

**Identify patients correctly**

**NPSG.01.01.01**: Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

**NPSG.01.03.01**

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

**Improve staff communication**

**NPSG.02.03.01**

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

**Use medicines safely**

**NPSG.03.04.01**

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

**NPSG.03.05.01**

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

**NPSG.03.06.01**

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

**Use alarms safely**

**NPSG.06.01.01**

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

**Prevent infection**

**NPSG.07.01.01**
Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

**NPSG.07.03.01**
Use proven guidelines to prevent infections that are difficult to treat.

**NPSG.07.04.01**
Use proven guidelines to prevent infection of the blood from central lines.

**NPSG.07.05.01**
Use proven guidelines to prevent infection after surgery.

**NPSG.07.06.01**
Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

**Identify patient safety risks**

**NPSG.15.01.01**
Find out which patients are most likely to try to commit suicide.

**Prevent mistakes in surgery**

**UP.01.01.01**
Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body.

**UP.01.02.01**
Mark the correct place on the patient’s body where the surgery is to be done.

**UP.01.03.01**
Pause before the surgery to make sure that a mistake is not being made.

**California Hospital Requirement**

- Implementation of applicable NPSG’s and associated requirements by competent and practitioners sites
- Staff is informed about NPSG’s during general orientation and ongoing
- Nursing orientation and department specific orientation also includes info about NPSG’s
- All department directors quiz staff on rounds about NPSG’s
- Staff is reeducated on NPSGs during safety fair and ongoing education

Additional information and exact language of the goals is available on [www.jointcommission.org](http://www.jointcommission.org)

**XVII. Sentinel Event**

Any serious occurrence or unanticipated event that causes serious physical or psychological injury, death, or the risk thereof is termed a sentinel event. An occurrence that may be a sentinel event should be reported to your manager/director immediately as well as to the Administrative Supervisor. When notified, the Risk Manager and Administration will take further action which may
include performing a root cause analysis, mandatory reporting to the State of California, and a corrective plan of action.

XVIII. Patient Rights

A copy of these rights and responsibilities is given to all patients and posted in the facility. This information is also included in patient handbook that patient receives at admission. These rights include:

- Access to Care
- Hospital Charges
- Advance Directives
- Hospital Rules and Regulations
- Communication
- Identity
- Complaints & Conflict Resolution
- Information
- Consent
- Pain Management
- Consultation
- Personal Safety
- Dying/Grieving Process
- Privacy and confidentiality
- Ethical Issues
- Refusal or Acceptance of Treatment
- Experimental Drugs/Devices/Clinical
- Respect and Dignity Trials
- Transfer and Continuity of Care

Patient responsibilities:

- Provide accurate, complete information
- Follow treatment plan; comply with instructions
- Accept responsibility if treatment refused
- Financial obligations
- Follow hospital rules; be considerate of others

Patients have the right to register complaints without fear of retribution, to have their complaints investigated and resolved, and be provided with timely follow up. Furthermore, a patient complaint will not compromise continued care or access to care in the future.

Additionally, patients and employees alike have the right to report concerns they may have about safety or quality of care provided in the hospital and may report these concerns to the Joint Commission. The hospital will take no disciplinary
action if an employee or patient reports safety or quality of care concerns to the Joint Commission.

See the California Medical Center Policy & Operations Manual for complete policy on Patient Rights for additional information.

XIX. Patient Satisfaction/Customer Service

It is the goal of California Hospital that every patient and customer is completely satisfied with the care and services provided. Our customers include patients, visitors, employees, and medical staff. It is our policy to follow up on patient concerns. If you should hear a patient or family member voice a concern while at California Hospital, please notify your department resource immediately so the appropriate action can be taken. Our approach to customer service is as below:

AIDET

Acknowledge our Customers
- Make eye contact
- Smile
- Stop what you are doing so your customer knows he/she is important

Introduce Yourself
- Offer greeting
- State your name
- State your department
- Explain how you will be serving them

Duration
- Explain how long before the treatment, procedure, test, process starts.
- Explain how long the activity will last.
- If applicable, explain the post-activity report process.

Explanation
- Explain the treatment, procedure, test or process.
- Explain who is involved providing their care/service.
- If a clinical procedure, explain if the test will cause pain or discomfort, or if post procedure instructions are necessary.
- Solicit and/or offer to answer any questions, concerns.

Customer Service Model

Anticipate Needs and Prevent the Need for Service Recovery
- The key to success is being able to anticipate the customers’ needs at each step and strive to ensure that processes are in place that will meet and exceed their expectations.
When we fail to understand and manage the expectations, dissatisfaction results.

**Prevent**- prevent the perception or actual miscommunication by providing correct:
- Handoffs
- Home Follow Up calls
- Leadership Rounds

**Recover**- Recognize when service recovery is needed

Remember that *perception is reality*. This is not the time to argue and explain your position. Service recovery begins the moment we recognize that expectations are not met.

Offering alternatives whenever possible is a method for helping dissatisfied customers regain a sense of control.

An apology, as simple as it may seem, is an important step in moving the situation away from the negative and into the positive.

**Service Recovery (HEART- Hear, Empathize, Apologize, Respond, Thank)**

Dignity health model for service recovery model comprises the following components:

- Concerns addressed immediately with HEART
- Concerns addressed with additional tools
- Referral to Risk Management as grievance

Despite our best efforts sometimes patients and families are dissatisfied with the care or their hospital experience. It is important to take the time to initiate service recovery efforts. Next few paragraphs will give you brief information about service recover initiative at CHMC. You will be oriented to service recovery information during unit orientation.

**What is Service Recovery?**

*Patients don’t expect you to be perfect. They do expect you to resolve the problem when things go wrong*

- Ownership of the issue – *It’s not my fault, but it is my problem*
- Responsive action to rectify the mistake
- A focus on enhancing relationships with patients to ensure their experience matches their expectations
- Opportunity to improve patient’s perception of our care
Why is Service Recovery important?

- It is a promise of kindness
- It is a promise of how we're going to treat everyone who comes to us for care
- It is a promise of how we're going to treat each other

Listening + Empathy + Respect + Kindness

When Do We Need Service Recovery?

- Situation or event where a patient or family member has perceived they have received less than an excellent experience
  - Procedure delays
  - Food complaint
  - Poor Communication
  - Unmet expectations
  - Employee behavior outside Dignity Health values and experience principles
  - Multiple bed transfers
Golden Rules of Service Recovery

- If you can't accommodate a patient’s request, an appropriate response might be: “I apologize that I cannot accommodate your request. However, here are some options I can offer that might work for you...Again I apologize and thank you for your patience.”
- Never blame another department or employee
- Never imply it is the patient’s fault
- Represent Dignity Health professionally
- Don’t interrupt the patient while he/she is speaking
• We are not able to control the responses of our patients and their families, however we DO have control over OUR own responses to certain situations and our interactions with patients.

XX. Population and Age Specific Care

• Healthcare providers are required to relate to their patients in age/population-appropriate ways. This is based on criteria identified for each unit and position description. The Joint commission (HR 01.05.03) requires that all healthcare staff that treats, manage, or work in areas that that have direct impact on patient care, initially and annually meet competency expectations in performing population age-specific care. Groups identified are spiritual, cultural, developmental disabilities, low income, low literacy, obese (HR 01.04.01)

• Age-specific groups are neonates 0-1, toddlers 1-3, pre-school 4-5, school-age 5-12, adolescent 13-18, young adult 19-35, adult 36-65, late adult 65+

Follow your Unit-specific guidelines for population/age-specific competency. Refer to standard or find more information visit: http://www.jointcomission.org

XXI. Forensic Services

Non-employee personnel and/or contract staff receive orientation to the facility as appropriate to their role.

XXII. End of Life Issues

All disciplines must comply with procedures to ensure respectful, responsive care of the dying patient. Special needs of a dying patient could include: support for completion of important tasks; knowing that loved ones cared for and not burdened; reconciliation with others, and potentially with God; a chance to say good-bye; fear of being alone; and being in pain or uncomfortable. Assessment for spiritual needs for the patients is done at the time of admission and support is provided by Chaplain Services to plan and meet the needs of the patient and family. Accommodations are made and Interdisciplinary approach is used to meet the needs of a dying patient.

XXIII. Organ/Tissue Donation

All deaths are reportable for possible donation to “ONE LEGACY”. See hospital policy for specifics. There are over 108,000 patients on the waiting list. Each referral makes a difference for those patients awaiting a transplant. Federal Regulations stipulate that every family of every suitable patient should be given the opportunity to make a decision with regards to donation. (42 CFR Part 482) Donation can provide the grieving family with a sense of purpose and comfort.
24-Hour Referral of all Imminent Brain Death and Cardiac Deaths should be made to: 1-800-338-6112.

Patients requiring ventilatory support and one or more of the following criteria:
- Glasgow Coma Scale (GCS) of 5 or less
- One or more loss of brain stem reflexes:
  - Pupils fixed and dilated
  - No cough
  - No gag
  - No spontaneous respirations
  - No purposeful movement in response to painful stimuli
- **Beginning** discussions of withdrawal of life-sustaining treatments
- Also if physician is ordering an electroencephalography (EEG), a cerebral blood flow (CBF), or an apnea test.
- Every death should be reported **within 1 hour** for the possibility of tissue donation.

**POINTER**S:
- Please do not rule patients out for disease or age
- If patient meets brain death criteria, do not extubate. OneLegacy will evaluate for medical suitability and offer the family that option if the patient is medically suitable for donation
- Please do not bring up donation as the patient may not be suitable or it may be too early for the family and the patient.
XXIV. Cultural Diversity

California Hospital recognizes the diverse cultural make-up of our local population, and seeks to accommodate each patient's cultural needs. Being aware of cultural diversity provides an atmosphere of sensitivity & trust

• We are an EQUAL OPPORTUNITY employer
• We recognize, respect, and are stronger due to our differences
• We will not discriminate

XXV. HIPAA/Patient Confidentiality

THE DIGNITY HEALTH INTEGRITY PROGRAM

Dignity Health is committed to the highest standards of business ethics and integrity. Employees, volunteers, students, medical staff members, and contractors are expected to always conduct themselves in a manner that reflects integrity, and shows respect and concern for others. Dignity Health also expects employees, supervisors, vendors, volunteers, students and medical staff members will treat one another with dignity, respect and courtesy. All of us as citizens, employees, students, contractors or volunteer care givers have a duty to adhere to rules and laws each day. At Dignity Health we require that our volunteers, employees, students, contractors and physicians understand and comply with all state/federal laws aimed at preventing fraud and abuse.

Dignity Health’s unique heritage and values demand higher Standards of Conduct, which are provided in our Integrity Program.

Personal Responsibilities

At Dignity Health, you will be expected to know and follow our Standards of Conduct:

Ethical Conduct - You must represent Dignity Health accurately and honestly, deal fairly with its competitors, customers, and vendors.

Honest Communication - Dignity Health staff are expected to communicate with candor and honesty in performing their job assignment responsibilities.

Misappropriation of Proprietary Information - Dignity Health workers must not steal or misappropriate confidential or proprietary information belong to another person or entity.

Confidential Information – You must not disclose confidential patient or business related information to unauthorized persons.
Report Violations - It is the responsibility of every member of the workforce to report suspected violations of the Standards of Conduct, a breach of privacy or data security, applicable regulations or Dignity Health policy.

Compliance and Ethics

We sincerely appreciate your contribution to Dignity Health. Dignity Health has a long and proud history of living our values. Maintaining an ethical culture is an obligation that each one of us shares.

Each day, as you go about your work, we ask that you:

- Take responsibility for your own actions;
- Know and comply with applicable laws and rules, including applicable Federal health care program requirements, the Dignity Health Standards of Conduct and Dignity Health policies and procedures as they apply to your particular assignment responsibilities;
- Seek guidance provided in the Dignity Health “Integrity Program: Standards of Conduct” booklet and/or policies when in doubt about your responsibilities;
- Refrain from involvement in illegal, unethical or other improper acts or any activity intended to defraud anyone of money, property or services;
- Promptly report any potential or suspected violation of the Dignity Health Standards of Conduct, Dignity Health policy or applicable laws or regulations;
- When requested, assist Dignity Health personnel and authorized outside personnel in investigating all allegations of violations.

PRIVACY & DATA SECURITY PRIVACY & DATA SECURITY REPORTING VIOLATIONS

Data Security

- Dignity Health computer network access is a privilege granted to users to facilitate the performance of Dignity Health business. Computer network users should have no expectation of privacy when using Dignity Health network resources. The contents and history of all user computer network activity is the property of Dignity Health. User responsibilities are covered in the Network Usage Policy (NUP) that every network user must read and sign. Dignity Health regularly monitors user activity. Any content that a user creates or receives via the Dignity Health network is not private or personal, including E-mail, web browsing, Instant Messages (IM) or any network application activity.
- Never post confidential information nor use a cell phone to take a photo of a patient and post it on a Social Media site (Facebook, Twitter, etc.), a personal blog, news groups or anywhere else on the Internet. Even if no name is attached, it violates our policies and HIPAA to reveal patient images or confidential information in public or on the Internet without authorization.
- Dignity Health policies address what information may be shared with authorized individuals and how authorization is obtained from the patient, patient’s
representative or guardian. If you need information regarding Dignity Health policies contact your volunteer coordinator or the Facility Compliance Professional (FCP).

Penalties for Privacy or Data Security Violations

- A violation of federal or state regulations or Dignity Health policy can result in discipline, fines or imprisonment. Both federal and state privacy laws carry criminal penalties, including fines and possible prison time for violations.
- Dignity Health would consider a willful breach of privacy or data security as being outside the scope of your assignment duties and would not defend you.
- It is the responsibility of every member of the workforce to report suspected violations of the Standards of Conduct, a breach of privacy or data security, applicable regulations, or Dignity Health policy. Reporting these concerns helps Dignity Health promptly determine whether conduct is proper and to correct problems quickly.
- Corporate Compliance has established the Dignity Health Hotline at 1-800-938-0031 for use by staff members to ask questions or report potential or suspected violations. The Hotline is accessible 24 hours per day, seven days a week.
- All reports are taken seriously, reviewed, and investigated promptly and, to the extent possible, be treated in a confidential manner. Any Dignity Health staff member may make a Hotline report anonymously. You should also understand that in a follow-up review of the report, the reporter’s identity may be learned as a natural consequence of an investigation.
- If you have questions or want to report a potential or suspected violation, you are encouraged to first speak with your immediate supervisor. If you do not feel you can candidly discuss an issue with your supervisor, you may take matters to the Facility Professional (FCP). If you are not comfortable speaking to the Supervisor or Facility Compliance Professional, you may call the Dignity Health Hotline at 1-800-938-0031.
- Retaliation against any person who, in good faith, reports potential or suspected violations is unlawful and will not be tolerated.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state privacy and data security regulations, Dignity Health maintains a high level of privacy and data security in all aspects of our facilities. Protecting our patients’ privacy and the security of their personal information is an essential part of the care we provide, and is the responsibility of all Dignity Health employees, physicians, business associates, students, volunteers and vendors.

Privacy & Confidentiality

Our patients have both legal and ethical rights concerning the privacy and confidentiality of their Protected Health Information (PHI). You may encounter PHI or other confidential information. PHI includes any private information that may identify the patient, including a patient’s name, medical record number, phone number, address, date of birth, financial records, social security number, insurance card, X-ray, test results, facility
patient directory, identification bracelet, prescription label, etc. All PHI must be safeguarded whether it is written on paper, spoken, heard, or stored electronically.

- PHI cannot be accessed by any employee, volunteer, student, contractor or physician unless they have a legitimate business purpose and require the information to do their job (e.g. treatment, payment or healthcare operations). Under no circumstances, discuss any patient PHI you have accessed with other staff members, unless the information is necessary for their jobs. If it is necessary to discuss PHI, do so in a private setting and not in public places such as hallways, elevators, or the cafeteria.

- You cannot access your own PHI or that of any member of your family without completing the proper written authorization procedures at the Health Information Management Department. Inappropriate access to PHI will result in disciplinary action according to Dignity Health policies.

- All paperwork containing patient information will be placed in the designated bins for proper disposal. IV bags have a perforated label that must be removed prior to disposal.

- Family members and visitors are not authorized to be in the nurses' stations.

- No photographs may be taken in the hospital unless associated with medical/surgical related documentation (a signed Consent for Photography must be obtained) and approved by a member of the leadership team.

- Employees, Contracted Staff, Students or Volunteers may not use cellular telephones to text or otherwise relay protected health information or the personal identification of patients to anyone whether they are involved with the patient’s care or not.

- Some patients may choose not to release their name on the general census. These patients are referred to as “no information”. The charts are labeled “No Info”, and “No Info” is placed on the census board instead of their name. The designation “occupied” also delineates patients for which no information is provided outside of direct care providers. At no time should information be shared with visitors or over the phone for either of these patient categories.

If you have any questions about the Dignity Health Compliance, Integrity, Privacy and Data Security Programs, please contact the CHMC FCP, Teresa Hayman.

**XXVI. Moderate Sedation**

California Hospital provides specific policies for the monitoring of patients receiving moderate sedation by the professional registered nurse and
medical staff during diagnostic and therapeutic procedures. Policies are available on the nursing unit and clinical department.

**XXVII. Pain Management**

All patients are entitled to pain management. Please let your department resource know immediately if your patient's pain is not well controlled. A variety of 0-10 pain scales are used based on the patient's age and cognitive status. Non-pharmaceutical pain management measures such as distraction, music, and relaxation techniques are used in addition to ordered medications. Reassessment of pain after intervention is required and must be documented.

**PRINCIPLES OF PAIN MANAGEMENT**

- Individualize the route and schedule of pain medication. Use the simplest dosing schedule and least invasive route of administration.
- Anticipate patient's pain, offer medication routinely, and use boards in patient rooms to document time of medication administration, have patient/family participate in management of pain. Use every contact with patient/family as an opportunity to teach and document comprehension of information provided.
- Individualize the route and schedule of pain medication. Use the simplest dosing schedule and least invasive route of administration.
- Be familiar with dosage and half-life of several opioids. Use equianalgesic chart for conversion of medications.
- Use multi-modal therapy; combine anti inflammatory medications and muscle relaxers for maximum effect, with physician's orders.
- Prepare patient for discharge; if patient has been on IV medication, begin weaning with oral medication to determine effect and patient tolerance prior to discharge.
- Never administer placebos, it is unethical and inappropriate. If physician writes order for placebo, notify nursing supervisor.
- Reassess by 30-60 minutes for relief. Document reassessment, even if pain goal has been obtained.

**AGE SPECIFIC CONSIDERATIONS:**

- A multidisciplinary approach will be taken to manage the pain including the parents/caregiver, physician, child-life, nurses and any ancillary staff who is involved in the care of pediatric patients will be included in the pediatric pain assessment orientation performing their role in interpreting behavioral changes noticed in the child that may indicate pain. The parent/caregiver is the expert on how the child copes with pain.
- Infants and children require pain medications for procedures that would routinely require no pain medications for adults.
- Non drug interventions will be developmentally appropriate. The child life specialist is available to assist with selection of non-drug interventions.
Infants: Supporting hand to mouth movement, allowing time to reorganize self, nonnutritive sucking, swaddling, facilitating hand and feet clasp ing.

- Toddlers: keeping mom present, providing comfort of favorite blanket or stuffed animal
- Preschooler: distraction, videos, keeping mom present, allowing play with a doctor's kit, blowing bubbles, a magic glove
- School-age children: honesty, discussion of feelings, blowing bubbles, providing a focal point- blowing, imagination, imagery, book
- Adolescents: distraction, discussion of concerns

XXVIII. Restraints
California Hospital promotes the minimal use of restraints. Restraint may be the most appropriate means of preventing patient injury. Restraints are only applied after all other alternatives have been attempted and found unsuccessful. Protocols for restraints are not used: each patient is individually assessed for the need for restraints. When restraints are applied, hospital policy and the manufacturer's directions must be followed. Non-Violent / Non-Behavioral restraints must be renewed every 24 hours by the MD. Written orders for Violent / Behavioral restraints are limited to 4 hours for adults 18 or older; 2 hours for children 9-17; or 1 hour for children under age 9. The restrained patient must be assessed, monitored and reassessed as per hospital policy. Documentation of restraints is to be done on the Restraint Flow Sheet. Refer to the Administration Manual for the Restraint and Seclusion policy.

XXIX. XXVII. Pain Management
All patients are entitled to pain management. Please let your department resource know immediately if your patient's pain is not well controlled. A variety of 0-10 pain scales are used based on the patient's age and cognitive status. Non-pharmaceutical pain management measures such as distraction, music, and relaxation techniques are used in addition to ordered medications. Reassessment of pain after intervention is required and must be documented.

PRINCIPLES OF PAIN MANAGEMENT

- Individualize the route and schedule of pain medication. Use the simplest dosing schedule and least invasive route of administration.
- Anticipate patient's pain, offer medication routinely, and use boards in patient rooms to document time of medication administration, have patient/family participate in management of pain. Use every contact with patient/family as an opportunity to teach and document comprehension of information provided.
- Individualize the route and schedule of pain medication. Use the simplest dosing schedule and least invasive route of administration.
• Be familiar with dosage and half-life of several opioids. Use equianalgesic chart for conversion of medications.

• Use multi-modal therapy; combine anti-inflammatory medications and muscle relaxers for maximum effect, with physician's orders.

• Prepare patient for discharge; if patient has been on IV medication, begin weaning with oral medication to determine effect and patient tolerance prior to discharge.

• Never administer placebos, it is unethical and inappropriate. If physician writes order for placebo, notify nursing supervisor.

• Reassess by 30-60 minutes for relief. Document reassessment, even if pain goal has been obtained.

AGE SPECIFIC CONSIDERATIONS:
• A multidisciplinary approach will be taken to manage the pain including the parents/caregiver, physician, child-life, nurses and any ancillary staff who is involved in the care of pediatric patients will be included in the pediatric pain assessment orientation performing their role in interpreting behavioral changes noticed in the child that may indicate pain. The parent/caregiver is the expert on how the child copes with pain.

• Infants and children require pain medications for procedures that would routinely require no pain medications for adults.

• Non drug interventions will be developmentally appropriate.
  - Infants: Supporting hand to mouth movement, allowing time to reorganize self, non nutritive sucking, swaddling, facilitating hand and feet clasping.
  - Toddlers: keeping mom present, providing comfort of favorite blanket or stuffed animal
  - Preschooler: distraction, videos, keeping mom present, allowing play with a doctor’s kit, blowing bubbles, a magic glove
  - School-age children: honesty, discussion of feelings, blowing bubbles, providing a focal point- blowing, imagination, imagery, book
  - Adolescents: distraction, discussion of concerns

XXVIII. Restraints
California Hospital promotes the minimal use of restraints. Restraint may be the most appropriate means of preventing patient injury. Restraints are only applied after all other alternatives have been attempted and found unsuccessful. Protocols for restraints are not used: each patient is individually assessed for the
need for restraints. When restraints are applied, hospital policy and the manufacturer’s directions must be followed. Medical / Non-Behavioral restraints must be renewed every 24 hours by the MD. Written orders for Violent / Behavioral restraints are limited to 4 hours for adults 18 or older; 2 hours for children 9-17; or 1 hour for children under age 9. The restrained patient must be assessed, monitored and reassessed as per hospital policy. Documentation of restraints is to be done on the Restraint Flow Sheet. Refer to the Administration Manual for the Restraint and Seclusion policy.

XXIX. Fall Prevention

California Hospital has a fall prevention program to promote patient safety. FALL PREVENTION. Falls have been identified as the second leading cause of accidental death in the United States, and 75% of those falls occur in the elderly population. Six percent of patient falls in the hospital result in serious injuries that further compromise health status or even result in death, either from the fall or from secondary causes. Injuries from falls dramatically increase health care costs by an estimated 34 billion dollars annually.

**Definition** of a *fall*: Sudden, uncontrolled, unintentional, downward displacement of the body to the ground

*Near Fall*- sudden loss of balance that does not result in a fall or other injury.

*Un-witnessed* fall- patient is found on the floor and neither patient nor anyone else knows how he or she got there.

**Global Fall Precautions**: Consider every single patient a fall risk!! due to unfamiliar environment; new medications; overall de-conditioning from being sick/in bed. Fall prevention is everyone’s responsibility.

**Following Fall Information should be reviewed by all nurses:**

**Fall Risk Assessment and Reassessment**: All patients (except newborns) will be assessed for their fall risk using an the John Hopkins Fall Risk Assessment tool: Upon admission to facility; At change of shift (during hand-off bed side report); After an operative or invasive procedure; Transfer from one unit to another; Any unplanned change in mental or medical status; and Following a fall. Global fall precautions will be implemented on every patient. If a patient is identified as a high risk, additional interventions will be implemented per the fall risk assessment, such as ensuring the patient is given the yellow fall kit and risk for injury.

**Communication of Fall Risk**

- All healthcare team members are notified of fall risk on admission, change of shift, change in patient’s condition, transfer to another floor and/or transfer for a procedure
- Fall risk kit (yellow blanket, booties, and armband)
• Fall risk sign on patient locator board in hallway
• Communicate during bedside report and transferring to another unit (SBAR)
• Documentation on nursing flow sheet, fall risk tool, and interdisciplinary care plan

**Provide a Safe Environment for all Patients:** Instruct all patients and family in their role and responsibilities. Maintain a safe environment by: keeping patients’ room clean and uncluttered; well lit; inspecting & maintaining all assistive devices in top working order; and correcting and reporting unsafe conditions immediately (x5454)

**Fall Prevention Interventions:** Orient patient to surroundings; instruct patient to call for help; place call light and other items in reach; place bed in low position, wheels locked, & side rails up; perform hourly rounding on days and every two hours at night; and evaluate MAR for medications causing increased fall risk

**High Risk Fall Precautions:** If a patient is “High Risk” for falls based on the assessment implement the following: room assignment closer to nurse’s station; assistive devices at exit bedside; night lights in room; handrails accessible; ask for the family member’s assistance and sitter assignment if needed.

**If Patient Falls:** Perform complete head to toe assessment, including vital signs and neuro check; ask patient what happened; check the Medication Administration Record (MAR) to determine if the patient is taking aspirin or an anticoagulant; notify physician, manager, family, and other team members; reassess for fall risk and additional interventions; and document on medical record and complete an event report.

**What to Document Post Fall:** Condition in which patient was found; statement from patient; any apparent injury and location; notification of physician and any new orders; medical/nursing actions; family and management notification; and reassessments and additional safety precautions. A fall debriefing form will also be documented by nurse and given to the supervisor or manager to complete.

**XXX. Abuse**

• All healthcare workers are mandated reporters of domestic violence, child abuse, elder and dependent abuse. Physical abuse is referred most commonly to social services. Clinical signs of physical abuse include:
  • Multiple bruises in different stages of healing
  • Burns- particularly on back or buttocks
  • Wearing excessive layers of clothing
Who reports abuse?
- Social workers
- Nurses
- ER doctors
- Other Types of Abuse can include: mental abuse; child abuse; elderly abuse; and financial abuse. See hospital policy for specific criteria.

XXXI. Recognition of Impairment

Impaired and disruptive behavior of a licensed independent practitioner can impact the safety and care of patients, endanger the physical safety of hospital employees and may create a working environment that is hostile and unproductive. California Hospital has program to identify and manage physician impairment. Please report symptoms of both impairment and disruption to your department supervisor.

XXXII. Team Dynamics

- The medical, nursing, and ancillary professional staff of California Hospital function collaboratively as part of a multi-disciplinary team united in a purpose to achieve positive patient outcomes. CHMC believes in collaborative practice and that none of us is as good as all of us.
- Collaboration provides cost-effective use of resources, heightened morale, and greater patient satisfaction
- Working with other disciplines cooperatively with team members to reach a common goal
- The focal point of all care delivery is the PATIENT. All decisions related to performance of patient care tasks must be based on maintaining the health, safety and welfare of the patient
- Clear communication and decision making makes teams successful and is a “norm” in team culture

XXXIII. Chain of Command

Each unit/department has a charge nurse or supervisor who is responsible for the function of the unit during their shift. The Administrative person on call and nursing supervisor is available at all times including nights and weekends. Unit managers have 24-hour responsibility for the unit. Nursing Unit directors answer to the Chief Nursing Officer. Other clinical Departments may report to CNO or Chief Operating Officer (COO). Organizational Charts are available on the nursing units and other departments for specific organizational chain of command. Issues related to medical staff are reported to the charge nurse or department supervisor for follow-up through the chain of command.
XXXIV. Verbal/Telephone Order Read Back

Verbal and telephone orders will be written on the “Physician’s Orders” form. Orders will be read back to the physician and noted as such on the physician orders form by placing a check-mark in the box next to “Verbal Order Read Back.” It is the policy of the facility to discourage verbal orders unless it is under an emergency situation or the physician is surgically scrubbed in and unable to write orders.

XXXV. Medication Administration

All licensed staff is required to follow the "Seven Rights" of medication administration. Two identifiers are used prior to administering medication: patient name and date of birth (for outpatient) and patient name and Medical Record number (for inpatient). Only approved abbreviations may be used. Refer to hospital policy.

MEDICATION SHORTAGES

How is staff notified of medications shortages or outages?
The Pharmacy Department sends a notice to all affected areas each time a shortage or outage occurs. The notice provides instructions as to alternative medications available.

USE OF INVESTIGATIONAL MEDICATIONS

How are investigational medications managed?
Investigational drugs should be delivered to the Pharmacy for evaluation, storage, preparation and appropriate labeling. A copy of the informed consent shall be available in the medical chart. Only RN may administer investigational medication. Staff should be oriented to any requirements regarding the medication.

STORING OF MEDICATIONS

How do you assure that medications are appropriately stored?
We have developed specific policies to assure that medications are appropriately stored. These policies require that:

• Internal and external medications are stored in separate locations.
• Medications requiring refrigeration are stored in refrigerators. The temperature is monitored and recorded once a day to assure that proper temperature is maintained. The temperature of refrigerators storing vaccine must be monitored and recorded twice a day.
• Medications are protected from light as required.
• Medications are made available in the most “ready to use” form as possible.
• Medications are provided in unit dose form whenever possible.
• Pharmacy staff makes routine inspections of medication storage areas to assure compliance with policy.
• “Look-alike” and “sound alike” medications are stored with special precautions (LASA stickers).
• Outdated medications are returned to Pharmacy for appropriate disposal

SECURITY OF MEDICATIONS

How do you keep medications secured?
We have developed specific policies to assure that medications are appropriately secured. These policies require that:
• Medication rooms are locked.
• Only authorized staff are permitted access to medication storage areas
• Emergency medication carts are checked daily. Security locks are controlled only by Pharmacy staff
• No medications are kept on top of the counter or in patient rooms unattended (unless ordered by the physician).
• Only pharmacy staff is allowed access into the main Pharmacy

CONTROL OF CONTROLLED SUBSTANCES

How do you keep controlled substances secure and reconciled?
We have developed specific policies to assure that controlled substances are appropriately controlled. These policies require that:
• Controlled substances are stored in Omnicell.
• Only licensed authorized staff will have access to controlled substances
• Discrepancies of controlled substances are reconciled each shift. If a discrepancy is noted, the Charge Nurse and nursing supervisor must be notified immediately.
• Any wastage of controlled substances is witnessed and documented in the Omnicell by two licensed personnel.
• Print Omnicell transaction of user report at the end of shift and confirm if controlled substance usages have been documented before leaving the unit.
• All medications administered (including all narcotics) must be documented in the EHR (Electronic Health Record).

HIGH RISK MEDICATIONS

What steps do you take to protect patients from risks of errors in care when dealing with high-risk medications?

We have taken steps to manage high-risk medications such as:
• Specific policies have been developed to manage high-risk medications such as insulin, heparin, and chemotherapy.
• Special warning labels and precautionary statements are placed on high-risk medications and look alike sound alike medications.
• These are also identified on the Omnicell machine using dispensing alert.
• Special precautions have been taken to reduce the risk of administration errors such as requiring two licensed nurses to verify identified high risk medications.

MEDICATION ERRORS & ADVERSE DRUG REACTIONS

How do you spot a potential adverse drug reaction?
The following strategies have been developed to spot potential adverse drug reactions

• Pay particular attention to the first time a patient receives a medication.
• Monitor for allergic reactions such as fever, rash, anaphylaxis.
• Monitor for hypersensitivity to a drug such as changes in vital signs, acute or severe manifestations of side effects.
• Look for drug intolerance – a lowered threshold to the normal pharmacological effect of the drug.
• Look for idiosyncratic reactions – an uncommon response by a patient to a drug given at normal doses.
• Chart notation should be made.

What do you do if you suspect an adverse drug reaction or a medication error?
Staff should take the following actions when there is a suspected adverse drug reaction or medication error:

• Notify the charge nurse and/or clinical Manager and Pharmacy
• Charge nurse will complete IVOS report. If a medication error occurred, complete IVOS report.
• Document the pertinent facts in the patient’s medical record.

CONCENTRATED ELECTROLYTES

Is there any concentrated Potassium or hypertonic saline stored in the various patient care areas?
No…concentrated Potassium and hypertonic saline are stored under the control of Pharmacy. They are not stored in patient care areas.
How do you assure that you administer medications to a patient safely and effectively?

We have developed specific policies to guide staff in administering medication. Key steps to safely administering medication include:

- Wash your hands.
- Correctly identify the patient using two patient identifiers. Using the patient’s armband and the medication administration record.
- Verify that you have the correct medication / dose / route against both the drug label and the medication order.
- Check the expiration date on the drug to make sure it is still good. Do not use if the drug has expired.
- As appropriate, visualize the medication for stability (i.e., color, clarity, presence of particulate matter). Do not use if the medication appears compromise.
- Check the patient’s medical record to make sure there are no contra-indications to giving the medication.
- Verify that you are giving the medication at the proper time.
- Advise the patient of the purpose of the medication, and, as appropriate, of any potential adverse reactions or side effects.
- If you have any questions or concerns regarding the medication, discuss them in advance with the Physician or call the Pharmacist for assistance.

Return Seven Rights: Right Drug, Right Dosage, Right Route, Right Time, Right Patient, Right reason, and Right Documentation

FIRST DOSE REVIEW BY PHARMACY

How do you process a new medication order?

Our policy requires that Pharmacy review all new non-emergency medication orders before staff may give the first dose. That means that staff cannot take the medication from Omnicell until Pharmacy has reviewed the order. There are some exceptions:

- The Physician is in control of the medication process such as in Surgery, ED, invasive procedures, etc.
- There is a clinical emergency and there is no time for Pharmacy to review the order (i.e. Code Blue, impending cardiovascular or respiratory failure, etc) when delay caused by pharmacy review may cause patient harm.

ADMIXTURE OUTSIDE OF PHARMACY
Can Nursing admix IV’s outside of Pharmacy?
Only under emergency conditions in which a delay could harm the patient or when the product’s stability is short.

Otherwise, all IV admixtures are prepared in Pharmacy. If Nursing must admix a medication, special training and precautions are taken.

XXXVI. Documentation/ Electronic Health Record (EHR)

Understand the documentation requirements for your department per your job description and scope of practice. Your Preceptor or Clinical Instructor will train you in EHR documentation. All documentation by the students will be cosigned by the clinical instructor or preceptor based on the nature of your orientation. Familiarize yourself about documentation tools with your preceptor during the orientation process. For assessment /reassessment and minimal required documentation guidelines, refer to the grid below on the next page.

Each nursing unit individualizes documentation. Please check with your department resource that will show you the EHR or paper record to use for your assignment.

In patient assessment, nursing flow sheets, nurse’s notes, interdisciplinary plan of care, patient and family education, and belonging list are some of the documentation areas that get initiated as part of initial assessment. Ask your resource on the floor to share these details with you.

Patient and Family education—

- The RN admitting the patient is responsible for coordinating the education assessment, formulation of the plan, referral to other disciplines and completing the initial "Core Education."
- Educational needs and barriers to learning will be assessed upon entry into the clinical setting.
- Educational interventions and response are by all disciplines throughout the hospitalization.

XXXVII. Performance Improvement

California Hospital is committed to continuously improving performance and patient care outcomes.

The medical staff, employees and contracted services participate in identifying opportunities to improve, data collection, multidisciplinary teams and implement actions to sustain improvements.

The methodology selected by California Hospital to analyze and
improve care/services and processes/outcomes is called the PDSA

P- Plan
D- Do
S- Study
A- Act

XXXVIII. Safety/Risk Management/Occurrence Reporting

Report the following to your department resource:

- Defective or damaged equipment.
- Injuries to self, staff, visitors, patients.
- “Sentinel Event” Any unexpected occurrence involving death or serious physical or psychological injury.
- “Near Miss” defined as any process variation which did not affect the outcome, but for which a recurrence carries a serious adverse outcome. “A close call.”
- Hazardous Condition-Any set of circumstances which significantly increases the likelihood of a serious adverse outcome.

How to Report an Event

- To report an event, contact your immediate charge nurse/supervisor. They will facilitate completion of an occurrence report.
- As a contract employee or student you will not have access to the electronic system.
- The report is limited to factual statements that document the occurrence, any interventions taken and shall not admit to or attempt to assign blame, liability or causation. Provide this information to the hospital employee that will help you report the incident.
  1. Hospital employees can access the IVOS system for event reporting. All CHMC employees have access to IVOS, They will log on to: www.MyDignityHealth.org
  2. Go to DignityHealth Connect: System Applications
  3. Click on Event Reporting System
  4. Click on California Hospital Medical Center
  5. Fill in event information
  6. Click Save

What is a Reportable Event?

- This occurrence isn’t consistent with the routine operation of the hospital or routine care of a patient/s. Even the potential for accident, injury, illness or property damage is considered a reportable event.
An unintended event or act of omission or commission that departs from or fails to achieve what was intended is considered reportable.

Errors may or may not result in negative consequences. This includes a system &/or an individual error of judgment or inaction. These are reportable.

REMEMBER: Any Hospital Staff, who witnesses, discovers or has direct involvement/knowledge of a reportable event, shall complete an occurrence report before the end of their shift.

**Examples of Reportable Events include** (but are not limited to):

<table>
<thead>
<tr>
<th>Patient falls</th>
<th>Property (loss of or damage to)</th>
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</thead>
<tbody>
<tr>
<td>Adverse drug events - medication errors</td>
<td>Equipment failure or malfunction</td>
</tr>
<tr>
<td>Adverse drug reaction (allergic reaction)</td>
<td>All stages of Hospital acquired pressure ulcers</td>
</tr>
<tr>
<td></td>
<td>Stage III and above decubitus ulcers</td>
</tr>
</tbody>
</table>

**Why Report Potential/Actual Occurrences?**

- Supports a culture of shared accountability for identification of events that may impact hospital & patient safety
- Integrates risk reduction strategies into the hospital's performance improvement, peer review, credentialing & liability prevention activities
- Supports compliance with requirements of federal/state law and standards of accrediting organizations

Establishes process to ensure documentation and investigation is conducted appropriate to the type/level of severity of reportable events

XXXIX. PRESENT ON ADMISSION (POA) FACTS

**What is a Present on Admission (POA)?**

Beginning October 01, 2008, the federal government and 3rd party payers will no longer pay for certain hospital acquired conditions (HAC). It is important to ensure the following conditions are assessed accurately and documentation is completed accurately upon your assessment at patient’s admission to the hospital. Documentation is an extremely important part of this process!

<table>
<thead>
<tr>
<th>Stage III &amp; IV Pressure ulcers</th>
<th>Catheter-associated urinary tract infections (UTI)</th>
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</thead>
<tbody>
<tr>
<td>Retained foreign object</td>
<td>Mediastinitis after CABG (Coronary Artery Bypass Graft surgery)</td>
</tr>
<tr>
<td>Air embolism</td>
<td>Blood incompatibility</td>
</tr>
</tbody>
</table>
| Manifestations of poor glycemic control (Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity) | Surgical site infections following certain elective procedures:  
- Orthopedic procedures involving repair/replacement/fusion of joints, shoulder, elbow, neck & spine  
- Bariatric surgery for obesity (Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery) |
<table>
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</thead>
<tbody>
<tr>
<td>Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total hip/knee replacement</td>
<td>Blood Incompatibility</td>
</tr>
</tbody>
</table>

Thank you for completing this self-study module
Please refer any questions/clarifications you might have to your resource. Complete the certificate on the first page and return it to the designated person. Do not hesitate to call Education department if you need additional information on any of the topics covered in this packet.