VOLUNTEER SERVICES

MANDATORY EDUCATION HANDBOOK

FOR

NON EMPLOYEES & VOLUNTEERS

Locations:

Capital Health Medical Center - Hopewell
One Capital Way
Pennington, NJ 08534

Capital Health Regional Medical Center - Trenton
750 Brunswick Ave.
Trenton, NJ 08638

Capital Health - Hamilton
1445 White Horse-Mercerville Road
Hamilton, NJ 08619

Some people are fortunate enough to earn their livelihoods in jobs that directly help to create a more peaceful, just and sustainable world. But much of the efforts to make life better for our communities and our world are done by volunteers -- people who work for a better world without pay. Volunteers ARE creating a better world, one person and one act of kindness at a time.
-- Robert Alan Silverstein

Dear Volunteer,

Welcome to Capital Health System and the Department of Volunteer Services!

We are pleased to welcome you to our volunteer program. Through the generous gift of your time, talent and personal interests, you supplement the work of staff members in offering many special services that are so important to our patients, their families and the hospital staff.

Volunteering is a great way to learn new skills, serve your community and meet new people. We hope you find the duties of your volunteer opportunity to be fulfilling and your volunteer experience with us rewarding and meaningful.

Capital Health's values are Integrity, Compassion, Excellence and Teamwork. In joining our volunteer program, you become a part of our team of people dedicated to providing high-quality patient care in an understanding and compassionate environment.

Please take the time to read this handbook carefully; it has been designed to acquaint you with the roles and responsibilities of our volunteers and also serves as your guide. If you have any questions, please feel free to contact me or the Department of Volunteer Services.

We welcome you as a member of our volunteer family and thank you for choosing Capital Health to volunteer and share your time.

Sincerely,

Dipti Padliya
Manager, Volunteer Services

At the end of the day it's not about what you have or even what you've accomplished… it's about who you've lifted up, who you've made better. It's about what you've given back." – Denzel Washington

Happy Volunteering!!

OUR LEADERSHIP

Al Maghazehe, PhD, FACHE
Chief Executive Officer & President of Capital Health

Al Maghazehe is the CEO and president of Capital Health, a very successful two-hospital health system comprised of the Capital Health Regional Medical Center in Trenton and Capital Health Medical Center – Hopewell and an outpatient facility in Hamilton Township. He has led the transformation of Capital Health from an inner-city health system to a regional healthcare destination, attracting patients from throughout New Jersey and Bucks County, PA and specialists from all over the country.

Maghazehe joined Helene Fuld Medical Center in 1979, where he began his professional career as a graduate school intern and progressed to Chief Executive Officer. He was named president and CEO of Capital Health in 1998.
Maghazehe received his doctorate in Business Management from Pacific International University, California, a master's degree in Health Services Administration from Wagner College, New York, and a bachelor's degree from the Institute of Paramedical Sciences. He is a Fellow of the American College of Healthcare Executives.

Mark Arcaro, MD, MHI
Vice President of Clinical Performance

Dr. Mark Arcaro is the Vice President of Clinical Performance overseeing the Quality, Regulatory Affairs, Infection Prevention and Patient Experience Departments. Prior to his current role, he was the Medical Director of Quality Improvement for Capital Health Medical Group where he oversaw quality and patient experience for a large multispecialty group since 2016.

He has been in clinical practice since 2008 and has experience in academic, inpatient and outpatient internal medicine. He graduated from UMDNJ-New Jersey Medical School (Now Rutgers-NJMS) in 2005 and completed his Internal Medicine Residency with UMDNJ-RWJMS (now Rutgers-RWJMS) in 2008.

Richa Bansal, MHA, CPHQ, LSSMBB
Dir. Patient Exp/Pastoral Care/Volunteer Services

Richa Bansal is our Director for Patient Experience/Pastoral Care/Volunteer Services. She is an experienced health care professional skilled in patient experience, organizational development, data analytics, EpicCare Analyst and Conflict Management & Negotiation.She completed her BDMS from India in 2006 and her Masters in Health Administration in 2011 from Boston.

She comes to us from Hunterdon Medical Center, Flemington NJ, where she led Patient Experience, Data Analytics, Regulatory Compliance and Performance Improvement.

VOLUNTEER SERVICES

OUR TEAM

Dipti Padliya
Manager, Volunteer Services

Falguni Patel
Department Secretary, Volunteer Services

CONTACT US

- **PHONE**: 609-303-4023
- **FAX:** 609-537-6076
- **EMAIL:** volunteer@capitalhealth.org
- **WEBSITE:** www.capitalhealth.org/volunteer

MAILING ADDRESS

Capital Health Medical Center – Hopewell
Volunteer Services
One Capital Way
Pennington, NJ 08534.

OFFICE HOURS

Monday – Friday 8:00am – 4:30pm

The Volunteer Services office is closed on recognized holidays, which include, New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

VOLUNTEERS – A DEFINITION

Capital Health Volunteers are unpaid personnel who provide services that support Capital Health's mission to improve the health and well-being of the populations we serve in urban and suburban communities. Volunteers provide services to patients, visitors, and staff.

VOLUNTEER PROCESS

The Volunteer Services Department provides equal opportunity to all qualified individuals without regard to race, color, religion, national origin, ancestry, sex, age, marital status, sexual orientation, medical conditions or disability.

The Department has the responsibility to recruit the most qualified volunteers, determine their capabilities, and make assignments accordingly.

All prospective volunteers must submit an online application specific to their area of interest of service, after which they will receive an initial interview. Completed applications and information regarding volunteers are kept in the volunteers' personnel file, which is confidential.

POSITION DESCRIPTION /COMPETENCY TRAINING

Each volunteer will be assigned to a specific volunteer opportunity. It is important that you only perform the functions of your assigned position. Going outside of the scope of your position is not permitted. **Volunteer position descriptions** are available for every volunteer position and should have been given to you during the interview process for review.

Volunteers must complete a re-orientation and be evaluated **annually** to maintain an active status. Volunteers must also fulfill mandatory educational requirements each year by reading the Capital Health Mandatory Education Book for Non-Employees. A current edition of the book and sign-off sheet will be provided by the Volunteers Services Department.
Certain volunteer opportunities will require annual competency evaluations to ensure our volunteers feel supported in their volunteer assignment. The competency records will be kept as a part of the volunteer's file in the Volunteer Services Department.

ORIENTATION & TRAINING

The initial interview process will include an introduction to the Volunteer Services Department and Capital Health. Volunteers will be provided with this Volunteer Manual and a Mandatory Education Book for Non-Employees that will provide information regarding standards of behavior, customer service, emergency codes, fire and safety policies, infection control policies, patient rights, customer service policies, patients rights, ADA, NJ Patient Safety Act, corporate compliance, confidentiality policies, and HIPAA Policies. Once a volunteer is assigned to a specific department, training will be coordinated with in that department.

UNIFORMS/IDENTIFICATION

The Volunteer Department provides one uniform free of charge to each new volunteer. Additional uniforms may be purchased through the Department.

Uniform for volunteers consists of a Blue – smock/vest, and black or khaki pants.

General Guidelines:

- Clothes must be neat, clean, and appropriate for a business environment.
- Open toe shoes (clogs, sandals, or flip flops) are not permitted.
- Heavy perfume and bulk jewelry should be avoided and keep makeup to a minimum.
- Jeans, shorts, or miniskirts are not permitted.

IDENTIFICATION BADGE

All on-duty volunteers are required to wear a Capital Health photo identification badge visibly attached to your clothing so others can identify you as a volunteer. No person may borrow or loan an identification badge**.**

The badge is the property of Capital Health and must be returned to the Volunteer Services Department when an individual is no longer volunteering.

MANDATORY HEALTH SCREENING

All volunteers are required to be screened for the following before they can start to volunteer –

- Tuberculosis (TB)
- Immunity for Measles/Mumps/Rubella (MMR) and Chicken Pox
- Hep B (for Maternal Fetal department volunteers only)
- Influenza /Flu

All Volunteers that were born after January 1, 1957 must provide documentation of the Varicella (chickenpox) and measles/mumps/rubella (MMR) vaccinations.

Alternately, the screening can be arranged through Corporate Health and the following are offered for free –

- Hepatitis B immunization (for Maternal Fetal department volunteers only).
- Dtap Vaccination for Diptheria, Tetanus & Pertussis (for Maternal Fetal department volunteers only).
- Influenza vaccine (offered free during flu season only and done annually).
- Quantiferon blood work to screen for Tuberculosis (TB).
- Lab Titer to screen for Measles/Mumps/Rubella (MMR) and Chicken Pox.

Without proper health screening, volunteers cannot continue their service activities.

ATTENDANCE / ILLNESS/ABSENCES

If a volunteer must be absent because of personal circumstances or illness, email or phone to notify your assigned work area and the Volunteer Services Department as far in advance as possible.
Capital Health expects consistent and reliable service from its employees and volunteers. Please report for duty on time and stay for the period that is assigned. Volunteer dependability is essential to effective performance.

Illness:

If you are ill, please do not come to volunteer. Colds, sore throats or other illness can be transmitted to patients, visitors, employees and other volunteers.

Vacations:

Please provide sufficient advanced notice of planned vacations to the Volunteer Service Department as well as to your assigned area.

Holidays:

The Volunteer Department is closed on recognized holidays, which include, New Years Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. However volunteers who are available to work on those days are welcome to report to their assigned areas, or assist in other areas if their work area is closed for the holiday.

SIGN-IN PROCEDURE

All Volunteers must **Sign in** when you **arrive** and **sign out** when you **leave**.

Hopewell –
Information Desk at the main Lobby – A touch Screen IPad is available on the desk.
Volunteer Services Office – A desktop is available in the office with the sign in screen logged in at all times.

Regional Medical Center –
Volunteer Services Office – A desktop is available in the office with the sign in screen logged in at all times.

Offsite Location –
For all offsite locations please sign in with your supervisor and remind them to email us the sign in sheets.

It is imperative that you always sign in otherwise your presence in the hospital cannot be regarded as authorized.

RESIGNATION

Volunteers wishing to resign from their assignment must provide notice to their supervisor and the Department of Volunteer Services. The hospital identification (ID) and the issued uniform **must be returned** to the Volunteer Services Office.

INCIDENT REPORTING

Any injury sustained by a volunteer must be reported to the volunteer's supervisor and to the Department of Volunteer Services regardless of the perceived seriousness of the injury. An incident report will be made for the injury. The volunteer will be seen in the Emergency Department for evaluation and treatment. Your personal health insurance will be used as primary coverage with the Hospital paying any balance if necessary.

PATIENT CONFIDENTIALITY

Every volunteer that works in the hospital who has access to information concerning patients must hold all information in strict confidence and shall abide by the Health Insurance Portability and Accountability Act (HIPAA) regulations. Volunteers are cautioned not to discuss any protected health information with any other individuals.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is the federal law regulating how an individual's protected health information is treated to ensure it is safe and will be kept private. It protects the privacy and security of health information by providing individuals with rights that must be protected. Protected health information is also known as "PHI." HIPAA is required to be understood by all individuals that are involved with health care, including volunteers.

As volunteers you need to understand and follow all the HIPPAA privacy regulations to stay what is called "*HIPAA Happy*." If you are adhering to and following all of HIPAA's privacy regulations, you are HIPAA Happy.

A patient's privacy is a top priority at Capital Health. Always follow these simple HIPAA rules:

- Do not discuss any patient information with other individuals at the hospital.
- Discard any patient information in a confidentiality bin. Do not dispose of it in a regular wastebasket.
- Never leave any protected health information unattended or where it can be read by other individuals.
- When you are finished with protected health information, return it to its proper location (locked file cabinet, nurses' station, medical records).
- Point computer screens so visitors or people walking by cannot view them.

If you stop volunteering, you must still continue to treat as private and privileged any and all confidential information. Capital Health may pursue legal action for unauthorized disclosure of sensitive, confidential information.

OTHER IMPORTANT INFORMATION

Smoking Policy
Capital Health is a smoke free environment.

Policies
Disregard of hospital policies by a volunteer such as theft, drinking while on duty, using or being under the influence of controlled substances, inappropriate behavior, HIPAA violations, etc., may require immediate dismissal by the Manager of Volunteer Services.

Change of Name or Address
Notify the Volunteer Office immediately whenever your name, address, telephone, email or emergency information changes.

Change and Flexibility
The health care environment is ever changing. A successful volunteer is someone who is flexible, adaptable to change and receptive to new ideas. Volunteers may ask for clarification from the Manager of the Volunteer Services for the reason for any changes. We do ask volunteers to please be mindful the only constant is change.

BENEFITS

The following is a list of some of the benefits offered to the volunteers by Capital Health:

- Volunteers volunteering for three or more hours a day are provided with a meal voucher worth **$8.00** on their badge. The voucher may be used in the hospital cafeteria toward the purchase of your meal on the day you volunteer.
- Volunteers are eligible for free flu vaccines when available.
- Volunteers receive a Capital Health pin after 100 hours of volunteer service and special recognition pins at intervals after that.
- 20% off all Oasis Spa Services at the Capital Health Medical Center - Hopewell.
- Volunteers may take advantage of discounts offered by the Human Resources Department, such as discount tickets for various theme parks and movie theaters.
- Volunteers may take advantage of classes and educational opportunities offered by Capital Health. Information regarding classes can be obtained through the Volunteer Services Department.

capitalhealth
Minds Advancing Medicine

Mandatory Education Book

2023-2024

Instructions for Cornerstone receipt of this book:
1. Read this mandatory self-study book
2. Mark Complete in Cornerstone

Instructions for paper receipt of this book:
1. Read this mandatory self-study book
2. Sign the acknowledgement page at the end of this book
3. Return the signed acknowledgement form to the department who issued this book

Brief Contents

Contents

DNV·GL

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

HIGH RELIABILITY HRO ORGANIZATION

The Joint Commission

American Heart Association

American Stroke Association

CERTIFICATION

Key Features

- **New Topics/Sections** – Management Team Listing, Just Culture, High Reliability Organization, Safety Enhancement Training, Influenza, Information Technology is its own section.
- **Removed Topics** – Worker Fatigue – detailed training delivered through other means.
- **Sections** – we have categorized the topics into fourteen main sections. This should make reading and searching for information more efficient for the reader.
- **Policy References** – some Capital Health policies are referenced either under the section title or within the text. Please make sure you are familiar with the context of listed policies. All policies can be found under the Policy under the left navigation bar on Capitalink. Policy references are by the name, (policystat number) and reference number.
- **One book** –
  - Content that applies to all three cohorts will show as regular content.
  - Blue outline box highlights additional considerations for the advanced clinical and/or clinical employee.
  - Content that applies ONLY to advanced clinical *and* clinical will be in their own section.
  - Content that applies ONLY to advanced clinical will be in their own section.
- **Footer Identifiers** – Each page footer will have the page number, the current section, and topic so the reader will always know where they are in the text.
- **Appreviations**
    - HPW – Hopewell
    - RMC – Regional Medical Center
    - SED – Satellite Emergency Department
    - Deborah – Emergency Room/Department at Deborah Heart and Lung Center
    - CHET – Capital Health East Trenton

Caution or Attention Required – If a statement needs special attention, it is enclosed by a red box and red triangle bordered exclamation symbol.

SECTION I: General Information

Management Team

Subject to change – see Capitalink for most recent version

AL MAGHAZEHE, Ph.D., FACHE President & CEO

Kelly Maer, Director Public Affairs
Jennifer Antinoro, Executive Director Development
Rona Remstein, Director Cancer Center

GENE MCMAHON, MD Chief Medical Officer

Lynne Kluin Director Medical Admin/Medical Affairs
Vacant Director Clinical Research Medical Affairs

MARK ARCARO, MD VP Clinical Performance

Cheryl Lang, Director Regulatory Affairs
Debbie Sansone, Director Quality & Patient Safety

ROBERT REMSTEIN, DO Chief Academics Officer, DIO

Christina Allen, Director Clinical Ed/EMS Training
Vacant Director Clinical Advancement & Ed Programs

SHANE FLEMING, Sr. VP & Chief Financial Officer

Colleen Ford, Director Health Information Management
Melissa Cieslak, Director Finance
Garrett Arneson, Finance Director Nursing Operations
Vacant Div Dir Fin Clin Svcs/Managed Care
Beth Rizzo, Director Call Center/Scheduling
Wendy Roberts, Director Health Access
Diane Castner, Director Provider/Facility Contract Mgmt/CBO
Nicole Staltmayer, Director Utilization & Resource Management

DEBBIE VISCONTI, Sr. VP Financial Operations

Layne Gambol, Director Patient Accounting
Vacant Director Budget/Reimbursement/Decision Support
Kian Seyed, Director Management Engineering
Christy Paul, Director Value Analysis
Steve Vincent, Director Food & Nutrition
James Lipp, Director Clinical Engineering
Kelly Brennan, Director Environmental Services, Escort Alfred Leone Director Facilities
Stephen Faup, Div Dir Supply Chain Management
David Maurer, Director Logistics & Distribution
Richard Woung, Director Procurement Services

AUDRA FARISH, Chief Human Resources Officer

Saitip (Sai) Vitale, Director Total Rewards

Richard Werner, Director HR Operations

Danielle Conroy, Director HR Business Partners

Rick Malacrea, Director Organizational Development

RAVI KOGANTI, Chief Information Officer

Janaki Saraiya (Acharya), Director Systems and Programs

Ken Szeliga, Director Technical Services

Barbara Grande, Director Clinical Informatics

Sara Walker, Director Information Technology

Terry Chong, Director Information Security

SUZANNE BORGOS, Chief Strategy Officer

Kate Stie,r Director Public Relations & Marketing

JoAnn Hopkins, Director Property & Project Mgmt

ERIC SCHWARTZ, MD VP Community Health & Transformation & Exec Dir, Institute of Urban Care

JEREMYE COHEN VP Strategy & Business Development

Chris Gennaro, Director Business Development

STEFFANIE ARCHBALD, VP Strategic Communications

STEPHEN MILLER, Chief Legal Officer

Christopher Waack, Deputy General Counsel Legal

Kevin Kramer, Deputy General Counsel CHMG

Rafael Villalobos, Jr. Deputy General Counsel Litigation & Risk

Paul Allena, Director Safety & Security

DAVID DAFILOU, Chief Population Officer

Angela Dito Director, Population Health & Care Mgmt

LAURA MCGUIRE, Chief Compliance Officer

Erica Spiro, Director Compliance

ARLENE WALSH, Chief Operating Officer

James Boozan, Director Emergency Preparedness & Planning

Alexander Lewinsky, Director EMS Operations

JOHN (MIKE) RUSSELL, VP CHMG Operations

Michelle Dougherty, Admin. Director Primary Care CHMG

Sean Varricchio, Admin. Director Hospital Based Division

Matthew Yorks, Admin. Director Specialty Care

Josephine Freiling, Admin. Director Specialty Care

COLLEEN DELSO VP Clinical Services & Ambulatory Diagnostics

Ken Bevenour, Director Pharmacy

Beth Ann Lussier, Administrative Director Laboratory
Janice Pesco, Director Rehab Services, Corporate Health
Rita Brooks, Director Cardiopulm/NeurodiagnosSvcs/Vasc Lab
Paulette Duckrey, Director Radiology Services

DEBORAH MICAN, VP Pat Svcs & Chief Nursing Officer

Vacant Dir. Patient Exp/Pastoral Care/Volunteer/Auxiliary
Rita Poss-Brant, Director Central Nursing Resources Marisa Borelli Nurse Manager Logistics/Staffing
Sean Murphy, Nurse Manager Central Resource Office
Alexandra Nelson, Div Dir Women's & Children's Service Line
Michelle Gorski, Nurse Mgr NICU Intermediate/NICU/MFM
Stephanie Singer, Nurse Mgr Peds/Peds Express 2l
Michele Russo, Nurse Manager 3M L&D
Amanda Lugg, Nurse Manager Antepartum/Postpartum
Tomi (Oluwatomi) Wahab, Director Renal Dialysis Services
Lyshus Mathews, Nurse Manager Hemodialysis (R)
Valerie Scannella, Div. Director, Perioperative Services
Donna Talley, RN Mgr ACP/GI/Endo/MOR/PACU/OR/PAT (R)
Vacant Nurse Manager OR/MOR (H)
June Wyrwas, Nurse Manager ACP/GI/PACU/PAT (H)
Kathleen Morris, Div. Dir Neuro/CardioVasc/Wound/CathLab/CIVR/Resp
Christine Young (Carter), Nurse Manager Neuro ICU/Telemetry S1
Gary Oravsky, Nurse Manager, Cardiac Cath Lab, IVR - Radiology
Gregg Sharp, Div. Director ED/Observation/CH@Deborah/Clinic
Megan Perna, Nurse Manager Observation Units H2M; R2N
Brian Decker, Nurse Manager ED (H)
Deborah Salamon, Nurse Manager ED (R)
Megan Martinson, Nurse Manager CH@Deborah-Emergency Services
Melissa Chichilliti, Div. Director Patient Care Services/Clinic (R) (H)
Kristen Stuenckel, Nurse Mgr Trauma/Medical ICU/CCU IMU (R) S3
Eric Elcenko, Nurse Manager ICU/CCU (H)
Cheyenne Rothermel, Nurse Manager Mental Hlth Inpatient 3E
Nana Breedy, Nurse Manager 2F Telemetry (R)
Tina D'Armiento, Nurse Manager OP1/OP2 Med/Surg (R)
Deb Lenart, Nurse Manager, Steen2/STU (R)
Bruce Burns, Nurse Manager 4M Surgical (H)
Donna Gottschall, Nurse Manager 5M Oncology (H)
Stephanie Cepparulo, Nurse Manager 6M Telemetry (H)

Purpose

Policy: Education and Competencies for Employees, (12436123), HR:2.25

This education/information is provided to all employees in order to create a safe working environment; provide progressive, quality patient care; and to satisfy the regulatory requirement needs of agencies such as: DNV-GL,; NJ Department of Health; Center for Medicare and Medicaid Services (CMS), Occupational Safety and Health Organization (OSHA), etc.

Mission Statement

Capital Health is committed to improve the health and well-being of the populations we serve in urban and suburban communities.

Vision Statement

Capital Health will be the region's provider of choice, bringing to our community superior clinicians and partners who improve services and quality of care, while maintaining local control.

Operational Values

Integrity

Adheres to an appropriate and effective set of core beliefs including honesty and serving the greater good. Does not blame others for their own mistakes or misrepresent themselves for personal gain or protection. Perceived by others as a direct, truthful individual and is widely trusted, with the ability to present the truth in an appropriate and helpful manner.

Excellence

Provides the most efficient and effective work processes to meet the needs of patients and other customers which leads to the highest quality services. Makes sound decisions based upon knowledge, judgment and experience. Is sought out by others for advice and solutions to issues and problems.

Compassion

Demonstrates caring and concern for the welfare of others, assisting wherever necessary. Uses understanding and insight when dealing with patients or other customers in all aspects of care or service delivery.

Teamwork

Displays a professional and collaborative spirit in fulfilling responsibilities and assisting others. Helps to create and maintain positive morale with their team, sharing in success, working through problems. Fosters open dialogue, and works toward creating an atmosphere where outcomes and successes are beneficial to the team and/or the organization at large.

Just Culture

Policy: Employee Accountability, (10026894), HR:6.17
Policy: Rules of Conduct, (10027051), HR: 6.5
Policy: Progressive Discipline, (10027000), HR: 6.7

Capital Health is committed to a fair and consistent approach for managing risk and accountability. Capital Health recognizes that employees are fallible and, as such, will make errors and drift away from their obligations. When this happens, the Just Culture philosophy is conducted to understand the risk, the behavioral choices and any system shaping factors. The investigation is conducted in a way that balances individual and system accountability in support of safety and Capital Health's values.

High Reliability Organization (HRO)

Policy: Quality & Patient Safety Plan, (12474061)), HR:6.1

High reliability reflects the cultural values and behaviors of Capital Health. High reliability is leadership's commitment to zero harm. In a high reliability organization, staff are encouraged to speak up about things that would negatively affect the organization. HRO empowers the workforce to employ robust process improvement (RPI) methods that drive significant and lasting change.

Additional education (HRO Universal and Leadership Skills), can be found via our Learning Management System, Cornerstone or by contacting the Quality and Patient Safety Department.

SECTION II: Employee Information

Personal Appearance of Employees

Policy: Personal Appearance of Employees, (10026974), HR:6.14

General attire is to reflect good taste and judgment and create a favorable impression on patients, visitors, guests, and co-workers.

Individual departments/offices may establish more restrictive requirements in accordance with the demands of care, patient or public contact, regulatory requirements and/or traditions of the professional group involved. Such requirements will be designed to ensure that the needs of the department/office will be met.

While Capital Health recognizes and respects everyone's right to express their social, religious, cultural, and ethnic personality in their mode of dress and grooming, Capital Health has a bona-fide business need to present a professional appearance to the community which it serves. Therefore, Capital Health maintains the exclusive right to determine and establish standards of dress and grooming dictated by such legitimate job-related business needs, the nature of work, safety, exposure to patients and visitors, modesty, and common sense.

Uniforms: Uniforms and footwear must conform to the regulations determined by the specific department/office. Uniforms must be clean, wrinkle-free, and in good condition at all times. Head covering may be worn as part of the uniform only when authorized or required by specific departmental code.

Business: Business dress must be clean, wrinkle-free, and in good condition at all times.

General Guidelines: Dresses, suits, dress slacks, skirts, blouses, tailored or sport shirts are appropriate and should reflect good taste and a professional business-like appearance.

Shoes must be well maintained, clean, safe, and functional for work responsibilities. Bare feet are not acceptable under any circumstances.

Head coverings (hats, caps, scarves) may **not** be worn except in areas where safety or hygienic conditions dictate otherwise. Special considerations will be given to anyone whose religious or ethnic background calls for the wearing of head coverings.

Not Acceptable: Jeans, sweatshirts and/or sweat pants, ill-fitting clothing, leggings, stirrup pants, shorts, sheer blouses, backless halters, tank tops, team shirts, midriffs and other distracting or provocative clothing are considered inappropriate. Tops with decorative insignias, logos or lettering which management deems to be offensive are not acceptable under any circumstances.

Good personal hygiene is important to patient care, the comfort of co-workers, and the image of Capital Health.

- Keep bodies and clothing clean.

- Hair must be neat, clean, and well groomed. Long hair must be controlled so as not to interfere with job functions. Facial hair must be neatly trimmed and well kept.
- Lightly scented perfume or after-shave is acceptable. Make-up must be in good taste.
- Fingernails must be at a functional, safe length, and relative to the specific job duties.
- If you have direct patient contact, artificial fingernails, extenders, or acrylics are prohibited.
- Jewelry may be worn provided that it is not excessive in amount or size, making it unsafe or hazardous based on required job duties.

In general, if you have any questions regarding departmental standards, it is recommended that you discuss your concerns with your manager.

Rules of Conduct

Policy: Rules of Conduct, (10027051), HR:6.5; Employee Accountability, (10026894), HR:6.17

For Capital Health to operate efficiently and safely, it is necessary for you to comply with the established rules of conduct. These rules are designed to protect the interests and rights of all employees, patients, visitors and others on the premises. Violation of these standards of behavior will initiate an investigation by the supervisor/manager utilizing the Just Culture algorithm as outlined in HR Policy 6.17 Employee Accountability.

Influenza Education

Influenza is a respiratory illness caused by the human influenza viruses. Two main types that spread among people are Types A and B and are the cause of seasonal flu epidemics. The Centers for Disease Control and Prevention (CDC) estimates that approximately 3% to 11% of the U.S. population experiences a symptomatic flu illness each year, with an average around 8%. Infected individuals are most contagious in the first 3-4 days after illness onset. Symptoms arise around day 2 of infection and can remain contagious for up to days 5-7 after that period. Virus can be spread via tiny droplets – typically released via sneezes, coughs, or even talking.

Serious influenza complications can result in hospitalization or even death. Young children, the elderly and individuals with certain health conditions are at a higher risk of serious complications. There is increasing recognition for the need to account for the diversity within the elderly population. Based on a study by the CDC, hospitalization rates for influenza among adults aged 85 years and older were two to six times higher compared to those aged 65-74 years.

Influenza Vaccination

Policy: Influenza Vaccination Policy (11129202), IC:2.12

CDC Recommendations:

- As influenza season approaches, it is essential that healthcare providers and patients maintain and initiate immunizations for preventable diseases.
- Routine vaccination is essential for all patients but, in particular, vulnerable populations including children, pregnant women, immunocompromised individuals and older adults.
- Routine vaccinations should not be avoided and delayed especially during the COVID-19 pandemic.

- Reducing the burden of respiratory illness is essential for healthcare facilities that must continue to prioritize care for acutely ill COVID patients and places patients at lesser risks of complications from COVID.
- Patients in quarantine due to a close contact/exposure to a person with COVID-19 can receive influenza vaccine, particularly if they might not have another opportunity to be vaccinated. However, if there are concerns that post-vaccination symptoms might cause diagnostic confusion, vaccination can be deferred until quarantine has ended.
- Patients who are fully vaccinated or who have no known recent exposure to a person with COVID-19 are recommended to receive influenza vaccine.
- Patients with suspected or confirmed COVID-19 who are asymptomatic or pre-symptomatic, or who have recovered and are now asymptomatic, can receive influenza vaccine, even if criteria for discontinuation of isolation are not yet met.
- For patients with suspected or confirmed COVID-19 who are symptomatic, healthcare personnel should consider deferring (postponing) influenza vaccination for at least the isolation period AND until COVID-19 symptoms are improving AND the patient is no longer moderately to severely ill. Consider further deferring vaccination until the patient has fully recovered from acute illness.

Why Vaccinate?

- Influenza viruses change from season to season and immunity decreases from previous season.
- Prevention of severe illness and hospitalization.
- Recommended for pregnant women and offers protection to the newborn for several months after birth.
- Decrease severity of illness.
- Decrease spread of influenza.

Anyone employed by Capital Health MUST receive the influenza vaccine by **December 1st** or will have applied for an exemption by **November 20th** of each year. Exemption requests are not guaranteed and must be submitted **each Influenza season.** Exemptions will be reviewed as received and completed by December 31st.

Volunteers, Students, Contractors and Vendors are not be eligible for exemption requests; therefore, vaccination is by December 1st is required to be on a Capital Health Campus. Proof of vaccine will be required to contact person for area of assignment.

Exemptions will be reviewed as received and more information may be requested.

Medical Exemptions:

- Employee must submit both the exemption request form and the Healthcare Medical Statement Form (completed by a medical provider), for approval.
- Must be submitted by November 20th of each year.
- New instructions for submission will be communicated in August.

Religious Exemptions:

- Employees can request a Religious Exemption.
- Employee must complete both the exemption request form AND the Religious Exemption Request Form.
- Must be submitted by November 20th of each year.
- New instructions for submission will be communicated in August.

Employees with Approved Exemptions:

- Must wear a mask when in direct contact with patients and in common areas, meetings, etc.)
- May be relocated or reassigned to other areas.
- Ensure to wash hands frequently.
- Always cover nose and mouth when coughing or sneezing.

If you received an influenza vaccine January thru July of previous flu season you are required to receive influenza vaccine for this influenza season. Flu season is from September to April of each year

Vaccine Opportunities:

- Open forum vaccine clinics - no appointment necessary.
- Occupational Health on Thursdays for walk-ins or make an appointment for egg free vaccine.
- External retail pharmacy or your own personal medical provider. Instructions on submission of proof will be provided in August.

Worker's Compensation and Return-to-Work

Policy: Workers' Compensation and Return-to-Work (11782215), HR:7.5; Employee Handbook, 2019

Report all accidents, regardless of how minor, to a supervisor immediately who will direct you to complete an Employee Accident Report. Failure to report an accident may result in a delay or denial of workers' compensation benefits. (Capitalink > Online Applications > Employee Event Report)

Any medical care you receive in connection with a work-related incident must receive authorization by the Occupational Health, unless you obtain authorization by your Manager or Supervisor to receive immediate treatment in the Emergency Department during business periods the Occupational Health is closed.

It is in everyone's best interest for you, as an injured employee, to return to work as soon as you are medically able. To encourage our employees to return to work, Capital Health offers a Return-to-Work program. Working together with the Corporate Health Center physician, we will attempt to structure productive job duties that are consistent with your physical abilities and the doctor's orders.

Parking and Shuttle

Policy: Parking Policy (10727736), EC:0005

Register all vehicles with the Security Department. Place parking decal in the back-most driver-side window. Employee parking at RMC are white-lined spots (lot adjacent to hospital across Brunswick Avenue and rear of hospital) and at Hopewell they are yellow-lined spots (Lot B and rear of hospital).

Shuttle Vans operate between Hopewell, RMC and Capital Health East Trenton from 6:00am-9:00pm.

RMC (on the hour) Pickup/drop-off – to left of main entrance, by the storeroom loading dock.
Hopewell (on the ½ hour) Pickup/drop-off - front of the building by handicap parking.
CHET corner of Hamilton and Bert Avenues and in front of School of Nursing.

SECTION III: Patient Experience and Patient-Centered Behaviors

When patients or visitors come to Capital Health they have certain expectations and we are here not only to meet those expectations for a caring and responsive experience, but wherever possible, to exceed those expectations. We also need to manage our patients' expectations so they are aware of the likely progression of their health care journey.

Once you become an employee of Capital Health, you are Capital Health. People see you as a representative of the hospital. If you provide exceptional service and the patient or customer has their needs met—we are all perceived as quite wonderful at Capital Health.

However, if you fail to meet what the customer expects—we all have failed as a whole.

Dissatisfied customers will tell eleven people about their experience; satisfied customers will tell one or two people. It is very hard to win back dissatisfied customers.

Whenever you receive a complaint, use it as an opportunity to improve—don't be offended. Always tell the customer what you can do for them, not what you cannot do!

The 10-5 Rule

All Capital Health employees will follow the 10-5 Rule while on the property. When coming upon a patient, visitor, or staff member while walking please remember to make eye contact and smile at ten feet and verbally greet or acknowledge at five feet.

Use Callbacks

Tell customers when they can expect to hear from you and make sure you call back. Rather than transferring callers, try to find out the information for them and call them back. Write notes.

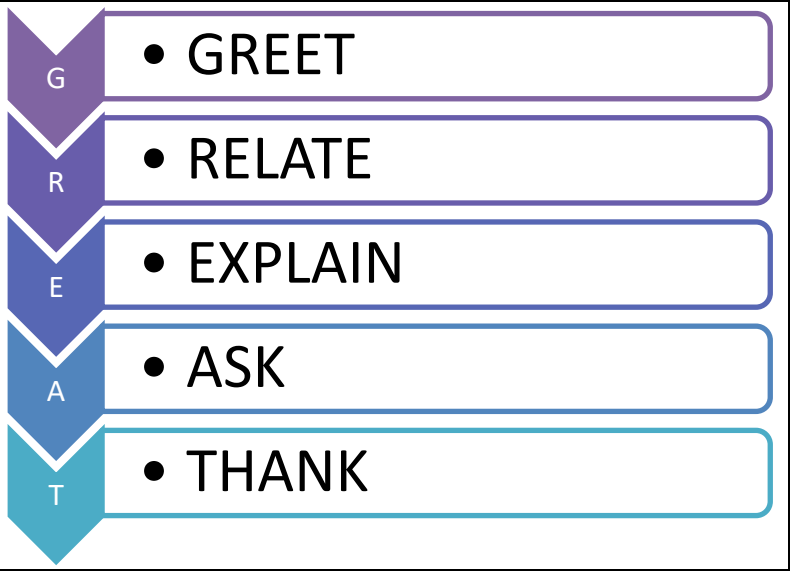
In general, go out of your way to anticipate and meet your patient or customer's needs; whenever possible exceed those needs. Ninety-nine percent (99%) of the time if you are nice to others, they will be nice to you. It will make your job a lot easier and you will feel good at the end of the day.

Service Recovery

When something goes wrong, immediately do something to correct the situation. The situation is to be corrected whether you created it or it found you. All employees need to be comfortable for apologizing when things do not go as smoothly as planned.

Guidelines for Service Recovery:

A = Apologize - I am sorry for what happened
C = Correct the situation – Make changes, notify staff as needed
T = Tell – Tell the patient what you are going to do **AND DO IT**

Five GREAT Fundamentals of Customer Service	

<u>Greet</u> – make others feel welcome. Builds trust • Ask permission to enter room. • Smile and make eye contact. • Acknowledge the patient by name. • Introduce yourself by name/title, share your role on the team of caregivers.	**<u>Explain</u> – narrate what will happen – ease fear, manage expectations** • Use understandable language. • Explain what is happening. • Review how what is going on fits in with the overall plan of care.
<u>Relate</u> – demonstrates concern, empathy and compassion. Builds relationship • Relate to the person; ask about their career, family, pets or weather. Offer a compliment. • Use empathy statements: "I'm sorry you're not feeling well." • Use calm tone of voice. • **Listening carefully is the most important way to relate.**	**<u>Ask</u> – manage and anticipate expectations.** • Anticipate the person's concerns and provide answers. • Ask – "Is there anything else I can do before I leave?" **<u>Thank</u> – show appreciation.** • Thank you for choosing Capital Health. • Thank you for waiting • Thank you for trusting us with your care.

Hourly Rounding

Hourly rounding is a national standard of patient care that needs to occur in all units, departments, and areas 24/7 and 365 days of the year.

We round hourly by washing our hands, knocking and asking permission to enter, stating our name and purpose, and inquiring about the needs of the patient including pain, position, and toileting assistance. We end the round with asking if there is anything else they may do for the patient.

Rounding also occurs in waiting areas, surgical family waiting rooms, exam rooms, and other key patient holding areas.

No Pass Zone

Patient and family needs are **EVERYONE'S** priority.

When a call light outside a patient room is on:

- All staff, regardless of discipline or assignment, are expected to acknowledge the call light.
- Wash in – wash out! Use Purell to wash your hands.
- Be G.R.EA.T.

Telephone Etiquette Script

Answering the Phone Directly – "Good Morning/Afternoon. This is (department/office name), (employee name) speaking. How may I help you?"

Voice Mail – Department - "Thank you for calling the (department/office name) of Capital Health. We are currently not available, but your call is very important to us. Please leave your name and number, and a brief message at the tone. Someone will get back to you as soon as possible. Thank you and have a nice day."

Voice Mail – Individual - "Hello. This is (employee name) of the (department/office name) of Capital Health. I am not available to take your call, please leave your name and number, along with a brief message, I will get back to you as soon as possible. Thank you for calling, have a nice day."

Interpreter Services

Policy: Communication Aids/ Interpretation and Translations Services, (12634465), RI:0028

At the time of registration, admission, scheduling, or contact with patient, Capital Health staff is responsible for asking the patient if they need help with translation or a sign language interpreter.

Family members and employees fluent in another language other than English **ARE NOT** the best interpreters for clinical/care information and instructions.


Clearlink


Clearlink Cordless


Any Phone

Use the following services to communicate with patients with language barriers:

1. *Medical Interpreter Phone Line available 24 hours a day.* Use blue phones with preprogrammed buttons, available in units. If blue phones are not available in units, use any hospital phone by **dialing 1567** and follow the prompts. Alternatively, call telecommunications switchboard operators from any hospital phone and request Medical Interpreter Phone Line Services.

2. *Language Bank List for in person interpretation.* A list of bilingual staff trained on medical interpretation is available on CapitaLink under Quick Links

3. *To assist patients with hearing or visual disabilities.*

   Equipment is available at the Nursing Administration Office at RMC and Hopewell. (See related topic found elsewhere in this document: Communication Aids for the Deaf and Hard of Hearing.)

Cultural Diversity & Implicit Bias

Healthcare professionals interact with people from all over the globe. These various people carry with them cultures and customs that affect the way they interpret the world, their experiences, and their relationships. If patients feel we understand and respect them as individuals, they will be more likely to trust us and comply with the prescribed therapies and treatments.

There is no universally accepted definition of cultural competency in healthcare. In general, it is a set of skills that allows someone to increase their understanding and appreciation of cultural differences between groups. When you are "culturally competent," you are able to provide effective and respectful healthcare to people of different cultures.

Objectives:

- Define what it means to be culturally competent and what it is not
- Identify the necessity to be culturally competent for better patient outcomes.
- Recognize we all have bias, but can learn to overcome them
- Appreciate availability of communication aid resources

Culture

There are many different things that make up a person's cultural identity including: country of origin, language, education, spiritual traditions, family traditions, diet & nutrition, traditional medical practices, attitudes about illness and death and migration experiences, to name a few. One's culture is transmitted, through language, material objects, rituals, institutions, and art from one generation to the next.

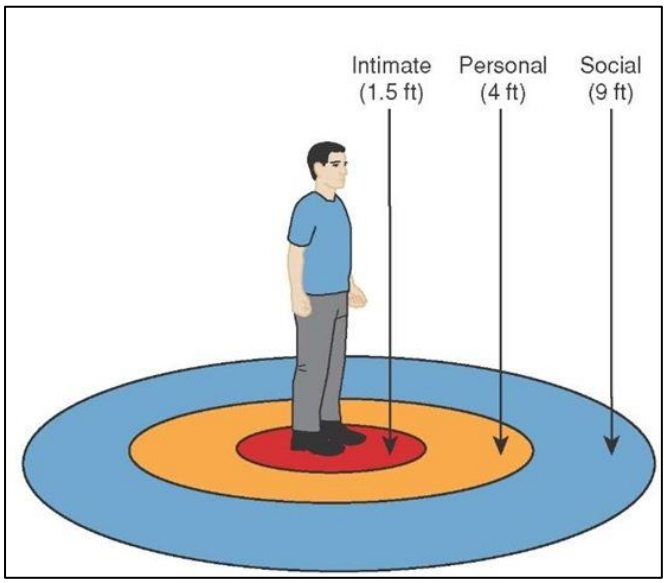
Becoming culturally competent is **not** about learning a lot of facts about many different cultures and it's more than just overcoming a language barrier.

Being culturally competent is about being respectful, open-minded to fundamental differences and willing to learn.

Cultural competency is the ability to interact successfully with patients, visitors, co-workers and other healthcare professionals from various ethnic and/or cultural groups, examples are:

- People from different areas of the world.
- People from different religions.
- People with different customs.
- People who are LGBTQ (Lesbian, Gay, Bisexual, Transgender, or Questioning)
- Non-traditional family structures (e.g., divorced parents, same gender parents, grandparents as caretakers)

In every culture there are basic standards for social interaction such as personal space, eye contact, amount of body language displayed in public, negotiating style, etc. For example, In the U.S. we stand about eighteen inches apart when engaged in normal conversation; prefer very direct eye contact; are demonstrative with body language, and negotiate very directly – usually asking the other party for their "bottom line". In other cultures, they may stand closer or farther together than we do, may view direct eye contact as rude, may be more or less open to displaying body language, and may negotiate more indirectly.



When it comes to cultural competency, we have to be careful not to stereotype people. Just because people are from one geographic area or community, gender, age, economic background, race, sexual orientation, etc.; does not mean they will think and act alike.

A stereotype is an ending point. No attempt is made to learn whether the individual in question fits the statement. Given the tremendous variation within each culture, stereotypes are often incorrect and can have negative results.

> *"Much of our social behavior is driven by learned stereotypes that operate automatically- and therefore unconsciously…"*
>
> *-1995 study from Greenwald & Benaji*

Implicit Bias

We all have biases. We cannot seek to change the implicit bias unless you know it's one you have.

Examples of how implicit bias leads to poor healthcare outcomes:

- Non-white patients are less likely to be prescribed pain medication
- Black women are more likely to die after being diagnosed with breast cancer
- Patients of color are more likely to be blamed for being too passive about their health care

We can overcome implicit bias in heathcare by:

- **Perspective –taking**: Being empathetic can reduce being biased
- **Emotional Skills**: Clinicians who experience positive emotions during clinical encounters are more inclusive
- **Partnership Skills**: Clinicians and patients work as a team toward a common goal

Culturally Sensitive Patient-Centered Communication

To improve the quality of care for all cultures, we need to learn about the main cultures of the population our facilities serve. Another important way to improve care is to learn how to solve problems before they get out of hand. The expectations of our patients and their families are that healthcare workers address all health care concerns in a cultural sensitive manner.

Ideally, we should be asking open-ended questions such as:

- Is there anything we should know about any customs or practices that are important to include in your care?
- What are your concerns regarding the condition and/or treatment?
- Whom do you want to know about your condition?
- Whom do you go to for support? (Family, friends, community leaders, religious leaders)
- Are there any foods you would like or that you want to avoid?

LGBTQ Status, Information and Confidentiality

Comfortable dialogue about a patient's identity and relationships can help to focus a provider's inquiries, personalize professional advice and assistance, and generate an overall higher quality of care. HIPAA protects the privacy of individually identifiable health information, including information related to a person's LGBTQ status. Information about a patient's sexual orientation and gender identity is an essential part of a person's medical history and very relevant to the provision of healthcare. Information regarding a patient's transgender status, such as diagnosis, medical history, birth-assigned sex, or anatomy, constitute PHI and such information should not be disclosed to anyone — including family, friends, and other patients — without the patient's consent. This information should only be disclosed for *treatment, billing or operational* purposes (gossip, curiosity, malicious intent etc. constitutes a violation of HIPAA and policy).

Some useful terms that will be helpful:

Ally (Heterosexual Ally, Straight Ally) is someone who is a friend, advocate, and/or activist for LGBTQ people. A heterosexual ally is also someone who confronts heterosexism in themselves and others.

Bisexual, or Bi, is an individual who is physically, romantically and/or emotionally attracted to men and women. Bisexuals need not have had sexual experience with both men and women; in fact, they need not have had any sexual experience at all to identify as bisexual.

Gay is the adjective used to describe people whose enduring physical, romantic, and or emotional attractions are to people of the same sex. Avoid identifying gay people as "homosexuals" an outdated term considered derogatory and offensive to many lesbian and gay

Gender Expression refers to how an individual expresses their socially constructed gender. This may refer to how an individual *dresses*, their general appearance, the way they speak, and/or the way they carry themselves. Gender expression is not always correlated to an individuals' gender identity or gender role.

Gender Identity--Since gender is a social construct, an individual may have a self-perception of their gender that is different or the same as their biological sex. Gender identity is an internalized realization of one's gender and may not be manifested in their outward appearance (gender expression) or their place in society (gender role). It is important to note that an individual's gender identity is completely separate from their sexual orientation or sexual preference.

Lesbian is a woman whose enduring physical, romantic and/or emotional attraction is to other women. Some lesbians may prefer to identify as gay (adj.) or as gay women.

Queer Traditionally a negative term, *queer* has been appropriated by some LGBT people to describe themselves. However, it is not universally accepted even within the LGBT community and should be avoided unless someone self-identifies that way.

Questioning is the process of considering or exploring one's sexual orientation and/or gender identity.

Sexual Orientation is the scientifically accurate term for an individual's enduring physical, romantic and/or emotional attraction to members of the same and/or opposite sex, including lesbian, gay, bisexual, and heterosexual (straight) orientations. Avoid the offensive term "sexual preference," which is used to suggest that being gay or lesbian is voluntary and therefore "curable."

Transgender is an umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

Patient Surveys and Hospital Ratings

HCAHPS

According to the Centers for Medicare & Medicaid Services (cms.gov):

Overview: HCAHPS is the first national, standardized, publicly-reported survey of patients' perspectives of hospital care. The HCAHPS Survey (pronounced "H-caps") is a 29-item instrument and data collection methodology for measuring patients' perceptions of their hospital experience. HCAHPS allows valid comparisons to be made across hospitals -- locally, regionally and nationally. The survey was nationally implemented in 2006 and public reporting of hospital scores began in 2008. Since 2012, HCAHPS scores have played a role in hospital payment through the Hospital Value-Based Purchasing program.

About the survey: The HCAHPS Survey captures the patient's experience of communication with doctors and nurses, responsiveness of hospital staff, communication about medicines, cleanliness and quietness of the hospital, discharge information, transition to post-hospital care and overall rating of the hospital. The survey is administered between 2 and 42 days after discharge to a random sample of adult patients. There are four approved modes of administration: Mail, Telephone, Mixed (mail with telephone follow-up), and Interactive Voice Response. Over 4,000 hospitals participate in HCAHPS and over 3.0 million patients complete the survey each year. The survey and its protocols for sampling, data collection and coding, and file submission can be found in the current HCAHPS Quality Assurance Guidelines, which is available on the official HCAHPS website, www.hcahpsonline.org.

Leapfrog Hospital Grades

The Leapfrog Hospital Survey is an annual voluntary survey in which Leapfrog asks hospitals to report quality and safety data and then publicly reports that information by hospital. The Leapfrog Hospital Safety

Grade is a letter grade Leapfrog bi-annually assigns to all general hospitals in the United States, whether they report to the Survey or not. If a hospital does not report to the Survey, the Safety Grade uses publicly available data from numerous secondary sources. The majority of data used to calculate the Safety Grade comes from the Centers for Medicare and Medicaid Services.

As of print, RMC has a B rating and HPW has an A.

SECTION IV: Workplace Violence Prevention & Security

Capital Health is committed to providing a safe working environment for all employees and has zero tolerance towards violence of any kind. Violence in any form, including physical assault, verbal threats, and other forms of intimidation, from anyone, including but not limited to a patient, visitor, vendor, physician, or another employee is not tolerated.

All incidents of violence are reported to the Security Department. These reports are forwarded to the Workplace Violence Prevention Team.

Serious incidents are referred to the Security Management Team of the Environment of Care Committee for review and action.

Capital Health takes violence prevention very seriously and uses a broader definition of workplace violence than the New Jersey state law.

Objectives:

- References to Capital Health's policies that are relevant to Workplace Violence Prevention
- Techniques to de-escalate and minimize violent behavior including restraining techniques
- Appropriate responses to Workplace Violence
- Reporting requirements
- Location and operation of safety devices

Employees are empowered to report to their supervisor any location or job activity that they think may pose a risk for violence.

Reporting Incidents

Capital Health requires **you** to report ANY incident of violent behavior or potential risk of violent behavior in the workplace as soon as possible to your supervisor and to the Security Department. The report is to be made whether the person involved is an employee, member of the medical staff, patient, or visitor.

According to the NJ "Violence Prevention in Health Care Facilities Act":

"Violence" or "violent act" means any physical assault, or any physical or credible verbal threat of assault or harm against a healthcare worker. (NJRS 26:2H-5.19)
"Health care worker" means an individual who is employed by a covered healthcare facility.
"Covered healthcare facility" is a general or special hospital.

Workplace Violence incidents or threats of violence should be reported to the Security Department and through the safety reporting system.

Every employee of Capital Health has the responsibility to report incidents through the safety reporting system. Capital Health promotes a non-punitive just culture and promotes reporting of incident and safety related concerns.

The person completing the report of an event should be the individual who witnessed, first discovered, or is most familiar with the event.

> Ignoring violent incidents will not make them go away.
>
> Reporting incidents allows us to take corrective action so Capital Health can protect its employees.
>
> Capital Health will not take any retaliatory action against a healthcare worker for reporting a violent incident.

A safety report shall be reported as soon as the factual information is available to the reporter in a timely manner.

Employee Actions

Anytime there is a threat of serious bodily harm or serious assault, any employee should contact the local police department through the Capital Health switchboard at extension 8888 or obtain an outside line and call 911. Give the Operator your location and details of the situation.

Safety Devices

Video systems monitor many public areas inside the buildings and many of the parking lots and approaches to the buildings.

Panic Buttons are located in some departments (check with your supervisor for details on your department). Activation of a Panic Button will bring an immediate security response. Screening Center personnel also respond on the RMC campus.

Portable Panic Buttons are issued to staff working in the Mental Health Units.

The Mental Health Unit, Screening Center, Pediatrics, and Maternity Units are always LOCKED.

When patients who have been victims of violent crimes are present, many patient care units will be LOCKED and visitors are restricted. (For further information, refer to the Hopewell and/or RMC Visitor Policy.)

All employees must wear an ID when on campus. In addition to ID cards identifying you as an employee, they are used to gain access to the many areas controlled by electric locks and card readers. (For more information, refer to the Hopewell and/or RMC Employee Identification Cards and Access Control System Policy.)

Annual Risk Assessments

Capital Health is committed to maintaining a SAFE environment for our employees. Workplace Violence risk Assessments of each hospital campus are done annually and are available upon request. Capital Health also has a Workplace Violence Prevention Plan for each hospital campus.

Violent Patients

In order to warn our employees of a potentially violent patient at Capital Health, patients who have a history of violence have their name highlighted in RED in the Clinical Information System. Here is the procedure for highlighting the name of a violent patient:

"When a patient demonstrates disruptive behaviors that are violent or assaultive in nature, the patient will be identified in the clinical information system to alert staff of potential behavioral problems. A licensed healthcare provider enters the patient's name, accesses patient indicators and selects the appropriate indicator that causes the indicator to appear in red letters. The first two indicators listed below will pull forward for each visit until removed by two healthcare providers."

For additional information, please refer to the Care of the Disruptive/Potentially Violent In-Patient policy.

At Capital Health, almost all Workplace Violence or potentially violent situation involved either patients or visitors. However, Workplace Violence can also involve one or more employees.

WARNING SIGNS that someone may become violent:

Red or White – faced
Sweating
Pacing, restless, or repetitive movements
Violating your personal space (they get too close)
Scowling, sneering or use of abusive language
Exaggerated or violent gestures
Trembling or shaking
Clenched jaws or fists
Change in voice
Loud talking or chanting
Glaring or avoiding eye contact
Shallow, rapid breathing

Other Warning Signs:

History of violence

Fascination with weapons, acts of violence or both
Demonstrated violence towards inanimate objects
Evidence of earlier violent behavior

Threatening behavior

States intention to hurt someone (verbal or written)
Holds grudges
Excessive behavior (e.g. phone calls, gift giving)
Escalating threats that appear well planned
Preoccupation with violence

Intimidating behavior

Argumentative
Displays unwarranted anger
Uncooperative, impulsive, easily frustrated
Challenges peers and authority figures

Increase in personal stress

An unreciprocated romantic obsession
Serious family or financial problems
Recent job loss

Negative personality characteristics

Suspicious of others

Believes they are entitled to something
Cannot take criticism
Feels victimized
Shows a lack of concern for the safety or well-being of others
Blames others for their problems or mistakes
Low Self-esteem

Marked changes in mood or behavior

Extreme or bizarre behavior
Irrational beliefs and ideas
Marked decline in work performance
Appears depressed or expresses hopelessness or heightened anxiety

Socially isolated

History of negative interpersonal relationships
Few family or friends
See the company as a "family"
Has an obsessive involvement with their job
Abuses drugs or alcohol

Warning Signs, Employees or Patients

Crying, sulking or temper tantrums
Excessive absenteeism or lateness
Disregard for the health and safety of others
Disrespect for authority
Increased mistakes or errors, unsatisfactory work quality
Refusal to acknowledge job performance problems
Faulty decision making
Testing the limits to see what they can get away with
Swearing or emotional language
Overreacting to criticism
Making inappropriate statements
Inability to focus
Blaming others for mistakes
Complaints of unfair treatment
Talking about the same problems repeatedly without resolving them
Insistence that they are always right
Misinterpretation of communications from supervisors or co-workers
Social isolation
Personal hygiene is poor or ignored
Sudden and/or unpredictable change in energy level
Complaints of unusual and/or non-specific illnesses
Forgetfulness, confusion or distraction

What You Should Do

Put the behaviors in context
Look for multiple warning signs

Look for signs of escalation (the behaviors are getting worse)
If it is an employee, notify your supervisor and/or the Human Resources Department
If it is a patient, notify your supervisor and the Security Department

Restraints

When a patient must be restrained for their own safety or the safety of the staff, the procedures listed in the Use of Restraints Policy must be followed. The purpose of using restraints is to provide safe management of the patient when less restrictive interventions have been unsuccessful. Capital Health does not permit the use of restraints for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.

It is the philosophy of Capital Health to prevent, reduce, and strive to eliminate the use of restraints.

Administrative Restraints

Capital Health recognizes that law enforcement officers, corrections officers, and forensic officers may use administrative restraints (handcuffs/shackles) on patients who are in their custody. These officers may use the restraints to maintain custody and control of these patients or to provide for the patient's own safety and the safety of others.

Unless medically contraindicated, the officer/guard may handcuff or shackle the patient by using the least restrictive means necessary to maintain the safety of the patient and others. Patients are restrained in a comfortable, natural position. Capital Health personnel do not apply or remove administrative restraints.

The security of patients who are in the custody of law enforcement officers, corrections officers, or forensic officers is the responsibility of those officers. The officer(s) remain in the patient's presence maintaining custody and control of the patient at all times. In the event the use of restraints may result in death or imminent harm to the patient, the restraints are removed immediately.

Safety Enhancement Training

Safety Enhancement Training is an educational event that will increase confidence and ability to intervene in a verbal de-escalation or hands on situation. It will provide development of safe workable skills to use in a crisis. The program emphasizes that physical interventions are only as a last resort. Students are taught that staff and client safety are equally important; to be sure to stay alert; have an exit; keep at a safe distance; have back up support; and to utilize common sense.

The course is required annually and recommended for all Capital Health Security Officers, Psychiatric Screening Center staff, Mental Health Unit personnel, Emergency Department staff and some other Nursing Unit staff receive training in Safety Enhancement Training techniques. There are variations of the course for everyone. Contact Department of Clinical Education for more information.

Response to Workplace Violence

Initial De-Escalation

1. Recognize Signs of Escalation: Changes in Speech; changes in Affect; changes in Behaviors
2. Be a Solid Object: Calm; Attentive, Firm; Non-Threatening
3. Share Concerns about what is Observed
4. Offer Reasonable Options
5. Give Simple Choices
6. Position Self with Adequate Distance
7. Position Self with a Safe Exit

Note: If the Workplace Violence is with a Co-Worker Steps 1-3 are utilized and 6-7 if necessary.

Secondary De-Escalation Involving a Co-Worker

Set Limits
Contact Supervisor
Contact Human Resources

Secondary De-Escalation Involving a Patient

Set Limits
Call Security – Security Alert
Use Restraints/Medication (Restraints are used only as a means of providing protection and safety for the patient, others and property when alternative methods of control are not appropriate or effective.)

If you are the victim of Workplace Violence

If an employee is injured as the result of a workplace violence event, they should follow the steps on the Workers' Compensation and Return-to Work Program.

Post Incident Crisis Response Team

After an incident of Workplace Violence occurs, employees have the following programs available to them:
The Screening Center available 24 hours a day for traumatic incidents.
The Screening Center can also provide follow-up counseling after the incident.
The Employee Assistance Program (Carebridge) is available for affected employees.

Carebridge CORPORATION

Firearms and Weapons

Policy: Prohibiting Firearms and Weapons on CHS Property, (13072449), EC:0045
As CHS is committed to providing a safe and secure environment for the entire CHS community, restrictions on the ability to carry Firearms or Weapons, concealed or otherwise, on CHS Property (as defined within the

policy) have been developed and will be implemented in order to optimize the safety, security and wellbeing of CHS patients, employees and visitors.

Weapons detection and amnesty boxes are at the main entrances of both campuses. Additionally, all location have increased signage pertaining to our intention to keep our community safe.

Security Department

Capital Health and the Security Department, run by Allied Universal, are committed to a safe work environment. A comprehensive Risk Assessment is performed annually at Capital Health. As part of the assessment, the Security Department looks at the following items and facts: facilities layout; crime rate in the surrounding areas; impact on staff of acts of workplace violence; review of records relating to violent incidents access restrictions (doors, exits, etc.); lighting, communication and alarm devices; and presence of individuals who may pose a risk of violence.

The Security Department is responsible for:

- Creating and maintaining identification badges and access permissions.
- Enforcing all restrictions on visitors or patients involved in violent incidents.
- Informing all security personnel when an employee provides a Domestic Violence Restraining Order or a Victim/Witness Protective Order.
- Providing staff members with escorts to parking areas in the evening or late hours.
- Monitoring lighting in parking areas, cameras and check panic alarms working conditions monthly.
- The Workplace Violence Prevention Plan, which consists of:
    - All lots are well lighted and monitored by cameras and security patrol.
    - Call boxes with blue lights installed at the front and rear of the RMC parking lots. An immediate response from the security officer is received by pushing the button.
    - Visitors' passes are color coded by day of the week.
    - All patients (in and outpatients) are issued wristbands.
    - All employees and medical staff are required to wear their badges at all times.
    - Security officers are available 24/7.
    - Security officers respond to all Security Alert calls.

Contact the Security Department if law enforcement assistance is needed for non- emergency situations. When there is a threat of serious bodily harm or a serious assault call the operator:

- 8888 at HPW or RMC,
- 55207 at CHET, and
- 911 all other locations

Report ANY incident of violent behavior in the workplace to your supervisor and to Security. The incident is documented in the Safety Reporting System when required by the Safety Reporting policy.

In the event of an incident of workplace violence at an Off-Campus location, the following notifications should be made:

Contact the local police, by placing a non-emergency or 911 emergency call.

Contact the Capital Health Security Department at the Hopewell Campus.

References:

Security Department
Policy Workplace Violence, (10726166), ADM:EC:0002
Policy Visitor Policy, (10726385), ADM:EC:0003
Policy Employee Identification Cards and Access Control System, (12164972), ADM:EC:0004
Policy Safety Reporting System, (10820615), ADM:PI:0002
Policy Disruptive / Potentially Violent Inpatient, Care of the, (10916782), ADM:TX:0001
Policy Administrative Restraints, (10754398), ADM:TX:0012
Policy Security Alert – Security Assistance, (10755361), ADM:TX:0013
Policy Patient Restraints, (12966459), EMS 3.14
Policy Restraints, Use of, (11610299), PC:R:9

SECTION V: Care Management and Social Work

Policy: Care Management Department, (11751625), CM:001

The Care Management Department provides care management, care transitions, social work services, and discharge planning utilizing a collaborative, integrated, multidisciplinary team approach.

Clinical caregivers need to be able to:

- Identify signs and behavioral indicators which may be found in victims of alleged or suspected abuse or neglect.
- Discuss the procedures to follow when abuse or neglect is alleged or suspected.

Five Types of Abuse and Neglect

Policy: Abuse, Neglect and Human Trafficking: Identifying, Managing, and Reporting (All Ages), (10820806), PE:0002

It is the policy of Capital Health that all personnel are prepared to identify and assist victims of abuse, neglect, and/or human trafficking of all ages. Any employee who has reasonable cause to suspect any type of abuse as defined below shall report the information to the appropriate regulatory agency, as mandated and guided by the applicable laws.

Identify the type of abuse or neglect, based on the following criteria:

Physical Abuse

Physical Signs

- Unexplained bruises, welts, burns, fractures, lacerations, or abrasions
- History of the injury is incompatible with the injury seen

Behavioral Signs

- Wary of contact with others
- Frightened of caretakers or family members
- Afraid to go home
- Reports of injury by others
- Extremes in behaviors such as being aggressive, withdrawn, or suicidal

Special Considerations

Child:

- Wary of adult contact
- Frightened of parents
- Reports injury inflicted by parents
- Apprehensive when other children cry
- Positive material/infant drug screen

Adult Woman:

- Fear of personal or children's safety
- Abuse may escalate during pregnancy
- Partner does not leave woman alone during hospital visit
- Isolated from family and friends, limited support system
- Exhibits secretive, worried affect

Physical Neglect

Physical Signs

- Consistent hunger
- Poor hygiene
- Inappropriate attire

Special Considerations

Children may:

- Arrive early or stay late at school

- Lack of supervision
- Constant fatigue or listlessness
- Unattended physical problems or medical needs
- Abandonment
- Malnutrition

Behavioral Signs
- Begging or stealing food
- Alcohol or drug abuse
- Delinquency
- Overtired
- May report neglect
- Fall asleep constantly in class
- Exhibit juvenile delinquency
- State there is no caregiver at home
- Have flat affect, limited interaction with others
- Homelessness

Elder patients may exhibit:
- Bedsores/decubitus ulcers
- Dehydration
- Neglected toileting
- Homelessness

Emotional and Mental Abuse

Physical Signs
- Impaired sense of self worth
- Delayed physical, emotional, or intellectual development
- Failure to thrive
- Habit disorders
- Conduct disorders
- Neurotic traits

Behavioral Signs
- Overly adaptive behavior such as inappropriately adult or infantile behavior
- Extremes in behavior such as overly aggressive or passive
- Attempted suicide
- Developmental delays

Special Considerations

Child:
- Overly friendly with strangers
- Passive behavior and/or withdrawn
- Exhibits developmental delay
- Limited interaction with others
- Too adult or too infantile in behavior
- Failure to thrive

Elder:
- Concerns/lack of knowledge about personal finances
- Afraid of requesting basic necessities from caregiver (for fear of repercussions)
- Reports threats/withholding of care by caregiver

Sexual Abuse/Rape

Physical Signs
- Difficulty in walking or sitting
- Torn, stained, or bloody underwear
- Pain or itching in the genital area
- Bruising or bleeding in the genital area
- Sexually transmitted diseases
- Pregnancy
- Foreign objects in the genital area
- Any forced act of sexual behavior which can range from fondling to intercourse

Behavioral Signs
- Withdrawn

Special Considerations

Child:
- Unwilling to change clothes or participate in gym class
- Exhibits withdrawal, fantasy, or infantile behavior
- Delinquent or run-away behavior
- Reports any sexual behavior, with an adult
- Exhibits unusual or sophisticated knowledge about sex
- Venereal diseases

Elder:

- Fantasy or infantile behavior
- Unusual sexual behavior or knowledge
- Poor peer relations
- Delinquent
- Runaway
- Reports of sexual abuse
- Venereal diseases
- Withdrawal
- Guilt/shame

Domestic Abuse/Violence

Physical Signs
- Physical signs
- Injuries inconsistent with history
- Assault/battering
- Sexual assault/criminal sexual contact
- Criminal trespass/criminal restraint
- Kidnapping/false imprisonment

Behavioral Signs
- Threats
- Harassment
- Emotional abuse
- Stalking
- Lewdness

This violence may be committed by a:
- Spouse, former spouse, or any other person who is a present or former household member.
- Person with whom the victim has a child in common.
- Person who the victim alleges is the parent of the unborn child.
- Person with whom the victim has a dating relationship.

Special Considerations
- Physical abuse, in our society is thought of **only** as women being victims of abuse and men as the aggressors in physical abuse. This is not true. Men as well as woman are assaulted by wives, girlfriends, and significant others.
- Many men do not report abuse because they do not want it to reflect on their masculinity.
- Alcohol and/or drug usage by victim or abuser can be a contributor to increased incidence of domestic abuse/violence.
- Abusive relationships can be difficult to leave. Some examples are:
  - Fear; Finances; Feeling of failure; Promises of change; Religious beliefs

If any of the five types of abuse or neglect is suspected or substantiated, take the following actions:

1. Avoid extensive questioning or interviewing of the victim without the assistance of qualified personnel as described in steps 2-6 below.

2. Contact a physician or other healthcare professional to examine the suspected victim and record the observations in the medical record.

3. During working hours, contact the Care Management and Social Work Department through the hospital operator to have a social worker interview the alleged victim, report to appropriate agencies as indicated, provide resources, and discuss safety plan.

If social worker is not available after hours, contact the Administrative Coordinator for assistance and report your case to the Care Management and Social Work Department through the hospital operator and leave a message requesting follow-up.

Any person having reasonable cause to believe a child has been abused or neglected has a legal responsibility to report it to the Division of Child Protection and Permanency. 1-800-THE-KIDS (843-5437)

4. If there is a risk of further abuse by the parents or caregiver to discharge the child with them, then invoke a protective custody hold. Child Protection and Permanency (CP&P) can also request the protective custody hold.

5. If abuse is suspected or substantiated to someone over age 18, obtain patient's verbal permission to call the authorities. **Do Not Call if the victim objects and has capacity to make the objection**. Call Adult Protective Services at (609) 989-4346 during working hours and the police, 911, after working hours.

6. If domestic violence is suspected or substantiated, give the victim the phone number for Womanspace. **Call only if the victim requests that the agency be called** at 609-394-9000 for placement in the shelter for counseling. The hotline number is 1-800-572-7233. At this time the shelter only houses women, but will find a suitable location for men.
   Men and women may call the Counseling and Support Office, a Division of Womanspace, at (609) 394-2532.
   Call the police ONLY if the victim wishes to press charges. Make referral to Social Work.

7. When reporting an incident of suspected abuse or neglect, obtain the following demographic information:
   Victim's name and address
   Phone number
   Date of birth
   Person responsible for the care of the victim, if applicable, such as in the case of a child or the elderly
   Names and dates of birth for any other potential victims (children or frail elderly) in the home
   The nature and extent of the victim's condition
   Any other relevant information

When making a phone call to a regulatory agency, make the call in a private area to maintain patient confidentiality.

8. If evidence needs to be obtained:
   a. If feasible, place any evidence such as written material, objects, clothing, contraband, or weapons in a Patient Property envelope (or a paper bag if objects are too large), and seal or tape it closed.
   b. Handle lab specimens and any other evidence in accordance with the "Chain of Custody for Medical Legal Specimens/Evidence" policy #10820649 (ADM:PE:0007).

c. Call Security Department to assist in securing and taking possession of any potential evidence of abuse/neglect.
d. Allow the Security Department or police officials (with proper identification) if involved, to take possession of any potential evidence of abuse/neglect.
e. For photographic evidence – handle in accordance with the "Abuse and Neglect: Identifying, Managing, and Reporting" policy #10820806 (ADM:PE:0002).

9. If a weapon is involved, call Security Department for assistance.

In the case of sexual abuse/rape, Refer to the Sexual Abuse/Assault Flow Chart attached to the above referenced policy.
Victims are referred to: Womanspace at 1860 Brunswick Avenue, Lawrenceville, NJ 08648
Phone: (609) 394-2532. www.Womanspace.org
24-Hour Crisis and Information Hotline (609) 394-9000

10. In the case of emotional or mental abuse:
Contact a psychiatrist on-call or the Crisis Center at **609-396-HELP (4357)** if needed.

Documentation

1. Document the following in the medical record:
   a. Assessment of abuse/neglect.
   b. Information given by the victim or others.
   c. Verbal consent obtained from the victim. If the victim is under 18 or unable to give consent, this consent is not needed to contact an agency to report abuse.
   d. Actions taken.
   e. Information provided to authorities and community agency personnel.

2. If applicable, place in the medical record the "Chain of Custody" documents if any specimens/material are obtained from the patient.

Human Trafficking

Policy: Abuse, Neglect and Human Trafficking: Identifying, Managing, and Reporting (All Ages), (10820806), PE:0002

In 2000, the U.S. Congress passed the "Trafficking Victim's Protection Act or TVPA." The law defines human trafficking as a crime including the mistreatment of someone for the purposes of labor or a commercial sex act through the use of force, fraud or coercion. It is not necessary to demonstrate force, fraud or coercion in sex trafficking cases involving children under age 18. The International Labor Organization estimated that in 2012, 18.7 million people are exploited internationally. Within the United States approximately 50,000 women and children are trafficked each year. Victims are often forced through physical violence to engage in sex acts or perform slavery-like labor. Top venues for sex trafficking include: illicit massage businesses, hotels/motels, residence-based, online ads, escort services. Top

National Human Trafficking Resource Center
1-888-373-7888.
It is confidential and toll free. The NHTRC is a national 24-hour anti-trafficking hotline
www.TraffickingResourceCenter.org.
1-888-373-7888

industries for labor trafficking includes: domestic work, agriculture, traveling sales crews, restaurant/food service and construction. Trafficking exposes victims to serious health risks. Women and children are exposed to sexually transmitted diseases, physical trauma and mental abuse. Studies have shown that the healthcare system is often one of the most frequently accessed services used by human trafficking victims. In one study, 87% of trafficking survivors reported accessing healthcare service and of this group 68% were seen in the emergency department.

New Jersey has been called a "hub for human trafficking" because of its accessibility to Interstate 95, its central location within the northeast corridor, its closeness to tourist destinations like Atlantic City, New York City and it is a major national and international transportation center.

On May 6, 2013, NJ passed the "Human Trafficking Prev ention and Protection Act" which directs the Department of Health to establish standards identifying the healthcare facility employees who are required as a condition of their employment, to receive training. Workers who have direct contact and/or interaction with facility patients and/or visitors of facility patients receive training regardless of whether or not the contact or interaction is clinical or non-clinical in nature.

<u>Healthcare workers are in a position to identify and help victims of human trafficking.</u>

Here are the **N**ational **H**uman **T**rafficking **R**esource **C**enter recommendations for victim-centered interactions:

- Meet their basic needs- *Food, Water, Shelter first*
- Reassure the Potential Victim- *You are there to help, not punish or judge them*
- Build Trust and Rapport- *Be non-judgmental and re-affirm the victim's strengths*
- Be Conscious of Language- *Ask open-ended questions*
- Avoid Re-Traumatization- *Recognize the symptoms of trauma and coping mechanisms*

Victims of trafficking will have many service needs for housing, clothing, food, medical care, social services, legal aid and protection. Coordinating care will help ensure that victims get the help they need. If you believe the patient with whom you are working with may be a victim of trafficking, it can be useful to give them the National Human Trafficking Resource Center Hotline number. Medical providers should abide by HIPAA or confidentiality restrictions.

SECTION VI: Patient Rights

Policy: Patient Rights, (10855262), ADM:RI:0006

Patient Rights are posted in each patient room and includes:

All Patients are entitled to the following:

Medical Care

- Receive an explanation of their medical condition including treatment, expected results, risks and alternatives. If information may be detrimental to the patient's health or beyond their ability to understand, the explanation is given to the next of kin or guardian.
- Give informed consent prior to specified, non-emergent medical procedures or treatments.
- Receive information regarding policies and procedures related to life-saving methods and the use or withdrawal of life-support.
- Refuse treatment and is informed of the medical consequences of refusal.
- Give informed consent to participate in experimental research.
- Private duty nurses: the hospital provides a list of local nursing agencies.
- Receive appropriate assessment and treatment for pain.

Transfers

- Be transferred to another facility if Capital Health System, Inc. (Capital) is unable to provide the appropriate level of care or if the transfer is requested by the patient or their legal representative.
- Be informed of the reason for transfer including alternatives, verification of acceptance from the receiving facility, and assurance that the move will not worsen their medical condition.

Communication and Information

- Be treated with courtesy, consideration and respect for their dignity and individuality.
- Know the names and functions of all members of healthcare professionals directly caring for them.
- Be provided with a medical interpreter.
- Be informed of the names, titles, and duties of other healthcare professionals and educational institutions that participate in their treatment. Patient has the right to refuse to allow their participation.
- Be advised of the rules regarding the conduct of patients and visitors.
- Receive a summary of patient rights including contact information for the patient advocate.

Medical Records

- Have access to their medical records.
- Obtain a copy of medical records at a reasonable fee within 30 days after submitting a written request.

Cost of Hospital Care

- Receive a copy of the hospital charges, an itemized bill, if requested, and an explanation.
- Appeal any charges and receive an explanation of the appeals process.
- Obtain the hospital's help in securing public assistance and private healthcare benefits.

Discharge Planning

- Be informed about need for follow-up care and receive assistance in obtaining that care.

- Receive sufficient time before discharge to arrange for follow-up care.
- Be informed about the discharge appeal process.

Privacy and Confidentiality

- Be provided with physical privacy.
- Confidentiality: medical and financial records shall not be released without the patient's approval.
- Be provided with individual storage space for private use.

Freedom from Abuse and Restraints

- Be free from physical and mental abuse.
- Be free from restraints or when indicated, ordered by a physician for a limited time to protect patient or the safety of others.

Civil Rights

- Receive treatment and medical services without discrimination.
- Exercise their constitutional rights.

Questions, Complaints and Appeals

- Ask questions or file grievances and receive a response within a reasonable period.
- Be provided with contact information for the New Jersey Department of Health and Senior Services unit that handles questions and complaints.

Patient's Responsibilities:

To Act in Accordance with Hospital Regulations:
Not to Smoke, observe visiting hours, pay bills promptly, update hospital records.

To Comply with Instructions:
Follow treatment plan and notify hospital personnel if diagnosis, treatment is not understood.

To Seek Further Information and Guidance:
Guidelines are recommendations to foster a spirit of mutual trust, cooperation, and respect.

Patient Safety Reporting System

Background

- **2004- NJ Patient Safety Act** P.L.2004, c.009 (S557 SCS 1R) (nj.gov) was signed into law. The statue is designed to improve patient safety in hospitals and other healthcare facilities.

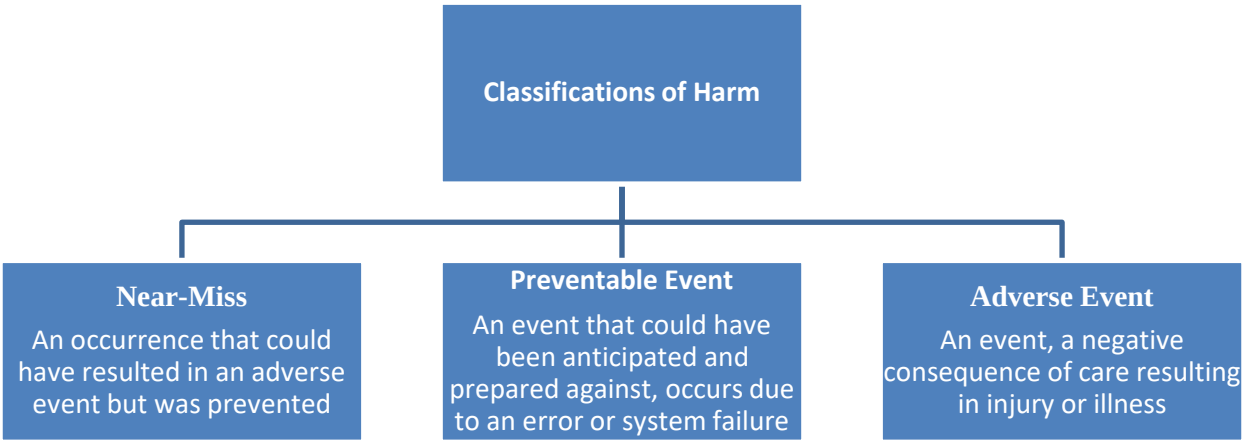
- **The Act established a serious preventable adverse (SPAE) reporting system including:**
  - Mandatory Reporting
  - Voluntary Reporting

A **serious adverse event** is an adverse event that is a preventable event and results in death or loss of body part, or disability or loss of bodily function lasting more than seven days or still present at discharge from a healthcare facility.

Patients' must be informed if a new allergy is discovered

How to Identify and Classify Harm

Each of the following indicate an event or potential event and requires reporting of the situation in an appropriate manner.



Mandatory Reporting a Safety Event or Near Miss at Capital Health

Capital Health established an environment to encourage disclosure of the most serious, preventable adverse events, and also encourages the voluntary, anonymous and confidential disclosure of less serious adverse events, as well as preventable events and near misses,

Action/Platform	What to report?	How to Access	When
Verge- Safety Reporting System	• Near Miss • Adverse Events • Preventable Events	Capitalink>>Online Applications>>Safety Events	As close to the event as possible
Call Quality & Safety Dept		Quality & Safety 801-6081	As close to the event as possible
Call your Supervisor		Internal phone system or smartphone	As close to the event as possible

Voluntary Reporting

The Patient Safety Voluntary Anonymous System allows employees and professionals working at a health care facility to submit voluntary anonymous reports to the Department regarding preventable adverse events that resulted in injury to a ***specific patient***.

Department of Health | Health Care Quality Assessment | Voluntary Anonymous Reporting System (nj.gov)

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) requires employers to reasonably accommodate qualified individuals with disabilities. It is the policy of Capital Health to comply with all Federal and State laws concerning the employment of persons and patients with disabilities. Commonly found communication disabilities are hearing, vision, and language barriers. Capital Health provides communication aids and services to assist with these disabilities.

Some of these services are:

- ✓ Video Remote ASL interpreters
- ✓ NJ Division of the Deaf and Hard of Hearing Interpreter Service
- ✓ Telephone Amplifiers
- ✓ Visual Fire/Smoke Detectors
- ✓ Closed Caption Television
- ✓ Braille/Large Number Phones
- ✓ Communication Boards in Spanish and English
- ✓ Medical Interpreter Phone Line
- ✓ Illuminated Doorknockers

Communication Aids for the Deaf and Hard of Hearing

Policy: Communication Aids for the Deaf and Hard of Hearing, (12634130), ADM:RI:0023

Deaf and Hard of Hearing (DHOH) patients and those individuals involved in the patient's treatment decision-making process are provided with auxiliary aids and services to ensure equal access to care.
Notice to Deaf and Hard of Hearing signs are posted in areas capable of being seen by the public. (Available in English and Spanish when indicated.)

Auxiliary Aids/Equipment (Available at switchboards):

- Video Remote Interpreting (VRI) - Stored at Nursing Administration Office. It is only used when patient consents
- Video Remote Interpreting (VRI) iPads - Available at Emergency Department and some Units
- Baby Cry Signaler - Available at Switchboard
- Telephone Amplifier - Available at Switchboard
- Door Knock Lights - Available at Switchboard
- Visual Smoke Detector
- Closed Caption Television - Available in patient rooms

When assistive device is needed, staff notifies the Security Department and Security delivers the communication device to the requesting area.
The location of equipment (requesting area) is documented on the Equipment Control Log.
Following terminal cleaning of devices, staff is responsible to notify Security to return and log in the equipment in their storing site.

Documentation Tools:
All forms are kept as part of the patient's medical record. To order, contact Storeroom or Print Shop:

- ***Request for Equipment and/or Sign Language Interpreter*** CI9203.02 (110364)
- ***Sign Language Interpreter Documentation*** CI9203.01 (110363)

- ***Refusal of Sign Language Interpreter Services*** CI9203.03 (110365)
- ***Business Associate Agreement*** document is signed by all non-CH qualified interpreters prior to interpretation. To obtain a copy, contact Corporate Compliance office at (609) 394-6105 on regular hours and Administrative Director after hours.

Capital Health Protocol:

- When in contact with a Deaf and Hard of Hearing patient, hospital staff is responsible for asking the patient, which form of communication and what type of auxiliary aids and/or equipment they need. At this time, **"*Request for Equipment and/or Sign Language Interpreter*"** form is completed.
- If the patient requests the services of an interpreter, the hospital staff promptly makes efforts to obtain a qualified interpreter and documents attempts and the name of the interpreter, what was interpreted, etc. utilizing the ***"Sing Language Interpreter Documentation"*** form.
- When hospital staff become aware of the need for a qualified sign language interpreter in advance of a scheduled appointment/admission, the staff contacts an interpreter and schedules the patient's appointment in coordination with the availability of the qualified interpreter.
- When there has been no advance notice of the need of a qualified interpreter and the patient needs an interpreter, hospital staff reschedules the appointment until such time that the services of a qualified interpreter can be obtained.
- If the DHOH patient refuses the services of a qualified sign language interpreter, then they are requested to sign the ***"Refusal of Sign Language Interpreter Services"*** form.
- In an emergency, in which the best interests of the patient preclude waiting for a qualified sign language interpreter, staff may use whatever means necessary to communicate with the patient, including but not limited to video remote interpreting, written notes, charts, diagrams, non-verbal gestures, lip reading and sign language or oral interpretation by staff employees or others who have such skills.

To obtain the services of a qualified sign language interpreter:
Unit/Department providing the services is responsible to contact and reimburse the interpreter.

Hospital staff:

- Call New Jersey Division of the Deaf and Hard of Hearing (NJDDHH) at 1-800-792-8339, or find an interpreter from the NJDDHH Directory of Sign Language Interpreters (Available on CapitaLink, under Quick Links, click Language Bank)
- Call ASL Interpreter Referral Services, Inc. Hotline: 1-800-275-7551 (Services are available 24/7)
  Provide:
  - ✓ Your name and telephone number
  - ✓ Nature an d anticipated duration of services
  - ✓ Date and time you need the interpreter
  - ✓ Name and address of location where the services is to be rendered
  - ✓ Type of sign language used by the patient (ASL, cued language, etc.)

Psychiatric Services staff utilizes "ACCESS" services:
A grant-funded program through the NJ Division of Mental Health Services

- Call (973) 754-5590 or (973)754-5595 during regular hours
- Call (973) 345-7357 after regular hours

If ACCESS Program is not available, follow the procedure for Hospital staff.

Advance Directives

Policy: Advance Directive, (12595733), PC:A:2

The provisions of the law are designed to:

- Provide to all adult patients written information about their rights under state law to make healthcare decisions; including the right to accept or refuse treatment and the right to execute advance directives. (All patients are asked if they have an Advance Directive upon admission to the hospital.)
- Inform patients about Capital Health's policy on implementation of advance directives.
- Document in the patient's medical record whether the patient has signed an advance directive. A copy is to be put on the chart. You must follow-up with the patient/family until their advance directive is on the chart.
- Ensure a hospital does **NOT** discriminate against an individual based on whether they have an advance directive.
- Ensure compliance with advance directives, consistent with the law.
- Provide staff and community education on advance directives.
- Please note: Conflicts between the patient/Health Care Representative and/or family members and/or physician(s) that cannot be resolved between the parties will be referred to the Administrator on Duty, who will when appropriate, consult with the Chief Medical Officer and/or General Counsel. If conflict cannot be resolved the Bioethics Committee will be convened. Treatment cannot be forgone unless there has been resolution of all conflicts.
- Ensure a copy of the advance directive for a patient transferred to another facility is sent.

Two types of Advance Directives:

1. Living Will – written instructions stating the patient's wishes regarding healthcare.
2. Durable Power of Attorney for Healthcare - a written directive in which the patient selects another person to make health care decisions.

Advance Directives only become effective when a physician(s) indicates the patient lacks capacity or has become terminally ill or is in a persistent vegetative state and is incapable of making treatment decisions. All decisions are documented in the medical record.

POLST – Practitioner Orders for Life-Sustaining Treatment

Policy: Code Status and Appropriateness of Care, (11439097), ADM:RI:0009

What is the POLST form?

POLST is a set of medical orders that help give seriously ill or frail elderly patients more control over their end-of-life care. POLST is printed on a green form and signed by both the doctor/advanced practice nurse and patient or healthcare representative. POLST specifies the types of medical treatments that the patient wishes to receive toward the end of life. POLST can help to prevent unwanted or medically ineffective treatment, reduce patient and family suffering, and help ensure that patient's wishes are honored.

Additional considerations for advanced clinical and clinical employees:

- **POLST** is appropriate for patients such as:
  - Terminal illness with limited life expectancy
  - Long term care residents with limited life expectancy
  - Frail elderly with progressive illness entering last phase of life

- **POLST** is filled out by the provider and patient. Patients without decision-making capacity can have the POLST completed by the provider and surrogate decision-maker.
- **NJ POLST** is on brightly colored green paper. Faxes and copies are accepted.
- **POLST** is voluntary. NJ law requires that medical orders contained in a POLST be followed by healthcare providers.
- The **POLST** is portable from one healthcare setting to another.
- The **POLST** complements, but does not replace, Advance Directives.
- Documentation on the **POLST** includes:
    - Goals of care for the patient
    - Preferences regarding cardiopulmonary resuscitation attempts
    - Preferences regarding use of intubation and mechanical ventilation for respiratory failure
    - Preferences for artificially administered nutrition and hydration
    - Other specific preferences regarding medical interventions that are desired or declined
- The Provider should review the **POLST** with the patient and/or surrogate decision maker any time there is a change in the patient's condition and/or when patient changes from one level of care to another (e.g. arrives at ED, admitted to hospital, transfer from ICU to medical floor, receiving homecare services, etc.)
- The **POLST** belongs to the patient. The patient should always have the original **POLST** form with them. The **POLST** form never expires. Always follow the most recent **POLST** form if patient presents with more than one form.

Nurse's Responsibility:

- Review the general hospital consent form for the presence of an advance directive or POLST upon each admission for accuracy.
- The Advance Directive or POLST must be on the chart. Complete and place Advance Directive stick on the front of the patient chart.
- If the Advance Directive cannot be located, a new one must be written.
- If the patient does not have an Advance Directive and would like information, call Social Service, a Patient Advocate, or an Administrative Coordinator.
    - Copies of Living Will and Health Care Proxy forms are available on CapitaLink (Guest Relations Page) and in the Patient & Visitors' Guide.
    - Durable Power of Attorney for Health Care forms have to be obtained through an outside service. Please contact Social Services / Care Management with any questions.
- A physician order is required for a patient to be a "No Code". The following represents a "No Code": Purple wristband placed on the patient and notification on the Kardex.
- If the patients POLST states they do not want any life sustaining treatment done, "No Code"; the physicians must fill out the purple code status form.

- A physician or other health care professional, for personal convictions, may decline to carry out requested forgoing of life sustaining treatments, but must, in such cases, arrange for appropriate and timely transfer of the patient's care. If you have questions or concerns about physicians not complying with advance directives or POLST, talk with your Nurse Manager or Patient Representative.
- Ethical concerns should be reported to your *manager* and the *palliative care team* first. Once assessed, the Hospital Ethics Committee may be brought in at that time.

The POLST form complements an Advance Directive and is not intended to replace that document. If it is determined that the patient has an Advance Directive or POLST form, obtain a copy for the medical record and notify the attending physician.

End of Life – Care and Considerations

Policy: End-of-Life Care Process for Withdrawing Artificial Life Support, (10915855), RI:0029

End of Life Care and Patient Rights:
A patient has the right to consent to, or refuse consent to any medical treatment, including the withholding or withdrawal of life-sustaining measures including, but not limited to cardiopulmonary resuscitation (CPR). Information for patients/families regarding health care decision making is provided by Capital Health.

Palliative Care is for patients with serious and life-threatening conditions and focuses on symptom relief. It can be initiated at any time during the illness and uses many disciplines to provide comfort. Palliative care supports family through complex decision making.

Hospice is usually for patients who have 6 months or less to live and can be provided in the home, facilities, or hospitals. It supports families through the dying process.

Why Palliative Care?
- People are living longer with chronic and advanced illnesses
- People face a complex and fragmented medical system
- People struggle to coordinate care among their doctors who have limited time
- People need help making decisions and communicating with all providers
- People need help maximizing their independence by receiving symptom control

SECTION VII: Information Technology

Cyber Security

Policy: Overall Security Policy, (12371754), IM:039

For Capital Health employees, it is essential that all sensitive data, both paper and electronic are protected from cyber and in-person threats. According to Forbes, your credit card number is worth about 25 cents, but an electronic health record (EHR) is worth anywhere from $100- $1000 depending on the detail of the record. The average healthcare cost of a lost record during a breach is $1411 per record according to a 2017 IBM data breach study.

Sensitive data: The table below defines the different ways we work with sensitive data and what steps to take to protect the data. It is every employee's responsibility to protect and safeguard their own information.

Encryption

Encryption is the method by which plaintext or any other type of data is converted from a readable form to an encoded version that can only be decoded by another entity if they have access to a decryption key. Encryption is one of the most important methods for providing data security.

Mobile Devices must be encrypted	Includes these devices: Laptops, CDs, USB "thumb drives"
Electronic Communication must be encrypted	Text messages and e-mail
Personal Computers must be locked if unattended	How to lock your PC: Hit Ctrl+Alt+Delete at the same time and Select Lock computer  OR Shortcut: Choose the Windows Key+L
User Logins and passwords should never be shared or placed on a post it notes on your computer screen. Passwords should be a combination of letters, numbers, and a combination of case. Pass phrases work well "August 29, 1983" instead of Name0883	 You are responsible for any use done on your account, whether your account has been shared knowingly or unknowingly.
Paper records are just as valuable to a criminal as digital records. All documents that would have adverse effects on your department are to be protected.	• Turning over paper records on your desk is not an effective method for securing paper records. • Always question unknown visitors vendors or patients in authorized areas. • Always be suspicious to an extent. Don't always believe someone is who they say they are until you're able to verify their identity.

Cyber Security Threats

Here are the different types of threats to data:

Malware

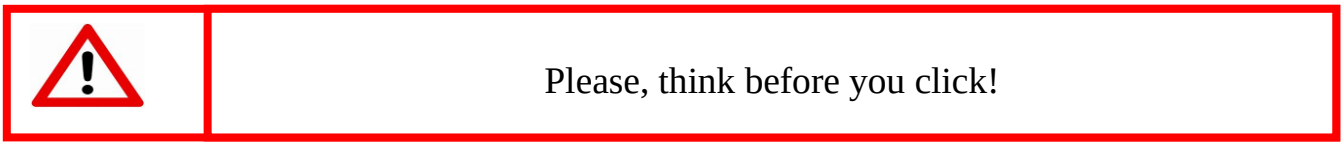
Term used to describe all types of threats such as Trojans, Viruses and worms. Ransomware is a type of malware that blocks access to a computer or its data and demands money to release it.

How does it work?

When a computer is infected, the ransomware typically contacts a central server for the information it needs to activate, and then begins encrypting files on the infected computer with that information. Once all the files are encrypted, it posts a message asking for payment to decrypt the files – and threatens to destroy the information if it doesn't get paid, often with a timer attached to ramp up the pressure.

How does it spread?

Most ransomware is spread hidden within Word documents, PDFs and other files normally sent via email, or through a secondary infection on computers already.



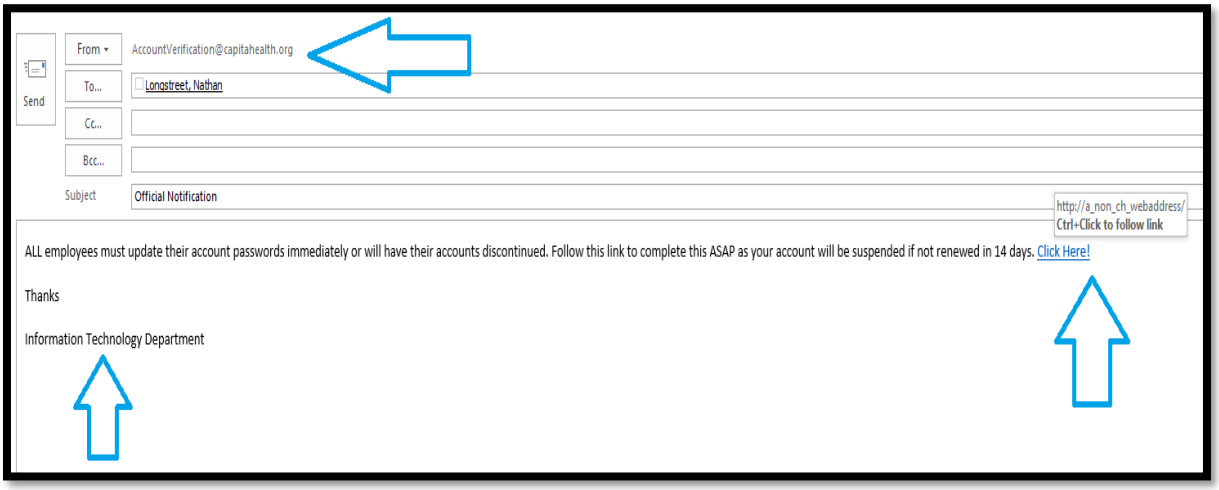
Phishing

The fraudulent practice of sending e-mails pretending to be reputable companies to reveal passwords or other sensitive information

Most Phishing e-mails will have 4 main components:

1. **False Credibility** – Will spoof some legitimate source such as banking or in the example below Capital Health E-Mail access.
2. **Call to Action** – Will ask you to click a link, respond with your password or in some way seek privileged information.
3. **Spoofed Web Address** – These can be hard to spot however hovering over a link will give you the true address. See the example. Note the example is pointing to a non-Capital Health owned webpage.
4. **False Urgency** – Will request the information right away because your account will expire or become unavailable.

Note the examples below. The web address is actually❶ AccountVerification@capitahealth.org and is missing the "L", The web address is a non CH owned address, and ❷the department name is incorrect.



Password attacks
A third part that is actively attempting to crack or guess your password

Denial of Service (DoD) attacks
An attack that's primary intent is disruption of network services by sending large volumes of traffic with the intention of overloading a network

Malvertising
A method to compromise your computer with malicious code by clicking on infected advertisements

Social Engineering

Social Engineering is a technique hackers and criminals use to trick users into revealing confidential information. This can be done via phone, email, or in person

- **Phone** - Callers attempt to spoof a legitimate employee or service seeking to gain information. This is usually referred to as Vishing. Any unauthorized requests to privileged information should be reported to Corporate Compliance. Either via their Capitalink departmental page or calling the office at 609-815-7494.

- **E-mail** – Attackers attempt to solicit personal information or account information by posing as a trustworthy source. Credit Card, Companies, charities, and financial institutions are the most common. This is commonly referred to as Phishing. Avoid any e-mail links or attachments from unknown individuals. If you are a victim of Phishing or a Cyber-Attack, call the Helpdesk X4343

- In person – Tailgating is one common form of an In-person attack. Someone who is seeking information will impersonate a delivery driver or other vendor to gain access to authorized areas for malicious purposes.

How You Can Help

- Learn How to Spot an attack. Some signs that you can use:
  - Refusal to give contact information
  - Rushing
  - Name-Dropping
  - Intimidation
  - Small mistakes such as misspellings or odd questions
  - Requesting forbidden information
- Passwords should be a combination of letters, numbers, and a combination of case. Pass phrases work well “August 29, 1983” instead of Name0883.
- Always be suspicious to an extent. Don’t always believe someone is who they say they are until you’re able to verify their identity.
- If you question the legitimacy of an email or any electronic form call the helpdesk at x4343 right away.
- If a message comes through you know is SPAM or phishing it can be forwarded to SPAM@capitalhealth.org

- Any unauthorized requests to privileged information should be reported to Corporate Compliance. Either via their Capitalink departmental page or calling the office at 609-815-7494.
- It is every employee’s responsibility to protect and safeguard their own information.
- If by chance you were a victim of a Cyber Attack such as a phishing email or a malware link, report the incident immediately! Call x4343 to report the incident.
- Avoid any e-mail links or attachments from unknown individuals
- Think before you click!

SECTION VIII: Infection Prevention

Policy: Infection Prevention Scope of Service, (10919195), SOS

For any Infection Prevention question, call the Operator and ask to be connect to Infection Prevention staff at 609-303-4277, 609-815-7678, 609 537-7462.

It is your responsibility to know and use infection control techniques to prevent the spread of infection.

Coronavirus – COVID-19

Important information about COVID-19 is found by using the COVID-19 Resources link in the left margin on CapiaLink (example below)

Masking and Eye Protection

- Staff must wear either a surgical mask or cloth mask at all times while in the facility. Staff is prohibited from wearing any type of mask with a valve.
- Eye protection must be worn at all times while taking care of patients**.**
- For general interactions with non-covid patients, a surgical mask is required (not just a cloth mask).
- Cloth face masks may be used for offices and in hallways where there is no patient interaction.
- COVID-19 patients are placed on Contact, Airborne and Eye protection signage posted outside the room.
- A N95 respirator or higher (example Elastomeric respirator with P100 filter) should be worn at all times while working with COVID-19 positive patients and those under investigation. Eye protection is also mandatory, the full face shield being the preferred type of eye protection.

N95 Respirators

- Many new different N95 respirators have become available, while others are now in short supply. Please make sure you know name and size of **at least two types** of N95 respirators which are a good fit for you and check with your manager to make sure we still have these respirators in stock.
- Fit testing for N95 respirators are done frequently and the schedule can be found on Capitalink
- Do not enter a COVID-19 room unless you have a reason to be there.
- Frequent hand washing/hand hygiene is essential and do not touch your face/eyes.

Self-Monitoring

All staff is required to perform a daily self-monitoring evaluation. **All employees should contact their manager if they have symptoms associated with COVID-19 or have been exposed to a person that is COVID positive. If you have any questions or concerns, please contact your manager, HR, or Infection Prevention.**

Hand Hygiene

Policy: Hand Hygiene, (10262652), IC 2.1

Washing your hands is one of the most important things you can do to provide safe care to your patients as well as to keep yourself safe. Healthcare providers might need to clean their hands as many as 100 times per 12-

hour shift depending on the number of patients and intensity of care. The number one way to prevent the transmission of healthcare-associated infections is by performing hand hygiene.

Your 5 Moments to perform Hand Hygiene are:

1. Before touching a patient
2. Before clean aseptic procedure
3. After body fluid exposure risk
4. After touching a patient
5. After touching items or surfaces in the immediate patient care environment, ***even if you didn't touch the patient***

Hand hygiene should also be practiced- ***Before and after wearing gloves***

If you notice that hand hygiene supplies such as alcohol gel, soap, batteries for dispenser, or paper towels, are empty:

<u>Call H.A.N.D. or ext.4263</u>
<u>at either campus</u>

Technique for Soap and Water

Washing your hands with soap and water:

1. Start by wetting your hands in water
2. Scrub your hands in the soap for ***15 seconds***
3. Scrub the backs of your hands and fingers, wrists, between fingers, under fingernails, and thumbs
4. Rinse your hands
5. Use a towel to dry
6. Turn the faucet off **with the towel.**

Use soap and water***, not hand gel,*** when caring for patients with C. difficile or anthrax spores, or if your hands are visibly soiled.

Washing hands properly makes a difference!

Technique for Alcohol Gel

1. Push the handle or hold hand under the hand sanitizer to dispense product
2. Rub the backs of your hands and fingers, wrists, between fingers, under fingernails, and thumbs
3. Repeat step number two until ***hands are dry.***

Using alcohol based hand rub is the *more effective* way to kill bacteria.

Hand Hygiene Surveillance

The SwipeSense electronic hand hygiene system has been installed at both campuses. It is a vital tool to reduce hospital-acquired infections and will help us in our goal of achieving Zero Preventable Harm. The system relies

on Communication Hubs and Location hubs to transmit data. Communication Hubs are located in centralized work areas such as nursing stations and offices. Location Hubs are located in each patient room or care area to capture hand hygiene data. They are pictured below to help you recognize them. **Please do not unplug any of these devices.** Contact Facilities if you need any assistance in managing the devices or require additional outlets installed in your area.

If you have more than 50 patient room entries per month, it is very important that you **consistently wear your SwipeSense badge**. Contact Infection Prevention if you have lost your badge or if you believe you meet the criteria for being issued a badge.

Bloodborne Pathogen Exposure Control Plan – tells you what to do in the case of an exposure. Located in the Infection Prevention Manual.

- Specifies measures that to take to minimize your risk of exposure.
- Identifies procedures to follow if there is an exposure incident.

Blood and Body Fluid Exposure

Wash or irrigate area immediately. Report ALL blood or body fluid exposures promptly to your manager and complete an Employee Accident Report. Report immediately to The Occupational Health Center for an evaluation or the emergency room after hours, holidays and weekends.

Post Exposure Incident Documentation

- Record circumstances surrounding incident
- Note personal protective equipment in use at time of incident
- Note actions taken:
  Decontamination/first aid
  Notification of Employee Health

Post Exposure Medical Evaluation

- Identify and test source patient, all patients upon registration have signed a consent which allows for testing in the event that a physician, employee, worker or student is accidently stuck with a needle or otherwise directly exposed to their blood.
- Baseline HIV testing of employee, if so desired:
  May have blood drawn and held for 90 days pending decision.

- Follow up HIV testing.
- Written findings/recommendations to employee.
- HIV Prophylaxis offered and best administered between 2 – 24 hours after exposure.

Should you have any questions or concerns, please contact your Department Manager, Employee Health, Occupational Health, or the Infection Prevention Department.

Standard Precautions

Policy: Standard and Transmission Based Precautions, (10313100), IC:2.3

Standard Precautions requires that you treat all blood and body fluids (i.e. semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pericardial fluid, amniotic fluid) as if they are infected with Hepatitis B, Hepatitis C or HIV regardless of the patient's diagnosis.

The most common bloodborne pathogen infections related to the exposure of blood or body fluid that you could be exposed to on the job are HBV (Hepatitis B Virus), HIV (Human Immunodeficiency Virus) and Hepatitis C.

Means of Transmission:

- Direct exposure to blood and/or body fluids
- Accidental injury by a contaminated sharp object
- Open cuts, nicks, and skin abrasions
- Indirectly by touching contaminated surfaces

1. **Engineering Controls** – These are physical/mechanical systems Capital Health provides to eliminate hazards at their source:
    - Self-sheathing needles and other safety sharp devices
    - Sharps disposal container
    - Needleless IV system
    - Disposable equipment

2. **Work Practice Controls** – These are specific procedures you must follow on the job to reduce your risk of exposure:
    - Handwashing
    - Use caution when handling contaminated sharps. All sharps are placed in puncture proof containers immediately after use.
    - No eating, drinking, or applying cosmetics (including lip balm) in any patient care area.
    - No bending, breaking, or re-capping of needles. Never place sharps in the trash.
    - Clean up blood spills promptly using the hospital disinfectant and proper use of personal protective equipment.

3. **Personal Protective Equipment (PPE) – PPE is NOT an option, all personnel must wear PPE whenever working with blood and body fluid.**
    - PPE is equipment that is provided by the hospital and protects you from contact with potentially infectious materials (gloves, gowns, masks, and eye protection).
    - The type of PPE appropriate for a given task depends on the degree of exposure that is anticipated.
    - You MUST use appropriate PPE each time you perform a task.
    - Regular eyeglasses are not considered personal protective equipment.

- Failure to follow the requirements of the PPE program can result in disciplinary action.

Gloves must be worn when:

- Examination of clients and other circumstances (i.e. Security Alert) when it is reasonably anticipated that hospital personnel will have contact with blood, body fluids, other potentially infectious materials, mucous membranes and non-intact skin and contaminated items or surfaces.
- Collection and/or handling of specimens containing blood or body fluids
- Cleaning of soiled instruments and surfaces
- Handling of soiled linen
- Handling of dirty equipment

Additional considerations for advanced clinical and clinical employees:

- Gloves must be worn for:
  - Blood draws
  - **Routine patient care (i.e., bed bath)**
  - Wound care
  - Patients with a rash
  - IV starts
- Eyewear and gloves: Pouring of body fluids into specimen containers or graduated measuring containers (i.e., emptying Foley bags, drains or hemovacs), suctioning.
- Protective gown and gloves must be worn when:
  - Changing of a dressing on a draining wound
  - Changing of excessive soiled linen
  - Splashing, spraying, splattering or droplets of blood or body fluids is possible
- Gloves, goggles, and masks, or face shields must be worn when:
  - Suctioning of an endotracheal tube or tracheostomy tube using an open suction set
  - Flushing of nasogastric, gastrostomy or drainage tubes.
  - Splashing, splattering or droplets of blood or body fluids is possible
  - Performing bronchoscope
  - Working with ET tubes
  - Working with a patient who has an open tracheostomy
- Gloves, gowns, goggles, and masks or face shields must be worn during:
  - Trauma
  - Wound irrigation
  - Central line insertions
  - Delivery of an infant

4. **Disinfection and Good Housekeeping -** Protects every healthcare worker and is EVERY employee's responsibility:

- Place contaminated sharps and infectious waste in designated containers.
- Place all soiled laundry in designated linen bags (non-leaking).

- Handle all linen with Standard Precautions – do not shake linens.
- Use approved hospital disinfectant to decontaminate environmental surfaces, and pay attention to dwell times on the product you are using.
- Use proper utilization of biohazard label.
- Clean, disinfect, or sterilize contaminated equipment according to the manufacturer's directions between uses and before sending equipment for repairs.

5. Hepatitis B Vaccine

- Is available FREE to all employees.
- Is administered by three injections over a six-month period through at The Occupational Health Center.
- Is 85% - 97% effective in protecting you from getting the disease or becoming a carrier for nine years or longer.
- If you decline, you must sign a statement. You can ALWAYS take it at a later date if desired.

6. Tetanus/Diphtheria and Pertussis Vaccine (TdaP)

- Is available FREE to all employees and may be obtained at The Occupational Health Center

7. Influenza Vaccine

Is available FREE to all employees and is mandatory each year (see also **Influenza Vaccine** under **Section II: General Employee Information**). Staff who are approved for an exemption, are required to wear a mask while providing direct patient care, offering a service to a patient, or when working in the patient's room during flu season from December 1st through to March 31st. Any flu season may be extended based upon surveillance from CDC, local or county boards of health and Infection Prevention Department.

8. COVID-19 Vaccine

Capital Health continues to administer COVID-19 vaccines to all employees. If you are interested in receiving one, you can book your appointment on the Employee Health page of CapitaLink. This information may change, so for the latest information please visit the COVID-19 section on CapitaLink. Visit the CDC website to learn more about how you can stay "up to date" with COVID-19 vaccinations.

9. Staff Vaccination to common Vaccine Preventable Communicable Diseases

It is in your best interest, and our patients' best interest, to keep your immunizations up to date. Also, if you are exposed to a communicable disease at work, and have elected NOT to obtain immunizations, you will be **furloughed without pay** during the period of communicability.

Take care of yourself – Keep your immunizations up to date!

Many vaccinations against communicable diseases are available free of charge at the Occupational Health Center. If you don't remember your immune status to mumps, measles, rubella and chickenpox (varicella), or you do not have the letter that was sent to your home address at time of hire, please contact The Occupational Health Center for more information.

Alone, none of these approaches are 100% effective.
They must be used together, to fight against infection.

Transmission-Based Precautions

Policy: Standard and Transmission Based Precautions, (10313100), IC:2.3

In addition to Standard Precautions that hospitals use for all patients and situations, patients with certain infections may need **additional infection control measures** to protect other patients, health care workers, and visitors.

Contact Precautions: Green Sign at both facilities

Use these precautions when caring for patients who are infected or colonized by a microorganism that spreads by direct contact (skin to skin) with patient or by indirect contact (touch) with a contaminated object (i.e. dressing, bed rail) in the infected patient's environment. Some of these infectious pathogens include C. difficile, vancomycin resistant enterococcus (VRE), methicillin resistant Staphylococcus aureus (MRSA), Scabies, Lice, Zoster and uncontrolled drainage not contained in a dressing.

Contact Precautions for C. Difficile diarrhea:

White Sign with a red stop sign at Hopewell, Deborah and CH East Trenton
Green Sign plus a red stop sign at RMC

If patient is on contact precautions for C. Difficile or Norovirus then this special signage is needed.

Hopewell:

Use the white **Enteric contact precaution** sign with a small "Stop sign." 

on it.

RMC:

Use **two** signs – Use the green contact precaution sign plus the larger red "Stop sign" which says "hand wash with soap and water". The large stop sign is **only** to be used for C. difficile rooms or norovirus.

All signage for both Hopewell and RMC serves as a reminder for these two items:

- Wash hands with soap and water when exiting the room.
  A "Wash Out" Stop Sign is placed above the Purell dispenser to remind staff to wash with soap and water on the way out.
- Bleach wipes should be used for both room cleaning and on any equipment that is removed from this room

Contact Isolation MUSTS:

1. Private Room – when a private room is not available, group with patient(s) who have active infection with the same microorganism but with no other infection.
2. Gloves – **MUST wear gloves upon entering room*** Change gloves after contact with infective material. Remove gloves before leaving the patient's room.
3. Wash hands – with soap and water or alcohol hand sanitizer immediately after glove removal and before leaving the patient's room.
4. Gown – **Gown is worn upon entering a room*** and prior to providing any patient care or coming into contact with patient's environment. Remove gown before leaving the room.
   - At RMC gloves and gowns are located in the isolation cart placed outside of room
   - At Hopewell gloves and gowns are located above the sink in patient's room

5. Transport – limit the movement/transport of patients from room to essential purposes only. During transport, ensure that all precautions are maintained at all times.
6. When possible, dedicate the use of non-critical patient-care equipment or disposable equipment to a single patient. If common equipment is used, clean and disinfect between patients.

Droplet Precautions:

Orange sign at RMC
Teal sign at Hopewell, Deborah and CH East Trenton

Apply these precautions when caring for patients whose infections are spread via large particle droplets. Diseases include rubella, mumps, influenza, and adenovirus. These large particles generally can only travel within a 3 foot radius from the patient.

Droplet Isolation MUSTS:

1. Private Room - When a private room is not available, group with patient(s) who has active infection with the same microorganism but with no other infection. Maintain spatial separation of at least 3 feet from other patients and visitors if grouping or private room is not available. Door may remain open.
2. Respiratory Protection – Standard surgical procedure mask with visor required when working within 3 feet of patient or when entering room.
3. Transport - Limit the movement/transport of patients from room to essential purposes only. During transport, place surgical mask on the patient, if possible.

Airborne Precautions:

Hot Pink Sign at RMC
Yellow sign at Hopewell, Deborah and CH East Trenton

These are used when caring for patients whose infections can be spread through the air, such as pulmonary tuberculosis (TB), measles (Rubeola), chicken pox (Varicella), Smallpox, COVID-19 (SARS-CoV-2) and disseminated shingles (Zoster). These pathogens, which can remain suspended in the air for long periods, are transmitted when a well individual inhales the small-contaminated airborne particles that are exhaled (via cough, sneeze, etc.) by the contagious patient.

Airborne Isolation MUSTS:

1. Private room with negative pressure ventilation – door is kept closed.
2. If negative pressure room is **not** available, obtain a portable HEPA filter machine from Central Supply – door is kept closed
3. Respiratory Protection - Wear an N95 particulate respirator mask when entering the room of patient with known or suspected AFB disease. Susceptible persons should not enter the room of patients with known or suspected measles (rubeola) or chicken pox (varicella) if immune caregivers are available.
4. Patient Transport - Limit the movement/transport of patients from room to essential purposes only. During transport outside of room, patient must wear a surgical mask to filter their expired contaminated air.
5. Limit visitation – offer visitors N95 masks upon entering the patient's room.

COVID-19 Precautions:

Hot Pink Sign at all hospital locations and satellite ED's.

Airborne, Contact and Eye protection are required for patients with confirmed or suspected COVID-19.
COVID-19 MUSTS:

1. Private room with negative pressure ventilation or room with HEPA filter.
2. If negative pressure room is **not** available, obtain a portable HEPA filter machine from Central Supply.
3. N95, elastomeric respirator with P100 filters, or PAPR is required for room entry.
4. Eye protection is required – full face shield is preferred form of eye protection
5. Gown and Gloves are required.
6. Hand hygiene can be with either soap and water or alcohol hand rub
7. Patient Transport - Limit the movement/transport of patients from room to essential purposes only. During transport outside of room, patient must wear a surgical mask to filter expired contaminated air.
8. No visitation without permission - offer visitors N95 masks upon entering the patient's room.

Protective Environment Precautions: Orange Sign Hopewell Campus

In addition to Standard Precautions, use Protective Environment Precautions when caring for patients admitted to the Capital Health Medical Center Hopewell Leukemia Program when ANC is below 1,000.

1. When ANC is below 1,000 in a leukemia patient:
   a. Enter "Protective" in the hospital's Clinical Information System (i.e., KEANE, TELETRACKING)
   b. Place portable HEPA filter in room (must be cleaned prior to placing in room)
   c. Place orange Protective Environment sign at door
2. **Strict hand hygiene MUST be adhered to by all staff, patients, and visitors**
3. The door to the room is to remain closed
4. Staff and visitors should wear surgical masks when entering room
5. No fresh, dried, or artificial flowers or plants in room
6. Visitors
   a. None under the age of 5 without special permission
   b. Free of obvious signs of illness (i.e., respiratory illness, diarrhea in past 48 hours, etc.)
7. **No** Pet Therapy; pet visitation as per policy
8. Patients should wear a surgical mask when leaving room

Packaged Items (sterile and nonsterile items)

1. Check sterile products for expiration dates prior to use, discard expired items.
2. Dispose of all sharps properly.
3. The sterility of items sterilized in house is determined by event rather than date and time.
4. All sterile items either sterilized in house, or purchased sterile, are considered sterile unless the package or container has been opened, is wet, damaged, or has been exposed to blood or body fluids. *Damage may include but is not limited to*:
   a. holes and/or tears in the wrapper or pouch
   b. broken seals of peel pouches or dust covers
   c. Securing tapes are missing or compromised container locks are missing/compromised
   d. item has been exposed to an unsafe environment or the package is wet
   e. package has been dropped

5. Return all in house sterilized items that need to be repackaged/re-sterilized to Central Supply/SPD.
6. Sterile items are stored in a clean, dry enclosed area where the package is positioned to prevent it from being crushed, bent, compressed or punctured.
7. All departments storing sterile supplies are responsible for monitoring the storage area on a monthly basis.

Tuberculosis Education

Policy: Tuberculosis Exposure Control Plan, (12549874), IC:4.1

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal.

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs (pulmonary TB). TB disease in the lungs may cause symptoms such as

- a bad cough that lasts 3 weeks or longer
- pain in the chest
- coughing up blood or sputum (phlegm from deep inside the lungs)

Other symptoms of TB disease are

- weakness or fatigue
- weight loss
- no appetite
- chills
- fever
- sweating at night

Symptoms of TB disease in other parts of the body depend on the area affected.
Generally, persons at high risk for developing TB disease fall into two categories:

1. Persons who have been recently infected with TB bacteria (close contact of a person with infectious TB, persons who have immigrated from areas of the world with high rates of TB)
2. Persons with medical conditions that weaken the immune system (HIV infection, substance abuse, diabetes, organ transplant)

Latent TB Infection

TB bacteria can live in the body without making you sick. This is called latent TB infection. Most people who breathe in TB bacteria and become infected, their body is able to fight the bacteria to stop it from growing.

People with latent TB infection:

- Have no symptoms
- Don't feel sick
- Can't spread TB bacteria to others
- Usually have a positive TB skin test reaction or positive TB blood test

- May develop TB disease if they do not receive treatment for latent TB infection

Many people who have latent TB infection never develop TB disease. In these people, the TB bacteria remain inactive for a lifetime without causing disease. But in other people, especially people who have a weak immune system, the bacteria become active, multiply, and cause TB disease.

Employees who have been diagnosed with latent TB and develop signs & symptoms of TB (as listed above) shall be screened/evaluated by The Occupational Health Center.

Health Care N95 Particulate Respirator and Surgical Mask – Fit Mask Testing

All N95 users must undergo a fit test. Fit testers measure the fit of various masks until you are able to PASS a test with a specific mask type and size. Each employee is responsible to know which mask they have been passed on, and to wear this mask type to minimize exposure to airborne particles.

System-wide announcements will alert employees of masks that become unavailable due to supply issues. If the mask that fits you becomes unavailable, you are responsible to undergo another fit test to be "passed" with a different mask type for your protection.

Please note that facial hair is incompatible with the wearing of a respirator. Therefore, if an individual's job category requires respirator use, the employee is to be free of facial hair. If an employee has facial hair and is unable to pass a fit test, they will use a Portable Air Powered Respirator (PAPR).

Description:
Latex free disposable half mask. Multiple brands in use:

Prestige Ameritech (ProGear) regular
Prestige Ameritech (ProGear) small
Multiple other N95 masks (e.g.: 3M N95 products, Venus 4400, etc.)
Reusable Half-face masks (elastomeric, with filters)

Indications:

a. As a respirator, it is intended to minimize exposure to airborne particles in a size range of 0.1 to >10.0 microns. The N95 meets CDC guidelines for TB exposure control. Used for airborne precautions.
b. As a surgical mask, it is resistant to splash of blood and other infectious materials.

Limitations:

a. Do not use in the event of immediate danger such as a fire.
b. Not for industrial use.
c. Not for use with beards or other facial hair that prevents direct contact between the face and edge of the respirator.

Instructions for Use:

a. Follow manufacturer specific guidelines for proper placement and removal.
b. Always check the respirator seal before each use.
c. The mask is used for the workday – use one separate mask per patient who requires airborne precautions.
d. The mask is not a threat to other patients or individuals.
e. The mask may be stored in a bag with your name on it and then discarded at the end of the workday. If the mask becomes wet or contaminated, discard and do not reuse.

f. If using an elastomeric respirator that has an exhalation valve which is not covered with a filter or plug, you must tape (surgical tape, duct tape) over the exhalation valve from the inside of the mask.

Fitting Instructions (Follow each time respirator is worn)

Fig. 1 Fig. 2 Fig. 3 Fig. 4

1. Cup the respirator in your hand, with the nosepiece at your fingertips, allowing the headbands to hang freely below your hand.
2. Position the respirator under your chin with the nosepiece up. Pull the top strap over your head resting it high at the top back of your head. Pull the bottom strap over your head and position it around the neck below the ears.
3. Place your fingertips from both hands at the top of the metal nosepiece. Using two hands, mold the nose area to the shape of your nose by pushing inward while moving your fingertips down both sides of the nosepiece.
   - Pinching the nosepiece using one hand may result in improper fit and less effective respirator performance. Use two hands!

4. Perform a User Seal Check prior to each wearing. To check the respirator-to-face seal, place both hands completely over the respirator and exhale. Be careful not to disturb the position of the respirator. If air leaks around nose, readjust the nosepiece as described in step 3. If air leaks at the respirator edges, work the straps back along the sides of your head.

   If you CANNOT achieve proper seal, DO NOT enter the isolation or treatment area.
   See your supervisor.

Removal Instructions

See step 2 of *Fitting Instructions* and cup respirator in hand to maintain position on face. Pull bottom strap over your head. Still holding respirator in position, pull top strap over your head and remove respirator.

Environment Risks

Shipping Containers and Tape

Policy: Storage of Items in their Original Shipping Containers; IP:2.13

1. Adhesive tape residue on walls, computers, fridges, anywhere, impedes cleaning. **Avoid** using tape to hang signs and **never** use tape to repair an item (remove it from service).
   - Alternatives to using tape include, "mounting putty", magnets, clear plastic holders.
   - All surfaces must be free from adhesive residue – **secure adhesive remover from storeroom and remove all sticky residue**.
2. Outside shipping containers and boxes
   - No **outside** shipping containers are allowed in patient care areas No cardboard boxes of any kind on floor of clean utility rooms

Ectoparasitic Infestation

Policy: Ectoparasitic Infestation (Bed Bugs, Lice, Maggots, Scabies), (12607635), IC:2.8

1. Patients suspected of having bed bugs are placed in a private room and put on Contact Precautions. The patient's belongings are double-bagged and sent home if possible.
2. If patient has to travel within the facility, the sending department must include the patient's isolation status and suspicion of bed bugs. The receiving department is responsible for ensuring that the patient does not exposure more areas than necessary and that the area is treated as soon as patient is returned to their unit.
3. Notify EVS/Housekeeping of patient's bed bug status. Once patient is discharged or transferred to another unit, housekeeping will clean and treat the room as per hospital protocol.

SECTION IX: Emergency Alerts and Codes

Policy: Quiet Hospital; (10726303), EC:0033

Capital Health uses an overhead paging system at the HPW and RMC campuses to alert about various situations or emergencies. Due to a Nationwide Standard, announcements use plain language terminology to assure that the appropriate message is understood. The only color code still used is "Code Blue", which is universally recognized as a respiratory or cardiac arrest in an adult patient. The following is the approved list for authorized emergency alerts:

- Code Clear
- Code PCI (Percutaneous Coronary Intervention)
- Facility Alert: Decontamination
- Facility Alert: Fire Alarm/Smoke Condition/Fire Condition
- Facility Alert: Hazmat
- Facility Alert: Specific System (phone, sewer, etc.)
- Medical Alert: Code Blue
- Medical Alert: Mass Patient Influx
- Medical Alert: Medical Emergency, Non-Patient
- Medical Alert: Pediatric Medical Emergency
- Medical Alert: Rapid Response Team
- Mobile Stroke Unit (MSU) Alert (Regional Medical Center)
- OB Alert: Childbirth
- OB Alert: Emergency Cesarean
- OB Alert: LDR Triage
- OB Alert: Shoulder
- Pre-Hospital Stroke Alert
- Security Alert: Active Assailant
- Security Alert: Child Abduction
- Security Alert: Hostage Situation
- Security Alert: Missing Adult
- Security Alert: Security Assistance
- Security Alert: Suspicious Item
- Stroke Alert
- Trauma Alert (Regional Medical Center)

Each alert type will be followed by the event type such as fire alarm, security assistance needed etc. After the alert type and event type, the location. Finally, any instructions relevant to the alert is provided.

EXAMPLES:

Alert Type	Event Type	Location/Instructions
Medical alert	medical emergency	non-patient in the cafeteria
Security alert	security assistance needed	main lobby
Facility alert	fire alarm	Pharmacy

To activate any of these alerts, dial 8888 from any HPW or RMC phone; 55207 at CH East Trenton; and tell the operator the nature and location of the emergency. If you have an emergency at any other CH site, call 911.

Please note: Alerts are subject to review and/or change. Additional information and education will be released at that time. Locations other than HPW and RMC will have location-specific education provided by the manager or educator of that site.

Alert Cleared – Termination of Called Code/Alert

(Event Type) Alert All Clear

The situation has been cleared.

Code Blue - Adult Medical Emergency

Policy: Emergency Medication and Equipment Exchange System Code Blue (Adult) Protocol; (10755267), ADM:TX:0014

- Establish unresponsiveness, shake the person and shout …Are you OK?
- If there is no response, you or someone else needs to dial 8888 on any in-house telephone (including patient's phone).
- Delegate someone to bring the Code Cart/ AED to the location.
- Begin CPR if you are certified. The operator will announce the code.
- It is very important that you remain calm. The appropriate personnel will respond and take over the code situation upon arrival.

Code PCI

Policy: Primary Coronary Intervention, (12204643), P:46

Stroke Alert

Policy: EMS – Stroke and Neurologic Emergencies, (12966348), CSP-11

A stroke occurs when blood flow in the brain slows down or stops. The symptoms relate to the area of the brain affected. Call a Stroke Alert to activate the Stroke Team for all patients (Emergency Department or In-patient) with signs and symptoms of stroke whose onset is within 24 hours.

For patients unable to provide this information or who awaken with stroke symptoms, the time of onset is defined as when the patient was last awake and symptom free or known to be "normal." This is necessary due to the immediate assessment needed to determine the patient's eligibility for thrombolytic therapy that will restore blood flow to the brain up to four and a half hours of first symptoms and/or to determine the patient's eligibility for advance therapy and procedures available for stroke patients.

Stroke is a serious medical emergency. Know these warning signs of stroke and teach them to others. Every second counts:

Sudden numbness or weakness of the face, arm or leg, especially on one side of the body

Sudden confusion, trouble speaking or understanding

Sudden trouble seeing in one or both eyes

Sudden trouble walking, dizziness, loss of balance or coordination

Sudden, severe headache with no known cause

IN THE EVENT OF A STROKE, REMEMBER:

BE-FAST!

B - Balance loss
E - Eyesight changes
F - Face drooping
A - Arm weakness
S - Speech difficulty
T - Time to call for help

Trauma Alert - RMC Only

Policy Reference: Trauma Activation Criteria, TR:T-3 III; Prehospital Alerting, CSP-10

The purpose of the Trauma Alert is to provide rapid and efficient resuscitation and stabilization to the injured patient. A trauma is considered any patient with serious physical injuries meeting the American College of Surgeons and Department of Health guidelines. When a trauma alert is activated, the operator will call the on-call Trauma Surgeon by phone then announce overhead "Trauma Alert, Emergency Department" or "Trauma Alert, Heliport."

Medical Alert – Mass Patient Influx

Policy: Medical Alert – Mass Patient Influx, (12298622)

Mass Casualty Incident

A situation where injuries or casualties overwhelm available emergency medical services, facilities, and resources.

What is a Disaster?

Any natural or man-made event that significantly disrupts the environment of care, such as damage to the organization's building(s) and grounds due to severe windstorms, tornadoes, hurricanes, or earthquakes. Also, an event that disrupts care and treatment, such as loss of utilities (power, water, telephones) due to floods, civil disturbances, accidents, or emergencies within the organization or in the surrounding community.

Types of Disasters:

External – require a hospital to admit and treat many casualties. This type of emergency doesn't damage the facility itself or threaten personnel.

Internal – cause or threaten to cause injury or damage to the hospital, its patients, and staff.

Purpose of the Disaster Plan:

To provide the framework for Capital Health to adjust to the situation of caring for a large number of victims. The four basic elements of the disaster plan are:

1) Coordinate all efforts through the use of communications and command systems.
2) Treat Patients – this includes procedures for triage and tagging victims and how to protect the safety of patients during an internal emergency.
3) Use available resources – this lists alternative sources of water and electricity.
4) Transport Casualties – the plan identifies other care sites and ways to evacuate patients.

Activation of Disaster Plan:

The emergency response plan is activated by the Administrator on Duty (AOD). In their absence, the Administrative Coordinator has the authority to notify the telecommunications operator. The operator will announce "Mass Patient Influx" Internal, if in-house or "Mass Patient Influx" External, when an influx of victims is expected to arrive in the Emergency Department.

General Responsibilities for All Departments:

When a Mass Patient Influx is called, all personnel are to report to the charge person of their area. The charge person is to account for all staff members.

All available personnel are to report to the **Staging Area** not to the site:

Staging Areas: Hopewell Campus – 1st floor Patient Access corridor between the ED and Lobby/ Atrium. Next to the gold elevators.
RMC – Main building front hallway ground/basement level. Hallway with purple elevators.

All personnel are to follow their unit specific emergency plan for an emergency response – located in the forward of their Emergency Management Response Manual. Unit telephone trees are kept in the same area and are to be current at all times.

When a Mass Patient Influx is called, the Emergency Operations Center (EOC) will open with administrative personnel who are trained in emergency management. The EOC will begin addressing the issues related to the event and will have assignments for employees that respond to the staging areas. An Emergency Operations Center will be created on each campus.

RMC in the 3FN Conference Room
Hopewell Campus in the 1st floor Administration Building, Nursing Office Conference Room.

The "System" command center will be located in the 1st Floor Administration Conference Room at the Hopewell Campus. Security will control access and egress procedures on both campuses.

Only essential telephone calls are to be made during a disaster. Personnel are to use stairs whenever possible.

All CH employees should update their emergency contact information for telephone tree with their manager on an annual basis or if changes occur.

Employees who may be impacted by an emergent requirement to remain on duty should have current arrangements in place for childcare, eldercare, and pet care needs. All employees who may not have current arrangement for these services and who may be required to remain on duty should contact Carebridge EAP to secure a listing of available resources in advance by calling the Carebridge EAP access number 1 -800-437-0911.

Staff responsibilities during Mass Patient Influx:

- Return to assigned department immediately
- Reassign patients and send staff and medical equipment to staging area
- Bring available stretchers and wheelchairs that may have been left in your department
- Review current patients to identify discharges or transfers
- Report discharges to EOC
- Check Capitalink and the Emergency Management Blog for EOC updates

Staff Responsibilities during a Facility or Weather related Emergency

- Plug equipment into red outlets
- Conserve linen supplies on unit
- Keep the Power Failure Phone (red phone) plugged in at all times
- Review how to use a walkie-talkie
- Review your Emergency Management Manual for your unit specific plan
- Check Capitalink and the Emergency Management Blog for EOC updates
- All personnel will remain on duty until all relief arrives
- Bring additional food and cell phone charger as well as any personal care items (including medications) that may be needed
- If your department is closed notify the switchboard and check with EOC for reassignment
- Outpatient areas should cancel cases if required

In the event of a Mass Patient Influx, the Emergency Management Team activates the following to communicate with employees:

- An emergency phone line with information: 1-877-247-2038 or 609-303-4284
- Emergency Management Blog is activated and emailed to all @capitalhealth.org email accounts and posted on Capitalink
- CH Website will be given to employees to access pertinent information
- Emergency Management Department website on CapitaLink
- Blast pager notification

Medical Alert - Rapid Response Team

Policy: Medical Alert – Rapid Response Team, (10755308), ADM:TX:0008

The Rapid Response Team (RRT) provides critical care expertise to the patient's bedside or wherever it is needed 24 hours a day, 7 days a week. The team is comprised of a Licensed Respiratory Care provider, a physician (house physician, hospitalist, or resident), a registered nurse from the ICU/CCU, ED, and/or a telemetry nurse. The patient's primary care nurse remains at the bedside to facilitate communication, provide the patient's history, and describe the symptoms leading up the event. The role of the Rapid Response Team is to immediately intervene, assess, stabilize, facilitate communication, and assist with a potential transfer to a higher level of care when indicated. The RRT fosters collaboration between units through assessment, communication, support, and education.

Guidelines for calling the RRT include acute change in:

- Blood pressure, systolic less than 90 or greater than 200 mmHg
- Heart rate less than 40 or greater than 130 beats/minute
- Respiratory rate less than 6 or greater than 30/minute
- Pulse oximetry less than 90%
- Temperature less than 95 or greater than 104 degrees F.
- Acute change in mental status
- Signs and symptoms of stroke
- Urine output less than 50 ml for 4 hours
- If the patient or family strongly feels that there is a change in the patient's condition
- Chest Pain/Discomfort
- + SIRS and is in need of Sepsis screening by an LIP

Medical Alert – Medical Emergency Non-Patient

Policy: Medical Alert – Medical Emergency / Non-Patient, (11492812), ADM:EC:0037

The purpose of this Alert is to provide care during medical emergencies occurring within 250 yards of the main hospital building, or on Capital Health Property that is contiguous to the main hospital (Hopewell Medical Office Building (MOB) and Central Utility Plant (CUP)). Any staff member or employee upon finding someone, on Capital Health property contiguous to the main hospital building or within 250 yards of the main hospital building who requests examination or treatment for a medical condition, or has such a request made on their behalf, or if a prudent layperson observer would believe, based on the individuals appearance or behavior that the individual needs examination or treatment for a medical condition immediately calls for help by doing the following:

Hopewell Campus and RMC Campus

- The staff person will call for help by calling the operator by dialing 8888 on any in-house hospital phone, or via Capital Health portable radio or uses the Emergency Call Boxes. The staff person clearly states "Medical Alert" and gives the location of the patient. Do not leave the sick or injured person.
- The operator announces a "Medical Alert" including the location. A security officer is dispatched to the location.
- An Emergency Department (ED) RN, a Critical Care Technician (CCT) and Security respond to outside locations if it is within close proximity to the ED and if the area is deemed safe, and the weather conditions would not inhibit the provision of medical care.

- If the patient is not in the immediate vicinity of the Emergency Department (ED), the operator calls 911 for Emergency Medical Service (EMS) ambulance.
- An Emergency Department (ED) RN, a Critical Care Technician (CCT) and Security respond to all medical emergencies in the MOB and CUP.
- The patient will be transported to the ED for a medical screening and any necessary treatment.

Capital Health Emergency Services at Deborah (SED)

- The Northern entrance lobby, the South and South East Emergency Department parking lots, parking lot adjacent to Trenton Road, SED waiting room and entrance hallway adjacent to the SED waiting room, ambulance bay, or any contiguous space within a close proximity of the SED.
- Capital Health employees do no leave the sick or injured person.
- Capital Health staff stays with the person and provides treatment within their capabilities until transportation is arranged.

- Transportation is either coordinated by calling 911, or when Capital Health staff have the ability to do so based on location of the person, and/or other factors like time of day, weather and other factors that impact the ability to respond and transport.
- Capital Health employees alert Deborah Heart and Lung Security to the location of all Medical Alert – Medical Emergency – Non-Patient situations.

Medical Alert – Pediatric Medical Emergency

Policy: Medical Alert – Pediatric Medical Emergency, (10755353), ADM:TX:0025

- Establish unresponsiveness; ask them…Are you OK?
- If age appropriate, visualize if child is breathing and/or conscious.
- If there is no response, you or someone else needs to dial 8888 on any in-house telephone (including patient's phone).
- Delegate someone to bring the Code Cart/ AED to the location.
- Begin CPR if you have attended a training session.
- It is very important that you remain calm. Do not panic! The appropriate personnel will respond ASAP and will take over upon arrival.

OB Alert – Childbirth

Policy: OB Alert – Childbirth Management of Extramural Births, (11438860), ADM:TX:0019

The purpose of an Emergency Childbirth alert is to provide medical care when a birth occurs outside Labor and Delivery. In the event that a pregnant patient/visitor/community member either is going to imminently deliver or has delivered outside of Labor and Delivery an "Emergency Childbirth" is activated by calling 8888 from any in-house phone and provide the location. An Obstetrical LIP and Labor nurse attend and care for the mother. If the mother has not delivered, the OB LIP determines where the delivery will occur. The staff in the pediatric ED prepares the infant warmer and mobilizes the infant transport crib to the area. A neonatologist, NICU nurse and licensed respiratory therapist attend and care for the newborn. The neonatologist determines the level of care required. Separation of mother and baby is limited to medical reasons only.

If the code occurs at RMC, the operator notifies the HPW operator, who announces "Emergency Childbirth at RMC" The appropriate staff are alerted and preparations are made according to above referenced policy.

Security Alerts

Security Alert – Missing Adult

Policy: Security Alert – Missing Adult / Patient at Risk for Wandering, (10726616), ADM:EC:0039

The purpose of this code is to initiate a campus wide search for a missing adult patient who is incapable of adequately protecting themselves and is found to be missing from their room.

Patients with dementia, cognitive impairment, suicidal patients, patients with Alzheimer's disease or who are under the influence of alcohol or drugs (including prescribed drugs) are identified as risk for wandering. This includes patients that are involuntarily committed and are admitted to adult acute care beds. This policy does not pertain to patients admitted to the locked psychiatric unit.

People who have been identified are at risk for wandering away from the safety of the care setting and becoming lost in the community. There is no predictable action that a person with dementia will take after becoming lost. The patient may hide and will probably not respond to calling out. It is imperative that all areas are searched moving equipment as needed.

Hospital Staff

Upon hearing the overhead page for a Code Find, hospital staff immediately responds to the exit assigned to their department (same exit assignments as for a Security Alert – Infant/Child Abduction)

If after 10 minutes, the patient is not located, the nurse manager or designee instruction the Operator to announce a second Security Alert – Missing Adult/Child.

- During non-business hours, staff members from the nearby departments cover the exits the closed departments are assigned to cover.
- Exits are manned by assigned staff until the Security Alert is cancelled or there is confirmation from the Emergency Operations Center (EOC) that security is monitoring the exit with cameras
- If the patient is located, they are escorted back to the unit or to the Emergency Department if the patient is located outside of the hospital.
- Once the patient's identification is confirmed, the Operator is called and the Security Alert is cancelled.

Security

- Upon hearing Security Alert overhead, the Command Post (CP) Security Officer transmits Security Alert and the description of the patient over the Security radio.
- The CP immediately brings up the exit doors on the monitors and scans for the patient
- The security shift supervisor assigns an officer to patrol the outside of the building
- The security shift supervisor responds to the unit from which the patient is missing to obtain firsthand information on the patient.

Security Alert – Missing or Abducted Infant/Child

Policy: Security Alert – Missing or Abducted Infant/Child, (10726256), ADM:EC:0036

A child abduction can occur anywhere not just in facilities with Maternity or Pediatric Units.

Profile of a "typical" abductor

- Woman of childbearing age (teens to 50s)
- Often overweight
- Lives in the community where the abduction takes place
- Asks questions about hospital procedures
- Recently lost a pregnancy or cannot have children
- Dresses like a healthcare worker to gain access to the hospital and patients

What is Security Alert – Child Abduction?

- It signals a potential or confirmed newborn, infant, or child abduction

ALL SECURITY ALERT – MISSING OR ABDUCTED INFANT/CHILD NEED TO TREATED AS REAL, NOT DRILLS.

Who is protected by an electronic protection system?

- Every non-NICU baby
- NICU babies who are in an open crib
- Every child under the age of 18 years admitted to Pediatrics

Who is protected by a double-bracelet system (newborn/infant/child and parent/guardian)?

- All inpatient and outpatient newborns/infants/children under the age of 18

What is your responsibility as an employee when you hear that Security Alert-Child Abduction has been called?

- Representatives from each department need to go to the exit points from their department (stairwells, lobby areas, etc.) and look for *"suspicious"* activity.

What kinds of people/activities are considered "suspicious"?

- Anyone carrying a newborn (hospitalized newborns are always transported in cribs or isolettes)
- Anyone with an infant or child who is struggling or crying
- Anyone carrying/cradling a tote bag or duffle bag (baby could be inside) or wearing an oversized coat
- Anyone whose behavior gets your attention
- Anyone who asks questions about the layout of the hospital (Where is the nursery? I just want to go and see the babies.)
- Anyone with a newborn/infant/child who does not wear a bracelet that matches the one that the newborn/infant/child wears

Individuals without a specific reason to be in the Maternity, NICU, or Pediatrics Units are not permitted to enter those units.
*****This includes non-Maternal Child Health Capital Health staff members. *****

How should you respond if you see someone/something suspicious?

- ***STAY CALM!*** Do not call attention to yourself or put yourself at risk.
- **Remember—the safety of the newborn/infant/child is our top priority.**
- Ask to inspect the inside of the person's coat or tote bag if indicated.
- Memorize as detailed a description of the person(s) as possible.
- Notify (or have someone else) the switchboard at ext. **8888 at HPW or RMC, or 55207 at CH East Trenton**
- **Offsite locations** call 911 and report the incident.
- Follow the person(s) at a safe distance as long as you can.

Security Alert – Suspicious Item

Policy: Capital Health Suspicious Item Plan, (12384651)

All threats must be taken seriously.

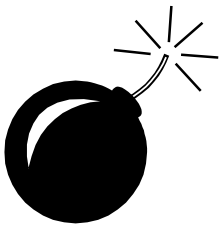
Receipt of Call

Although the telecommunications operator stands the best chance of receiving a bomb threat call, anyone at Capital Health can receive a bomb threat call.

- Remain calm.
- Listen for any sounds that could indicate where the caller is located.
- Use the Bomb Threat Phone Call Form and ask the questions listed on the form; found in the Emergency Management Response Manual.

Things to ask:
When is the bomb going to explode?
Where is the bomb right now?
What kind of bomb is it?
What does it look like?
Why did you place the bomb?

- Try to keep the caller on the phone for as long as possible.



Notifications

- Have someone dial 8888 from any in-house phone
- Notify your immediate supervisor
- Use the Bomb Threat Phone Call Form
- Report suspicious items to Security

General Information

When a "**Security Alert – Suspicious Item**" is announced **for a specific area or building**, workers in that area are to pay particular attention to objects that are new, strange, or unfamiliar. Receiving areas, unlocked offices, etc., need particular attention. When a "Security Alert – Suspicious Item" is announced **for a non-specific area**, all workers will check their areas for new, strange, or unfamiliar objects.

Portable hand-held radios and cellular telephones may be used except in certain prohibited areas. The regular hospital telephones may be used.

Discovering a Bomb

If anyone discovers what appears to be a suspicious device or package - **Do not touch it!** Notify Security immediately and move away from the item. Security will notify the police.

If a decision to evacuate a campus is made, all visitors will be asked to leave the facility by an overhead announcement "We are having a drill, all visitors please leave the building."

Remain on duty unless directed to vacate the building.

Termination of "Security Alert – Suspicious Item"

Announcement will be "Security Alert – Suspicious Item …Alert Cleared."

Security Alert – Security Assistance

Policy: Security Alert – Security Assistance, (10755361), ADM:TX:0013

If there is a disturbance in your area:

- Any type of escalating disturbance - verbal, emotional, belligerent, or physical, needs to be reported immediately.
- Dial 8888 from any in-house phone and state, "We have a Security Alert-Security Assistance Needed in the _____ unit or _____ area."
- Calling this code will bring members "STAT" from Security, Nursing Administration, and Crisis **(RMC)**.
- **At sites away from the main campuses**, get an outside line and call 911.

Tips

- Do not try to subdue the individual yourself.
- Attempt to verbally de-escalate the situation.
- Protect yourself, other staff members, patients, and visitors.
- Try to keep the individual calm and under observation until help arrives.
- Maintain as much distance between the individual and others as possible.
- If patient attempts physical assault, remove yourself from the situation.

Security Alert – Hostage Situation

Policy: Hostage Situation, (10726419), ADM:EC:0023

- At the **RMC and Hopewell** campuses call for assistance by dialing 8888 from any in-house phone; at locations away from the main campuses, get an outside line and call 911.
- Leave the area and assist others out of the area.
- When it is a *contained* Hostage Situation, secure the area pending the arrival of security/police.

- DO NOT enter the area or allow others to enter. Refer to the above referenced policy on Capitalink for further details.

Security Alert – Active Assailant

Policy: Security Alert – Active Assailant, (10726654), ADM:EC:0022

- At the **RMC and Hopewell** campuses call for assistance by dialing 8888 from any in-house phone; at locations away from the main campuses, get an outside line and call 911.
- Leave the area and assist others out of the area, if it is safe to do so.
- When it is an Active Assailant Situation (someone moving from place to place randomly shooting people) – vacate the area and the surrounding areas move to a secure location.
- DO NOT enter the area or allow others to enter. Refer to the above referenced policy on Capitalink for further details.

STAFF SHOULD NOT ENTER AN AREA TO PROVIDE MEDICAL CARE WHERE AN ACTIVE SHOOTER MAY BE PRESENT UNTIL THE AREA IS DECLARED SAFE BY LAW ENFORCEMENT PERSONNEL TO ENTER.

Facility Alerts

Facility Alert – (Specific system)

Policy: Facility Alert – Utility Service Interruptions, (12080924)

1. At the direction of the Administrator on Duty (AOD) or their designee, the operators shall announce Facility Alert followed by one or more of the following as dictated by the scenario:

    - Facility Alert - Electrical
    - Facility Alert - Elevator
    - Facility Alert - Generator Power Transfer
    - Facility Alert - HVAC (Heating, Ventilation, Air Conditioning)
    - Facility Alert - Information Systems
    - Facility Alert - Internal Flood
    - Facility Alert - Medical Gases / Vacuum
    - Facility Alert - Phone
    - Facility Alert - Steam
    - Facility Alert - Water

    Once a Facility Alert is called:

2. The Administrative Nursing Coordinator will coordinate the following:

- Report to the Emergency Operations Center (EOC)
- Ensure the fax machine is set up to receive reports from the units

3. Units shall fax the Facilities Assessment Form (Located in the Tab 3, Appendix 1 section of the Emergency Management Response Manual or Capitalink at http://chsworld/resources.cfm?deptid=106&cat=1. Follow the recommendations in the Unit Specific Quick Reference Guide to Disaster Response, located at the front of the Emergency Management Response Manual.)
4. Representatives from the affected service shall report to the EOC.
5. Units will follow this guide until the EOC declares "Facility Alert All Clear."

Facility Alert – Fire Alarm or Smoke Condition or Fire Condition

Throughout the hospital, campuses there are fire alarm pull stations and fire extinguishers. Learn the locations of the equipment that is near your workstation. Employees should report every fire or smoke condition. There are two ways to report a fire or smoke condition: From a hospital campus phone dial 8888 and tell the Operator the exact location of the fire or activate the nearest Fire Alarm Pull Station. Even if you have reported the fire to the Operator, you should still pull the nearest Fire Alarm since that will close the smoke doors. Initiate the R.A.C.E procedure. If the fire or smoke condition is not readily apparent stay at the fire alarm pull station to direct arriving responders.

On the **RMC** Campus when a Fire Alarm Pull Station is activated, bells will sound giving the location of the alarm based upon a code. Bell code alarm locations are posted near the Fire Alarm Pull Stations; you should know the code for your area. An announcement will also be made giving the location of the alarm or fire.

On the **Hopewell** Campus there are no bell codes, an announcement giving the location of the fire will be made after the fire alarm sounds.

Capital Health - **Hamilton** is equipped with fire alarm pull stations and you should dial 911.

At off site locations or any area with an outside phone system the fire should be reported by calling 911. **Outlying buildings** that are at onsite locations dial 8888 from any in-house phone.

If you find a fire, the fire protocol is **R. A. C. E.**:

R = Rescue (all patients, staff, and self from immediate danger)
A = Alarm (pull the fire alarm, telephone the operator using ext. **8888,** shout "Fire Condition" to fellow employees)
C = Confine (close doors and windows)
E = Extinguish (evacuation if needed)

Additional Information:

- **All Clear** – remain in designated area until the **"All Clear"** is announced by Operator.
- Using the nearest stairway, nursing must return to your unit when a "Smoke Condition or Fire Condition" is announced.

- Evening/Night shift – one nursing representative from each unit will report to the "Smoke Condition or Fire Condition" location as staffing permits.
- **Visitors** – are to remain with patients and await further instructions. When a fire alarm is activated, all people entering the building should be stopped at the door and not allowed to enter until the alarm is cleared.
- **Oxygen Shut Off Valve** – Know the location on your unit and how to shut it off. Upon the request of the Fire Department, a Respiratory Therapist (RT) will shut off oxygen to the affected area. If an RT is not available, a staff RN may shut off the oxygen.
- Discourage people (physicians/visitors/employees) from passing through the fire doors until the operator announces "All Clear."
- When relocating patients first, use horizontal relocation beyond the fire doors on the same unit or floor. **If necessary, then use vertical evacuation.**

If a Fire or Smoke Condition is announced for another area of the hospital:

1) Close all windows and doors and move all equipment to one side of the hall.
2) Follow the instructions of your department head or supervisor.
3) Reassure patients and visitors. DO NOT PANIC!
4) Stay where you are until an "All Clear" is announced.

To use a fire extinguisher, remember PASS:

P = Pull (pin)
A =Aim (nozzle at base of fire)
S = Squeeze (lever and handle)
S = Sweep (nozzle back and forth)

Before extinguishing a flammable gas or electrical fire, if possible turn off the gas or unplug the device from the electrical source.

Facility Alert – Hazardous Material

Policy: Facility Alert – Hazmat, (11473118), EM 4.1

The purpose of this alert is to assist in the response to a chemical, biological, radiological, nuclear, or explosive (CBRNE) event and to ensure appropriate care is taken for those victims potentially exposed to any agent, whether accidental or terroristic in nature.

After reviewing the facts of the incident, **Administrative personnel** will decide whether to call a "Hazardous Material" and contact local public safety officials.

Refer to the Hazardous Material policy in the Emergency Management Response Manual for procedures, department responsibilities, and the Quick Reference Guides.

SECTION X: Workplace Safety

Workplace Safety is everyone's responsibility. One of Capital Health's Standard of Behaviors is maintaining a Professional Appearance, which includes having a clean and organized work area. An area clean and clear of clutter is much safer than one that is not.

The safety of staff and patients is always a primary focus at Capital Health. That is why hospital leadership has provided the following mechanisms to address any safety issue:

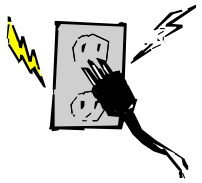
- Notify a supervisor of the safety concern. If the issue is not resolved on a timely basis, utilize the chain of command and contact the manager or director of the department.

- Access the safety reporting system on CapitaLink under on-line applications and complete the on-line form. The form is easy to use and it is classified by the type of safety concern that needs to be addressed. For example, if the concern is regarding an equipment failure, click on the icon marked equipment/device/catheter and complete the form. The form is submitted directly to the Quality Management Department and it could be submitted anonymously.

Reporting a potential safety issue is the first step to improve the environment of care for Capital Health's patients, visitors and staff.

Electrical Safety

All electrical equipment or devices must be UL or CSA listed. If device has a three-prong plug, all prongs must be present. This includes medical equipment and patient belongings.



A frayed cord is the most common problem found with electrical equipment, so pay attention to all electrical cords.

Use of electrical power strips is discouraged and in some locations prohibited. Areas without sufficient electrical outlets should request Maintenance to install additional outlets.

Patients with CVC catheters, external/temporary pacemakers, and anyone with an electrical conductor that originates outside the body and ends in or near the heart are very electrically sensitive. Because of this invasive conductor, they are subject to dysrhythmias from even extremely small currents of electricity that now have a path directly to the heart. A microshock (100 micro amps or less) is enough to cause ventricular fibrillation and even death. Current leakage (especially from equipment not grounded) and static electricity are enough to cause microshock. Grounding electrical equipment is the most important means of protecting the patient against electrical current leakage.

Actions for Safety

1. Inspect cords before using equipment. Report frays or breaks to Maintenance Department. DO NOT USE.
2. Always grasp the plug to remove it from the wall socket; do not pull by the wires.
3. All equipment is to have 3-prong plug or double insulation and be UL approved.
4. If third prong (grounding prong) is missing on a plug, report to Maintenance Department. DO NOT USE.
5. Report any plugs, wires, or sockets that form a connection that is warm to touch. DO NOT USE.
6. Do not stand in or near wet spots when working with electrical equipment. Keep bed wheels away from cords. Alert Environmental Services when spills occur.
7. If equipment smokes, unplug it or turn it off. Report to Maintenance Department. DO NOT USE.

8. Report electrical problems immediately. Even a small shock can be an URGENT WARNING!

OSHA – Chemical Safety

Policy: Safety Data Sheet, ADM:EC:0034

OSHA - Occupational Safety and Health Administration Hazard Communication Standard, protects the health and safety of employees at Capital Health.

Under OSHA law, employees need to know:

1. When they are working with hazardous chemical and disease-causing organisms.
2. How to minimize the risk of exposure.
3. What to do if they are exposed.
4. They have the right to know about chemicals in their workplace. The federal law that provides these rights is the OSHA HAZARD COMMUNICATIONS STANDARD (29CFR 1910.1200)

Know the Hazard	How to Minimize the Risk	Safety Issues
Chemicals Thousands of different chemicals are a necessary part of hospital life. But when handled incorrectly, they can burn, explode, cause skin damage, or lead to serious health hazards. There is a SDS chemical list on CapitaLink, under Quick Links. This is a list of specific products that are potentially hazardous to your health. The list also contains plans for: HAZCOM, HAZARDOUS MATERIALS/WASTE MANAGEMENT, SPILL RESPONSE AND UNIVERSAL WASTE.	1. Employees are trained to be aware of potential hazards. a) **Safety Data Sheets** are available on CapitaLink under Quick Links within the "Chemical List SDS". *SDS's* give you detailed information on health risks and safe handling for every chemical you work with. SDS information may also be found by loading the SDS App from VelocityEHS onto a smart device. Access is provided by using the Capital Health E-binder web address from CapitaLink: https://chemmanagement.ehs.com/9/80d6c99b-d710-4607-ae04-b708e611732c/ebinder/?nas=True 2. There are warning labels on all potentially hazardous products. 3. Hospitals are required to keep SDS sheets on products used for 30 years.	Follow directions on SDS's for safe use and to clean up spills. **Forms/Equipment:** 1. Incidental spill kits are determined by department. 2. Event Report through the Safety Reporting System 3. SDS 4. (PPE) Personal Protective Equipment 5. Hazardous Materials and Waste Management Spill Form

Know the Hazard	How to Minimize the Risk	Safety Issues
	4. Spills will be remedied according to department policy. Emergency calls are made to Hazmat by Security.	

HAZ-MAT - Hazardous Materials

What are hazardous materials?

Hazardous materials and wastes require special precautions. If mishandled, they can cause fires, injuries, poisoning, infections, or other health problems.

How do I know what the HAZ-MAT substances are where I work?

Prior to working with hazardous materials, the department manager/preceptor or supervisor will introduce new employees to the hazards in the area. Location of personal protective equipment (PPE) is discussed and available in the department. Training for all personnel, if applicable, in these areas must be reviewed annually.

Each department that has hazardous materials will have a contact who has attended a HAZ-MAT Awareness Class. This person will be responsible for assisting with developing the departmental plan for risk assessment, storage, use of PPE, and containment and cleanup of hazardous materials. The SDS chemical list on CapitaLink contains an inventory of the materials used at Capital Health.

What if I accidentally spill hazardous substances and/or become exposed to them?

At Capital Health, every department has an Emergency Management Response Manual, which outlines appropriate responses to a hazardous material spill or exposure. Please refer to the manual for specific guidance. Listed below is general information regarding these events.

Spills

All spills that can be contained by the incidental spill kit and do not constitute an emergency will be remediated according to the department policy and procedure as outlined in the spill kit instructions.

The Security Department and department director will be notified in case of a spill that cannot be contained by the department. Any spill that meets emergency criteria will be referred to an outside agency. All spills must be reported to the Hazardous Material and Waste Management Committee via Verge.

Exposures

The first thing to remember in case of an exposure is to isolate the area and anyone involved. Employees working outside of their own department who are exposed, or suspect they were exposed to hazardous chemicals shall immediately notify the supervisor of the department where the exposure occurred. If there is no supervisor working, the Administrative Coordinator is notified. That supervisor or coordinator assists in getting copies of the SDS and directs the employee to seek medical attention following the procedure for reporting a work related injury as outlined in Workers' Compensation and Return-to-Work Program policy, HR:7.5.

The Emergency Department will render emergency treatment of exposed persons. Personnel trained in decontamination procedures will conduct decontamination in the designated decontamination area.

If an exposure is too dangerous to handle internally, the Trenton Hazardous Material Response Team or an outside contractor will be contacted.

Potentially Hazardous Material Disposal Education Program

The following substances have been known to be used throughout Capital Health. Many of the chemicals listed below are not to be disposed into the sewer system in any amounts. The following is a recommended guideline to establish a means of controlling and initiating the proper disposal of potentially hazardous materials.

SUBSTANCE	DISPOSAL METHOD
Alcohols	Send out with hazardous waste
Formaldehyde	Neutralize or send out with hazardous waste
Xylene	Send out with hazardous waste
Barium	Used product (patients) - Sanitary Sewer System Expired product – Send out with hazardous waste
Chemotherapeutic Drugs	Pharmacy sends out with chemo waste, expired medication is returned to Pharmaceutical Company
Gluderaldehyde	Should not be used at Capital Health
Developer/Fixer	Send out with hazardous waste
Radioactive Material	Licensed hauler after half-life has expired
Acids	Should be disposed as hazardous waste only
pH Chemicals> 9.5	Should be handled as hazardous waste only
Fuel Oil / Gasoline	Send out with Recycling as Used Oil
Ethanol	Send out with hazardous waste
Grease	Approved hauler from designated clean out pit
Cadmium/Copper/Zinc	Send out with hazardous waste or recycle if possible
Acetone	Send out with hazardous waste
Chloroform	Send out with hazardous waste
Mercury	Send out with universal waste
Lead	Send out with universal waste
Rechargeable Batteries	Send to Maintenance for disposal

The Environment of Care Committee and the Hazardous Material and Waste Management Team are interested in raising awareness in our responsibility as a community leader to protect our environment. Please consider your part in protecting our environment in following the proper disposal method for all chemical substances you may use in your daily activities.

- Disposal of Medical Waste costs Capital Health thousands of dollars each year. Proper separation will reduce this cost.

Regulated Medical Waste (RMW) manifests can ONLY be signed by USDOT certified employees.

- Proper disposal is important for patient, employees, and environmental safety.
- Follow the Disposal Checklist to properly dispose of waste.

Medical Waste Disposal Checklist - OSHA

Policy: Regulated Medical Waste and Solid Waste Management, (10266394), 8:43 A 17.5
Policy: Proper Disposal of Sharps, (12167466), EVS .04

WASTE MATERIAL *See contaminated definition below	Sharps Container	Red Bag Container	Trash Container	Chemotherapy Container	Recycling Container	Blue Trash Container
Needles/Syringes	X					
Lancets	X					
Sutures	X					
Scalpels	X					
Scissors	X					
Specimen tubes	X					
Contaminated Broken Glass	X					
IV Catheters	X					
Contaminated gloves, gowns, and masks		X				
Uncontaminated gloves, gowns, and masks			X			
Contaminated gauze or dressings		X				
Uncontaminated gauze or dressings			X			
Contaminated Foley catheters/bags		X				
Uncontaminated Foley catheters/bags			X			
Contaminated ET tubes		X				
Uncontaminated ET tubes			X			
Contaminated chux pads		X				
Uncontaminated chux pads			X			
Hemovacs		X				
Suction canisters (Must be solidified, placed in double bio-hazard bags)		X				
Blood bags		X				
IV lines and bags with blood or unrecognizable fluids		X				
IV lines and bags with no blood or unrecognizable fluids			X			
Bedpans, urinals, and emesis basins			X			
Diapers			X			
Chemotherapy residual vials over 3% and other P, U, and D list Hazardous drugs				X (Hazmat) Black		
Chemotherapy Sharps	X (Chemo) Yellow					
Chemotherapy gowns gloves and non-hazardous wastes				X Yellow		

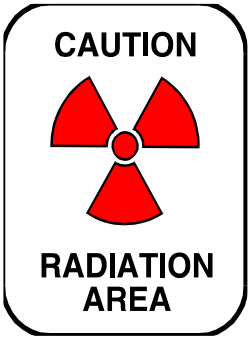
WASTE MATERIAL *See contaminated definition below	Sharps Container	Red Bag Container	Trash Container	Chemotherapy Container	Recycling Container	Blue Trash Container
Cardboard boxes, newspapers, packaging, magazines, plastic bottles, aluminum cans and non-confidential paper					X	
Empty medical vials (non-chemo or P, U, or D list Hazmats)			X			
Non-hazardous vials and piggybacks containing medication						X
Tissues and paper towels			X			
Food and food packaging			X			
Plates, cups, and disposable, utensils			X			
Guaiac/hemoccult card			X			
Alkaline Batteries			X			

*Contaminated is defined as being visibly saturated or knowingly contaminated with blood or an undetermined bodily fluid. Items with urine or feces are not necessarily considered contaminated. See NJ Regulated Medical Waste Regulations and OSHA BBP Standard for further details.

Radiation Safety

Policy: Radiation Safety, (10262702), RAD:5.08
Policy: Radiation Safety, (10266410), 8.0

When using proper radiation safety procedures, a person is able to keep their exposure to radiation as minimal as possible. Capital Health uses the policy of ALARA – exposure to radiation should be **A**s **L**ow **A**s **R**easonably **A**chievable. It is important to recognize the areas in which radiation sources are located at Capital Health and to know which precautions to follow. In general, you want to use the principles of time, distance and shielding when dealing with radiation – limit your time with the source of radiation, put as much distance as possible between you and the source, and use the proper shielding (like a protective apron) between you and the source.



The following chart describes the areas that you will find radiation sources at Capital Health.

Department	Exposure	Precautions
Radiology X-ray/Fluoroscopy Rooms/CT		

Department	Exposure	Precautions
Portable X-ray Machines/ Portable CT	A person can only be exposed to the x-rays generated by one of these machines when the machine is energized (exposure is taken). Same as above	Do not enter these rooms without checking with appropriate personnel to see if the machine is being used. If you must enter the room due to the nature of your job, you must wear a protective apron, spend as little time in the room as possible and stand as far away from the x-ray tube as possible. The control booth located within the x-ray room where the x-ray is taken is shielded with lead and is safe to stand behind with the Technologist's permission. Stand at least 6 feet from an activated portable x-ray machine or wear a protective apron during the exposure. Do not enter the room where a portable fluoroscopy machine (c-arm) is being used unless you have a protective apron on.
Nuclear Medicine Diagnostic Procedure	Patients are administered a small amount of a radiopharmaceutical in order to have diagnostic images taken. These patients are therefore "radioactive" for a limited amount of time.	In general, these patients are only "radioactive" for a short period of time and are allowed to leave the Nuclear Medicine Department and resume normal activities. Therefore, these patients do not require special precautions. For inpatients, the Nuclear Medicine procedure completed will be entered through Cerner, under hands of communication by Nuclear Medicine personnel. Normal universal precautions should be followed. The Hot Lab and scanning rooms in Nuclear Medicines are labeled with "Caution Radioactive Materials" signs. Do not enter or remove anything from these areas without approval from Nuclear Medicine staff. Do not eat or drink in these rooms.
Therapeutic Procedure	Patients are administered a larger amount of a radiopharmaceutical for treatment. These patients are "radioactive" for a limited amount of time.	If patient is admitted, the room may be posted with a radiation "Caution" sign. Patient bodily fluids can be radioactive and special precautions will need to be followed including the segregation of contaminated waste. Do not enter any patient room with a "Caution Radiation Area" sign unless approved by the supervising nurse and given the proper precautions. Use time, distance and shielding when around the patient. Inform the nurse if you are or may be pregnant. Do not re-assign room to another patient following discharge without approval from the Radiation Safety Officer.
Radiation Oncology Accelerator/Simulator	A person can only be exposed to the x-rays generated by one of these machines when the machine is energized.	Do not enter these rooms without proper supervision from someone in the department.

Department	Exposure	Precautions
Implants	A patient has encapsulated radioactive material temporarily implanted for treatment. Considerable radiation is emitted from the implant site when it is in place. This patient will no longer be "radioactive" when the implant is removed.	These patients will normally be placed in segregated rooms that are labeled with "Caution Radiation Area" signs. Do not enter these rooms without first checking with the supervising nurse. Use time, distance and shielding when around the patient. Inform the nurse if you are or may be pregnant.

MRI Safety

Policy: Magnetic Resonance Imaging (MRI) Safety, (10601748), M:26

The MRI Department has two 1.5 Tesla magnets in two separated exam rooms at the RMC campus and a 1.5 Tesla inpatient magnet and 3.0 Tesla outpatient magnet at the Hopewell campus. These units create a very strong magnetic field, thus causing magnetic hazards of which everyone must be aware. Anyone entering the MRI environment (Zone 3 and/or 4) must be cleared by a qualified MRI technologist. The Zone is based on the strength of the magnetic field at certain distances from the MRI Scanner and each Zone is posted. For this reason, it is important to have an understanding of the zones in the MRI area:

Zone Definitions:

Zone I

This includes all areas that are freely accessible to the general public. This area is typically outside of the Magnetic Resonance (MR) environment itself, and is the area through which patients, healthcare personnel, and other employees of the MR site access the MR environment. At Capital Health, this area is the access hall and reception area for the MRI departments.

Zone II

This area is the interface between the publicly accessible uncontrolled Zone I and the strictly controlled Zone III. Typically, the patients are greeted in Zone II and are not free to move throughout Zone II at will, but are rather under the supervision of MR personnel. At Capital Health this area is the nursing assessment area.

Zone III

This area is the region in which free access by unscreened Non-MR personnel and/or ferromagnetic objects and equipment can result in serious injury or death as a result of interactions between the individuals/equipment and the MR scanner's particular environment. All access to at least Zone III is to be strictly restricted. Access to regions within it (including Zone IV) are controlled by, and entirely under the supervision of, MR personnel. At Capital Health, this area is the ante-room, the control room, and the computer room.

Zone IV

This area is synonymous with the MR scanner magnet room itself: Zone IV by definition will always be located within Zone III as it is the MR magnet and its associated magnetic field, which generates the existence of Zone III itself. At Capital Health, this is the MR scanner room.

Flying Objects:

Once inside the actual exam room, any metal with magnetic properties has the potential to become a flying projectile, as it is attracted to the large magnetic core of the MRI unit. A code cart can actually be lifted off the floor and crash into the magnet. So can items such as an oxygen tank, floor buffer, buckets, wheelchair, stretchers, tools, etc. Stethoscopes, hairpins, ink pens, and paper clips are also examples of material that can become airborne. Persons with metal body piercing jewelry must remove it prior to entering the MRI room.

Other Considerations:

The magnetic field of the MRI unit cannot be turned on and off. All four magnets are ALWAYS ON. The magnetic field inside the exam room, would not only attract equipment, it also would render most electronic equipment (such as an ECG or Life Pack) unusable.

Credit Cards, Watches, Pacemakers, Insulin Pumps

Anyone entering the MRI exam room with wallets could have all magnetic information on credit cards erased. Watches may stop working in the magnetic field. Individuals with pacemakers or insulin pumps would experience malfunctions if they entered the room.

The Bottom Line:

NEVER attempt to enter Zone 3 and/or 4 unless cleared by the MRI technologist. Certain service employees may enter the exam room but only after being thoroughly oriented on proper procedures and assigned to do so by their supervisor.

Pneumatic Tube System Safety

Policy: Pneumatic Tube System, (10267875), PC:P:4

The pneumatic tube system ensures a safe and consistent mechanism for handling of specimens, pharmaceuticals, paperwork, materials and supplies. To promote personnel safety, minimize the risk of system contamination and to preserve specimen integrity it is important to follow the recommendations for pneumatic tube Do's and Don'ts.

Do's

- ✓ Use correct carrier for what it is you are sending:
  - ➔RED for "dirty" biohazardous items going to lab
  - ➔BLUE for "clean" items coming from Pharmacy
  - ➔Yellow for transport of blood products issued by blood bank
- ✓ Return excess carriers to Pharmacy, Lab, or their home base – do not hoard!!!
- ✓ Wear gloves when handling potentially infectious specimens
- ✓ Make sure to double bag all specimens
- ✓ Make sure carrier is latched securely (Listen for the click!)
- ✓ Double check display for proper address before sending
- ✓ Remove carriers as they arrive
- ✓ Place empty carriers on rack inside station
- ✓ Take carrier out of service and enter maintenance work order if:
  - ✶ it does not latch properly or it is missing foam inserts

- ✶ it arrives with something broken or spilled inside of it
- ✶ it arrives unlatched – call "Lab Specimen Receiving" to initiate an immediate emergency shutdown as the assumption is that something is loose inside the pipe

Immediately report all spills. Stop using the system.
RMC Lab 802-6092 Hopewell Lab 801-1026

Don'ts

- ⌦ Use damaged carriers. Call Maintenance, tag, and set aside.
  RMC Maintenance 802-6073 Hopewell Maintenance 801-4110
- ⌦ Overstuff the carrier or force it closed
- ⌦ Remove the foam inserts
- ⌦ Let anything hang out of carrier
- ⌦ Pull the carrier off the arm after your transaction has started
- ⌦ Allow carriers to build up in the receiving bin
- ⌦ Hoard carriers
- ⌦ Walk carriers between stations
- ⌦ Send CSF fluid in carrier (or anything else that you would not want to get another sample of)
- ⌦ Send suspected bioterrorism agents—hand deliver to the lab

Oxygen Tank Safety

Policy: Compressed Gas Cylinder Safety, (10726144), EC:0041

Employees in all areas of the hospital need to know the basics of Oxygen Tank Safety.
Oxygen tanks are used not only in the hospital environment but patients/visitors travel with their own portable oxygen tanks to office visits and in public areas. Oxygen is a gas, 21% of the air we breathe; it is odorless, tasteless, and most importantly combustible.

Pay attention to your surroundings and remember:

- Never leave a tank free standing
- Never place a tank on top of a stretcher/ bed
- Always store tanks in a proper carrier
- Store no more than 12 portable "E" tanks in the designated compressed gas cylinder room

If you find a freestanding tank:

- Non-clinical staff: Contact your manager/supervisor immediately.
- Clinical staff: Lay it down immediately and then place the tank in proper holder in the designated compressed gas cylinder room.

Contact Materials Management with any O2 tank issues: RMC 802-2585 or Hopewell 801-1421

Additional considerations for advanced clinical and clinical employees:

FIRE CONSIDERATIONS

- Oxygen is not flammable, but it does support combustion
- **Do not use around open flames, smoking or devices which create sparks**

- Never use oil or grease on a regulator
- **IMPORTANT – KEEP LIQUIDS THAT MAY CATCH FIRE AWAY FROM OXYGEN, PARTICULARLY OIL AND WATER. THIS INCLUDES THE OIL FROM VASELINE OR OTHER PETROLEUM-BASED LOTIONS AND CREAMS. WHILE AT WORK USE ONLY HOSPITAL APPROVED HAND LOTIONS.**

HIGH PRESSURE SAFETY

- A full tank is under more than 2000 pounds of pressure (PSI)
- The weakest point of the tank is the neck
- All tanks must be secured in a holder and/or carrier. If you find a freestanding tank, lay it down and find a carrier and/or notify your supervisor.

REGULATORS (non Grab-N-Go)

- Device used to step down tank pressure and deliver flow to patient
- Pin Index Safety System (PISS) assures that the regulator may only be used on the proper gas
- Regulators should never be used if there are any broken components
- Always require a washer. Some washers are disposable, some are not
- The "unibody" regulators should not be tightened onto the tank with a wrench. **Finger tighten only**.
- Always store tank with regulator depressurized
- **Tanks with the Grab-N-Go regulators only have to be turned off, the regulator is made to maintain the tank pressure at all times.**

DETERMINING CONTENTS OF TANK

- The label on the tank is the primary way to identify which gas is inside the tank
- All tanks are color-coded. Oxygen tanks are green
- Do not use a tank if the color and the label do not agree
- Oxygen is a medication in a compressed medical gas and may only be placed on a patient by licensed professionals including LRCP, RN, LPN and Radiology Technologists. It is the responsibility of nursing and respiratory care to check and regulate the function of the oxygen tank. Unlicensed personnel who have received a level of training and documented competency may set up, test and exchange basic oxygen tanks and regulators.

DURATION OF CYLINDER FLOW

- Always check tank to be sure that there is enough gas for the transport
- Change tanks at 500 psi (pounds per square inch)
- Formula to determine duration of an "E" cylinder flow is:
- 0.3 x tank pressure / liter flow = duration of flow in minutes

INFORMATION REGARDING TRANSPORTING PATIENTS

- If a patient runs out of oxygen while on a transport, it is the responsibility of the sending or receiving unit to change the tank.
- All patients who are being transported on oxygen **must** have the appropriate oxygen carrier. The oxygen is **not** put on top of a stretcher and/or bed.

EDUCATION

- Always Review Safety Education When Applying Oxygen and Document

SECTION XI: Patient Interaction

2023 Hospital National Patient Safety Goals

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

Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
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.
Identify patient safety risks	
NPSG.15.01.01	Reduce the risk for suicide.
Prevent mistakes in surgery	
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission Accreditation Hospital **This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.**

2023 Priorities for Quality and Patient Safety

Policy: Quality & Patient Safety, 11545951 (SOS)
Policy: Quality & Patient Safety Plan, 12474061 (ADM)
Policy: Safety Event Review and Reporting, 12663778 (PI:0001)
Policy: Safety Reporting System, 10820615 (PI:0002)

Pursue initiatives to humanize experience for our patients, families and teams by utilizing technology, innovations and empowering a compassionate workforce.

Increase organizational effectiveness to enhance the employee experience, meet employee needs and implement programs to support succession planning and establishes Capital Health as an employer of choice.

Pursue strategies to understand and address the community health needs and health disparities to address potential gaps and provide equitable healthcare.

Optimize patient flow and capacity management to ensure optimal clinical outcomes that reduce and/ or eliminate Hospital Acquired Conditions, Healthcare Acquired Infections, Readmissions and Mortalities. Promote evidenced-based bundles and reduction in clinical variation.

Sustain our reliability culture with commitment to zero harm by utilizing our universal and leadership skills for error prevention.

Pursue opportunities for awards and recognitions while maintaining International Organization for Standardization (ISO) 9001 certification and accreditation readiness.

Expansion of Phase II Cerner Electronic Medical Record (EMR) to include Real Time Health, RadNet RIS, Women's Health and Care Aware Connect.

Performance Improvement Methodology

The primary methodology used for performance improvement is rapid cycle improvement utilizing PDCA (Plan-Do-Check-Act). Through PDCA, knowledge of current process performance is gathered along with identification of barriers, indicted process change and required education. The purpose is to improve processes and patient outcomes. Other tools utilized for performance improvement are Failure Mode Effect Analysis (FMEA) for proactive risk assessments; Root Cause Analyses (RCA) to identify contributing factors, and LEAN to eliminate waste.

Quality and Patient Safety Council

The Quality and Patient Safety Council, a multidisciplinary committee of the Hospital, has oversight for the quality management system, quality, and patient safety initiatives. The Performance Improvement and Patient Safety Plan is reviewed and revised annually, and available under administrative policies. CH promotes Just Culture and High Reliability. Universal reliability skills include Clear Communication, Attention to Detail, Think Critically and Speak UP for Safety.

Latex- Safe Environment

Policy: Latex Allergy / Sensitivity Management Protocol, 10754334 (ADM:EC:0027)

Capital Health is NOT a latex free organization. When assessing or providing any patient with a known or suspected latex allergy, it is important to remember that common use items and equipment in the hospital may contain latex such as gloves, catheters, tubing, blood pressure cuffs, drains, masks, tourniquets, tape, etc. A latex free environment and equipment can be supplied upon request by the care provider. Please notify a manager and/or director for assistance.

Patient Identification

Policy: Patient Identification, 10267841 (I:11)

Every employee at Capital Health has the responsibility to promote safe practices and to follow the System-Wide Standard for Patient Identification. Patient Identification is a Priority Practice which "is a rule that cannot be broken and must be followed exactly as specified."

Accurate patient identification improves patient safety by:

- Reducing wrong person, wrong site procedures
- Reducing medication errors
- Reducing transfusion and diagnostic testing errors

All Capital Health employees must use the two hospital designated identifiers (Patient Name and Patient Date of Birth) to confirm the identity of a patient with the patient prior to providing care, treatment or services of any kind, every time.

All Capital Health employees will confirm any and all identifiers to confirm correct patient AND correct admission.

The ID bracelet is applied upon entry and remains for the duration of the patient stay. Pediatric patients (less than 18 years of age) receive two ID bracelets, one for the patient and one for the parent/guardian.

Example of Proper Patient Identification:

1. Have patient give their name and date of birth
   - "Please say and spell your full name and provide date of birth" when placing on an ID bracelet
   - "Please say your full name and state your date of birth" for all encounters

2. Verify their bracelet for confirmation (Name, DOB, Account#)

3. Verify ID (Name, DOB, Account #) on labels/products with ID on bracelet prior to:

- Administering medications
- Collecting blood samples and other specimens for clinical testing (label specimens **at the bedside** and compare name, DOB, account number on label against attached ID bracelet)
- Transfusing blood products
- Providing stored breast milk
- Providing treatments or procedures
- Escorting patients
- Passing meal trays

If you have any questions or concerns about this procedure, please ask your manager prior to attempting this practice.

Connecting Patient Identification and Lab Specimen Labeling

✓ First check:

- Identify the patient-check ID on patients arm band and ask the patient their name and date of birth

✓✓ Second check:

- Compare the information on the lab label with the patient's identification bracelet. The patients name, date of birth, and account number must match exactly or do not proceed with the procedure.
- Complete procedure for blood sampling
- Immediately label tubes at the bedside. Each tube must be labeled with the following information
    - Patients full name
    - Patients date of birth
    - Patients account number Date and time of collection
    - First initial, full last name and credentials of collector

✓✓✓ Triple Check:

- Compare labeled tubes against the arm band to confirm Patient ID name, DOB and account number match

Safe Patient Handling and Body Mechanics

Policy: Safe Patient Handling Program, 10601857 (S:24)
Policy: Use of Safe Patient Handling Equipment, 10601853 (S:27)

Capital Health is committed to keeping employees and patients safe. Staff can reduce the potential for injury by following the principles of good body mechanics along with the guidelines for safe patient handling. Although body mechanics alone may not always protect us, the principles remain an important component in reducing the possibility of injury.

Good Body Mechanics:

- Keep objects close to the body (carrying a 10-pound object at arm's length away from the body creates a 100-pound force on the spine).
- Use a wide stance (feet at least shoulder width apart).
- Bend at the knees for lifting and keep your back straight. Do NOT bend at the waist.
- Lift smoothly and use the strength of the legs to straighten the knees and hips.
- Do NOT twist when moving an object from one point to another. Pivot with your feet.
- To move a patient or object, pushing is usually safer than pulling. It is easier to keep your back straight while pushing. Lean into the object using your body weight to help push the object.

Safe Patient Handling:
Staff encounters many patients who are ill and have difficulty moving. Yearly education and training is provided to staff on the principles of safe handling. Safe patient handling equipment is critical to help protect staff from injury while moving patients. All patient units have access to a variety of specialized equipment that supports this safety initiative.

Capital Health teaches staff to minimize manual lifting and recommends keeping the load under 35 pounds whenever feasible, and replacing these lifting activities with the use of mechanical devices whenever possible.

Equipment currently used at Capital Health includes:

EQUIPMENT	PURPOSE	LOCATION
Slide Tube (single patient use)	• Lateral transfer • Repositioning in bed	• All patient care unit storage rooms
Ceiling lift	• Repositioning in bed • Lateral transfers	• Most units have at least 1 ceiling lift • Many units have multiple ceiling lifts
Mobile Full Body lift	• Transfer bed to chair	• Each adult unit • Dialysis unit at RMC • Radiology departments have at least 1 lift for all diagnostic areas (both main campuses)
Later air mats-34" (Bariatric only)	• Bariatric lateral transfer	• Escort department (both main campuses)
Hoverjack® lift	• Lift patient from floor to bed or stretcher	• Security Department (both main campuses)

Basic Falls Detection/Prevention

Policy: Fall Safety Program, 11274046 (EC:0030)

Fall Definition:
A sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface, on another person, or on an object.

An assisted fall is defined as a fall that occurs when a staff member was with the patient and attempted to minimize the impact of the fall by slowing the patient's descent. A fall is not considered assisted if a family member/visitor slows the patient's descent.

- All CH employees whose job responsibilities requires them to work in patient care areas participate in the ***Fall Safety Program*** by observing patients whose rooms have a yellow sign and/or yellow star in the doorway. They will immediately report to the nursing staff any fall risk patient observed attempting to get out of a bed/chair by themselves or an environmental problem such as a wet floor.

- All Ambulatory Care departments participate in the Fall Prevention Program for Ambulatory Care Areas.

- Patient falls compromise the patient's condition and may lead to a series of unfortunate events, such as injury, increased length of stay, increased nursing time, pain medications, and/or litigation. Immobility alone can result in several additional health problems – incontinence, decreased muscle tone, pressure injuries, contractures, invalidism, and decreased nutritional status.

- Educate the patient/significant other of the potential to fall and the safety measures that are taken and document education provided in the patient's chart. Information on fall prevention can be found in Krames, Lexicomp and in the Capital Health Patient Education and Health Information Guide.

Additional definitions for Advanced Clinical Staff.

NDNQI Fall Definitions

Physiological Fall - Falls which result from deficiencies in a patient's health status. A fall attributable to one or more intrinsic, physiological factors such as:

- A sudden physiologic event such as hypotension, dysrhythmia, seizure, transient ischemic attack (TIA), or stroke
- A side effect of known "culprit drugs" (e.g. Antihypertensives, narcotics, hypnotics, diuretics, antihistamines, antidepressants, anticholinergics)
- Some aspect of the patient's physical condition such as delirium, intoxication, dementia, gait instability, or visual impairment

Nonphysiological Fall- Can occur to any individual regardless of health status. They result from something other than the patient's health status. Examples: Tripping over clutter, missing a step because of poor lighting, slipping on a wet floor, or improper use of assistive devices.

Suspected Intentional Fall- An intentional event occurs when a patient age 5 or older falls on purpose or falsely claims to have fallen. There should be documentation in the medical record with supporting evidence that fall was intentional.

'Baby/Child Drop'- A fall in which a newborn, infant, or child being held or carried by a healthcare professional, patient, family member, or visitor falls or slips from that person's hands, arms, lap, etc. This can occur when a child is being transferred from one person to another. The fall is counted

regardless of the surface on which the child lands (e.g. bed, chair, or floor) and regardless of whether or not the fall results in an injury

Drops involve a child and another person who is carrying or holding the child. If a child rolls off of a bed or crib – that is classified as a fall.

Developmental Fall- A fall in which an infant, toddler, or preschooler who is learning to stand, walk, run, or pivot falls **as part of the developmental process of acquiring these skills**.

Developmental falls should be reported only when they result in **injury.**

Standard Fall Prevention Strategies

All hospitalized patients are at risk for a fall!

- Provide physically safe environment (eliminate spills, clutter, electrical cords, and unnecessary equipment).
- Provide adequate lighting.
- Make necessary repairs to wheelchairs and beds (check brakes). Ensure wheelchairs and beds are working and if notice any problems especially with brakes, tag, and remove from service. Keep bed in lowest position. Use Stryker iBed awareness technology to maintain bed set-up.
- Keep the bedside table, call light, TV remote and other necessary items within the patient's reach.
- Instruct the patient to wear slippers or socks with non-skid soles.
- When a patient is using a knee scooter for mobility the staff must notify the MD and have an order for physical therapy ensuring safe use while in the hospital.
- Instruct patient in safe use of assistive devices.
- Instruct the patient to call for assistance before getting out of bed.
- An educational fall reference guide is added to all bedsides for assistance.

What to do in case of a fall:

- Notify the nearest healthcare professional to examine the patient.
- Complete an incident report (document the facts: what you saw, heard, did, and what was the patient's response).
- Notify your immediate supervisor.

All hospital personnel are responsible for maintaining a **Fall Safety Program**. Ancillary Departments participate in the Fall Safety Program by monitoring any patients within their department who wear yellow wristbands.

Capital Health employees from departments whose job responsibilities require them to work in patient care areas (e.g., Dietary, Maintenance and Environmental Services) participate in the Fall Safety Program by observing patients whose rooms have a yellow sign and/or yellow star in the doorway. They will immediately report to the nursing staff any patient attempting to get out of a bed or chair by themselves or an environmental problem such as a wet floor.

You can help prevent a patient fall!

Additional Considerations for Advanced Clinical and Clinical Employees:

The RN assesses the patient for risk for fall twice a shift with a shift equaling 12 hours. Fall risk can change throughout the course of the hospital stay or even over the course of the day.

Patient who are at Highest Risk for Fall Related Injury

A = Age greater than 85
B = Bones meaning osteoporosis
C = Coagulation Lovenox greater than 30mg daily, Heparin IV (not sub-cu), anyone on Coumadin
C = Cognitive impulsive or impaired
S = Surgery

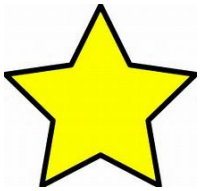
Be especially alert to these patients!

Fall Prevention Interventions for high risk patients:

- Use appropriate fall risk signs and a yellow wrist bracelet to communicate to all hospital staff that patient is at risk for a potential fall.
  - Keep the bed/stretcher in the lowest position
  - Keep personal items and call bell within patient's reach.
  - Patients with high-risk assessments **toileted every 2 hours.**
  - **A staff member must remain with the high-risk for fall patient when they are using the commode or assisted into the bathroom**.
  - Assist patient with ambulation
  - Assist with obtaining MD order for physical therapy.
  - Consider the use of bed/chair alarm. A cling should be at the doorway upon exiting the room if alarm is in use, "Bed Alarm".
  - When possible, move the patient at greatest risk near the nurse's station.
  - Ensure the appropriate fall prevention interventions are in place prior to and upon discontinuation levels of observation monitoring. Never discontinue 1:1 before transferring a patient to a different room for fall safety. Let the new unit reevaluate.
  - Consider use of tele-sitter.
  - Educate patient/family/caregiver of risk for fall and interventions to prevent falls.
  - Place yellow star on doorway of a patient who is impulsive or has fallen during hospital stay

If your patient falls (CLINICAL):

- Notify the RN to examine the patient.
- When appropriate, obtain the hoverjack patient lift device from security to get the patient back in bed. (Clean after use).
- The patient's nurse conducts a "Post Fall HUDDLE" within 15 minutes after the fall with co-workers.
- Place yellow star on door.



If your patient falls (ADVANCED CLINICAL):

- Assess the patient for injury and change in condition.

- Notify the LIP/designee, resident, or house physician to examine the patient.
- The physician orders related to the fall are processed **STAT** and results reported to the physician.
- When appropriate, obtain the hoverjack patient lift device from security to get the patient back into bed. (Clean after use).
- The patient's nurse conducts a "Post Fall HUDDLE" within 15 minutes after the fall with co-workers.
    - Nurse completes the Fall Huddle RECAP form. Team tries to determine:
        1. What happened? Why did it happen? Ask patient what was different this time?
        2. Core Problem: How could you have prevented this fall?
        3. Were all safety precautions used?
        4. What will you do in the future to prevent another fall?
- Complete a safety report and notify Nurse Manager or Administrative Coordinator.
- Document factual account of event and post-fall care in Multidisciplinary Progress Note.
    1. Objective assessment and subjective reports
    2. The patient's response to the fall
    3. The patient's clinical condition
    4. Who evaluated the patient
    5. The patient's response to treatments and/or medication.
- Update the Fall Prevention/Intervention in Hand-off Communication tool. Make notation on hand-off communication to alert others "this patient has fallen this admission."
- Place yellow star in door
- Assess the need for physical therapy.
- Assess the need for additional fall prevention interventions. (bed/chair alarm, self-releasing belt, increase observation checks, use of tele-sitter)
- Consider if a referral to the pharmacist is needed for a review of medications that may contribute to increase fall risk.
- Redo the Morse Scale
- Enter Falls indicator in electronic medical record.
- Return the completed Fall Huddle RECAP form to NM.

ADVANCED CLINICAL – Patient Assessment Risk for Falls

Inpatient areas: Assess fall risk using the Morse scale at time of admission, twice a shift with a shift equaling 12 hours, at time of transfer, after a fall, and with change in patient status. **Falls risk assessment is done with the patient and/or family member and an educational sheet is provided.**

- *Outpatient Ambulatory Areas:* Assess fall risk using Ambulatory Fall Risk. Questionnaire on arrival to outpatient area.

- *If at high risk:* Apply Yellow Falls Risk bracelet per policy.
- List interventions of "Fall Prevention" in hand-off communication tool
- Identify Fall Prevention Risk in Multidisciplinary Plan of Care.
- Document all fall prevention interventions in chart.
- Place Falls sign outside the door

***NOTE: The RN can make patients high risk for fall, based on clinical judgment, even if the patient does not meet high risk criteria on Morse Falls Scale.**

Restraints

Policy: Use of Restraints, 11610299 (PC:R:9)

Restraints are only to be used to provide safe management of the patient when less restrictive interventions have been unsuccessful. It is the policy of Capital Health to prevent, reduce, and strive to eliminate the use of restraints. The use of restraints for behavioral reasons is indicated if the patient is violent or self-destructive. The use of restraints for medical reasons is indicated to prevent serious disruption of medical treatment. Capital Health does not permit the use of restraints for any other purpose, such as coercion, discipline, convenience, or retaliation.

Restraints are to be used only as a means of providing protection and safety for the patient when alternative methods of control are not appropriate or effective. A patient must be seen and evaluated by a physician, advanced practice nurse (APN), or physician assistant (PA) who must write an order before restraints can be applied. In an emergency, the nurse may initiate restraints and must immediately notify the physician/APN/PA to obtain an order within one hour of restraint application.

At all times, the physical and psychological impact of restraints will be recognized and the patient's dignity, rights, safety, and comfort will be preserved.

- Depending on the intent of use, types of restraints may include soft wrist and ankle restraints, belt restraints, locking wrist and ankle restraints, restraint body net, mitts, and freedom splints.
- If a patient is in a geriatric chair and is unable to remove the tray and move independently, then the geriatric chair is considered a restraint.
- If the intent of the bedrail use is to restrict the patient's movement, and the patient cannot remove the bedrail by themselves, it is considered a restraint.
- Nursing is responsible for assessing skin integrity and circulation in patients who are in restraints. Your cooperation in observing and reporting problems is appreciated.
- Please refer any questions you may have regarding restraints to nursing.
- Four-point locking restraints must have a key accessible in the room at all times.
- The patient is maintained on continuous observation when in restraints for behavioral reasons or if the patient is in four-point restraints (either soft or locking).

Law Enforcement and Non-Law Enforcement Restraints (Handcuffs)

- Handcuffs may be indicated for patients in custody unless medically contraindicated. You are not to handle these restraints. The nurse will document the presence of the restraint and circulation checks in the patient record.
- Handcuffs are restraints used for non-clinical purposes.

For additional information on restraints, see Workplace Violence Prevention & Security.

Additional Considerations for Advanced Clinical and Clinical Employees:

It is the philosophy of Capital Health to prevent, reduce, and strive to eliminate the use of restraints. Providing safe management of care for the patient in restraints, when less restrictive interventions have been unsuccessful is our goal.

A. When Can Restraints Be Used?

- To prevent imminent harm to the patient, other persons or significant damage to the physical environment.
- To prevent serious disruption of treatment

Capital Health does not permit the use of restraints for any other purpose, such as coercion, discipline, convenience or retaliation by staff.

Restraints are only to be used after alternative interventions have been unsuccessful and then they are to be the least restrictive as possible.

B. What Are Some Alternatives To Be Used In Controlling Behavior First?

- Reality orientation
- Diversional activities
- Music
- Hide/Camouflage equipment
- Geri-Chair without table
- Bed/Chair Alarm
- Self-Releasing device (belt)
- Move the patient close to nurses station
- Continuous observation

C. What Is Considered A Restraint?

Any physical or mechanical device used to involuntarily restrain and prevent free bodily movement in order to protect the patient or others from injuries or serious disruption of medical treatment. **It is the INTENT not the modality that qualifies as a restraint.**
Examples of such include:

- Mitts (if they cannot remove them the way they were put on)
- Soft wrist/ankle restraint

- Yellow belt (if they cannot remove them the way they were put on)
- Four-point restraints
- Body nets
- Keeping all side rails up to prevent the patient from getting out of bed

Again, it is "the intent" not the name or the material used which determines whether or not an appliance is considered to be a restraint.

D. What Is Not A Restraint?

- Devices used to immobilize a patient temporarily during a diagnostic procedure
- Orthopedic supportive devices
- Helmets or age appropriate equipment, such as strollers and cribs
- Keeping all side rails up on a bed for seizure precautions and placing the patient on a narrow stretcher are considered safety interventions, not restraints.

E. Some General Guidelines For Restraints:

- DO NOT "KNOT." Secure with quick release tie or use restraints with quick release buckles.
- Ankles are not restrained unless wrists are also restrained.
- Include patient and/or family in decision-making process.
- Restraints should not restrict circulation.
- Restraints should be as inconspicuous as possible.
- Patients, who require restraints while in bed, require restraints during transportation.
- Keep beds in low position.
- Fasten restraints to the bed frame, not bedrails,
- Tie restraints in chairs low and back, out of patient's reach.
- Application is according to manufacturer's guidelines.
- Patent in restraints for behavioral reasons are to be on continuous observation.
- A key MUST be accessible in the room at all times for locked restraints.
- Remove personal clothing and place the patient in a hospital gown. When this is not feasible, any personal clothing remaining on the patient must be thoroughly searched.
- The RN is responsible to ensure that the patient, their belongings and the environment are searched for items or substances that could constitute a danger to self or others. Security should be involved in patient search if patient is in opposition, agitated or if deemed necessary. Potentially hazardous articles shall include but not limited to: razors, sharp instruments, wires/cords, jewelry, glass items, lighters, matches, aerosol cans, any weapons including firearms, noxious chemicals including nail polish remover, alcohol, prescription/over the counter medication, illegal drugs, scissors, nail clippers, mirrors, plastic bags, etc.
- Notify Nurse Manager/Administrative Coordinator of any patient in restraints.

– Enter into electronic medical record that patient is in restraints.

F. Orders Are Required For Restraints

What five items must be included in an order for restraints?

- Type of restraint
- Reason for restraint
- Time and date
- Specified length of time anticipated for restraint use
- Physician/ APN/ PA signature, date and time

G. Restraint Orders

Medical Restraint Management

- Patient must be seen and evaluated by Physician/ APN/ PA who must write an order for restraint use.
- In an emergency, a nurse may apply restraints and immediately notify the Physician/ APN/ PA to obtain a written order. The Physician/ APN/ PA must sign the verbal order and do a face-to-face assessment within one hour.
- No other verbal orders are permitted.
- PRN orders are NOT PERMITTED for restraint use.
- If restraints use continued, Physician/ APN/ PA MUST do a face-to-face assessment of the patient and write a new order at least once every 24 hours.

Behavioral Restraint Management Regardless of Setting

– Behavioral Management is **an emergency measure** reserved for occasions when **unanticipated aggressive or destructive behavior** places patients or others in immediate danger.
– This is an emergency measure for patients who are "acting out."
– This does not refer to other conditions for restraining patients.

Specific orders for behavioral management:

– RN may initiate restraint and then immediately obtain a verbal order.
– Face-to-face assessment and signature of Physician/ APN/ PA is needed within one hour.
– Patient is on continuous visual observation.

Behavioral Restraint orders are needed a minimum of every:

– 4 hours for adults

- 2 hours for children/adolescents 9 – 17
- 1 hour for patients below age 9
- RN completes an assessment and obtains a renewal order before allotted time has elapsed
- The Physician/ APN/ PA may verbally extend the original order according to the specified time limits for each age group, for a maximum of 24 consecutive hours
- If the patient remains in restraints, a face-to-face evaluation by the Physician/ APN/ PA and a new written order is required once every 24 hours
- Attending LIP must be notified when patient is restrained for behavior management.

H. What Aspects Of Patient Care Needs To Be Addressed?

- Security of the Patient
  - Disrobe patient and place in a hospital gown. All items that could harm the patient or others must be removed. When patient is in 4-point restraints, a Security Officer may be required to assist.
- Visual Observation
  - Medical Restraint Management
    - Continuously observed, if clinically indicated.
    - At least every 15 minutes when patient is unstable.
    - At least every 30-60 minutes based upon patient's level of acuity.
    - Minimally, every hour
- Release of Restraints (medical and behavioral management)
  - Restraints must be released at least every 2 hours.
  - Release one restraint at a time for a minimum of 5 minutes.
  - Check skin color and condition.
  - Check pulse.
  - Perform R. O. M.
  - Reposition as needed.
  - All patients in restraints must be assisted to ambulate every 4 hours as their condition permits.
  - Assess patient condition, physical and mental status every 2 hours.
  - Re-evaluate as to the continued need for restraints every 2 hours.
  - Monitor and provide adequate fluids and nutrition.
  - Toilet patient every 2 hours.
  - Vital signs as per unit protocol.
  - Bathe at least every 24 hours.
  - Patient reassessment and justification for continued restraint use done every 2 hours.
  - Document every 2 hours. If patient is on continuous observation, document visual observation every 15 minutes.
  - If patient's behavior resolves to the point where restraint can be discontinued, new Physician/ APN/ PA orders are required if restraints need to be re-applied.

I. New Restraint Classifications

Drugs (Chemical Restraint)

- If a medication is used **to control behavior** or **to restrict the patients freedom of movement** and it is not standard treatment for the patient's medical or psyche condition, **it is a restraint**.
- Medications ordered PRN for anxiety reactions, etc. are appropriate standard orders – **not restraints.**
- Medications ordered solely **to control behavior or restrict movement are restraints.**

Bedrails

- May or may not be restraints **depending on the intent.**
- If bedrails are used as a means of providing protection or intervention due to medical condition, it is not considered a restraint.
- On hospital beds with segmented side rails (two sections rather than one continuous rail), one section may be raised or lowered independently. For example, if the side rail closest to the head of the bed were raised so that the patient may be able to get out of bed easier, this would not be considered a restraint.
- If the **intent** is to keep patients confined to bed and they are unable to lower the side rails without assistance, the **side rails become restraints.**
- Four point or full length side rails are restraints.

J. Documentation

Physician/ APN/ PA orders are documented on the "Physicians Orders for Restraint Use" form. Face-to-face evaluation of the patient, which must be done once every 24 hours, is documented on the "Physician's Restraint Progress Note" form.

Alternatives utilized prior to restraint use, explanation of reason for restraints, notification of family if applicable, care and monitoring of the patient, assessment and reassessment of the patient, and time of release from restraints is to be documented on Restraint Flow Sheet by the nurse.

Documentation that the patient has been checked and is secure from harmful items must be done on the Restraint Documentation Form.

K. Collaboration/Consultation With Psychiatric Staff

When a patient is placed in restraints the following resources are available:

- Clinical Nurse Specialist of Inpatient Mental Health or Charge Nurse of Inpatient Mental Health Unit. For after hours, extension 609-394-6049.
- Nurse Supervisor of Psychiatric Emergency Screening Service (PESS) or Staff Nurse of Psychiatric Emergency Screening Services after hours; 609-394-6086.

- The CNS or designee, and the Nurse Manager of PESS or designee can provide staff education and ensure that appropriate assessment and care is given.

L. In each department, when any restraint is applied to a patient, information must be entered in a restraint logbook.

M. Whenever restraints are applied to a patient, the Nursing Supervisor must be notified.

N. The restraint data collection tool needs to be collected and filled out in real time. PI will be collected in the manner that is determined by the restraint committee. There is a database for every restrained person and the database holds several elements that are mandated for collection by the regulatory body. The database will be used to identify trends in restraint use.

O. <u>All deaths that occur when a patient is in restraints or has been in restraints 24 hours prior to a death will be reported to Quality Management. Quality Management will review the chart and if necessary will notify CMS (Center for Medicare Services).</u>

SECTION XII: ADVANCED CLINICAL AND CLINICAL TOPICS ONLY

The remainder of this book covers topic pertinent to Advanced Clinical and Clinical Staff Only.

Patient Wristbands

In addition to the patient's **white identification bracelet (RMC) or blue identification bracelet (HPW)**, various colored wristbands are used to identify patient-specific needs. All colored wristbands are to be worn on the **same** extremity as the patient identification bracelet.

►Allergy Identification – Red Wristband

Policy: Allergy Identification, 10267842 (A:30)

- ✓ Screen for medication and food allergies on admission to inpatient unit or arrival in outpatient department/physician office.
- ✓ Record all drug and food allergies on the medical record.
- ✓ If appropriate, indicate the patient has "No Known Allergies" in the medical record.

If allergies are identified:

- ✓ Apply a red allergy identification wristband to the patient's wrist or ankle. Place an allergy sticker on the outside of the patient's chart.
- ✓ Verify medication and food allergies on each admission to inpatient unit or arrival in outpatient department/physician office.
- ✓ Record all the allergies on the medical record, including the type of reaction.

►Latex Allergy/Sensitivity - Green Wristband and Signage

Policy: Latex Allergy/Sensitivity Management Protocol, 10754334 (EC:0027)

Outpatient Screening:

- ✓ Each department will question the patient to determine any latex allergy/sensitivity.

Inpatient Screening:

- ✓ Upon admission to a nursing unit, the RN assesses the patient's allergy/sensitivity to latex using the **Interdisciplinary Admission Record**.

If an allergy/sensitivity to latex is identified:

- Apply a green wristband to the patient's wrist.
- Post a green "Latex Allergy" sign outside the patient's room. For inpatient care, obtain a latex-free tote from Central Supply.
- Operating Room (OR) patients have a sign posted on the stretcher and OR door.

Capital Health is NOT a latex free organization. When assessing or providing any patient with a known or suspected latex allergy, it is important to remember that common use items and equipment in the hospital may contain latex such as gloves, catheters, tubing, blood pressure cuffs, drains, masks, tourniquets, tape, etc. A latex free environment and equipment can be supplied upon request by the care provider. Please notify a manager and/or director for assistance.

►**End-of-Life (EOL) – Purple Wristband (Hospital Only)**
Policy: Code Status and Appropriateness of Care, 11439097 (RI:0009)

When an AND (Allow Natural Death) order is written on a patient's chart, the patient receives all medically appropriate therapeutic care but cardiopulmonary resuscitation will not be initiated upon the patient's cardiac or respiratory arrest. A purple End of Life Physician Order form is completed and placed in the front of the Physician's Orders section of the chart where it is to remain throughout the patient's hospitalization. A purple wristband is to be used to alert the staff to the patient's end of life status. Enter AND order and code status on the nursing care kardex and Handoff Communication tool.

►**Limb Alert – Pink Wristband (Hospital Only)**
The color pink is used to indicate a limb that should not be used for taking a blood pressure, drawing blood, or inserting an IV. There may be a shunt, PICC line, or another medical reason why the limb is not appropriate for procedures. The wristband also alerts health care workers that a double-check is needed to be sure a procedure is done on the correct limb.

►**Falls Prevention - Yellow Wristband and Signage (Hospital Only)**
Policy: Falls Prevention Program, 11274046 (EC:0030)

Within in-patient settings, all patients will be assessed twice a shift or as needed for their risk of falling. A yellow ***Fall Risk*** wristband is applied to high-risk patients. Yellow ***Fall Safety Program*** signs are posted outside the patient's door. A yellow ***Star*** is placed on the door of a patient who is impulsive, noncompliant, or who has fallen during hospital stay.

►**Wandering Risk- Blue and White Wristband and Signage (Hospital Only)**
Policy: Code Find/ Patients at Risk for Wandering, 10726616 (EC:0039)

A blue and white striped wrist band is placed on all patients identified as being at risk for wandering and a "blue footprint magnet" is placed on the patient's door frame to alert all employees of patient's risk for wandering.

►**Surgical sponge(s)/packing intentionally left within the patient - Blue Wristband (Hospital Only)**
Policy: Surgical Counts, 10603933 (C 3.0)

If counted sponges are intentionally used as packing and the patient leaves the operating room with the packing in place, the number and type of sponge(s) retained will be documented on the intra-operative record and onto the "blue" wristband.

►**Nothing By Mouth (NPO) – Orange Wristband with White NPO Lettering (Hospital Only)**

- ➔ Wristband placed on *all* patients >17 years old in the Emergency Room when a Cat Scan of the head is ordered. This alerts the RN to complete a swallowing evaluation on the patient. If the patient passes, the NPO wristband may be removed. If that patient fails the swallowing evaluation, the NPO wristband remains on.
- ➔ Wristband placed on all *inpatient* patients when a stroke alert is called. This alerts the RN to complete a swallowing evaluation on the patient. If the patient passes, the NPO wristband may be removed. If that patient fails the swallowing evaluation, the NPO wristband remains on.

Patient Family Education

Policy: Patient/Family Education Resources, 12252864 (PC:E:4)

Patient and family education is multidisciplinary, collaborative, and ongoing throughout the patient's hospitalization or during an outpatient visit. Upon admission to an in-patient unit, every patient receives a Patient and Visitor Guide.

Elements of Patient and Family Education materials include:

- Provision of education and training based on the patients assessed needs.
- Each patient, the patient's family, and/or other persons significant to the patient receive education based on an assessment of their learning needs, preferences, abilities, and readiness to learn.
- The hospital coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, and services.
- Based on the patient's condition and assessed needs, the education and training provided to the patient by the hospital may include the following:
    - Information on the plan of care, tests, treatments, and services
    - Pre-hospital education
    - Basic health practices and safety
    - Safe and effective use of medication
    - The safe and effective use of medical equipment, or supplies when provided by the hospital
    - Instruction on potential food-drug interventions
    - Counseling on modified diets and nutrition interventions
    - Smoking cessation interventions
    - Management of pain and symptoms, understanding pain, the importance of effective pain management, the pain assessment process, and methods for pain management
    - Self-care activities including hygiene/oral health, hand hygiene, and isolation
    - Habilitation or rehabilitation techniques to help them reach maximum independence
    - Process of obtaining follow-up care and treatment
    - Possible complications post discharge and when to seek emergency care

- Provision of education appropriate to patient's abilities and provided in an understandable manner which accommodate various learning styles (written, verbal, video, demonstration)

- The **TEACH-BACK METHOD** is used to evaluate patient's comprehension of information taught. The teach back method is a way of checking understanding by asking the patient to repeat in their own words what they need to know about self-care, medications and/or treatment plan. This method provides a chance to check for understanding and if necessary, re-teach the information.

- Learning needs are identified on the Multidisciplinary Plan of Care and education is charted in the patient's chart.

What special considerations are taken for patient education regarding medications?

Elements of performance for education in the Medication Management Standard include:

- Persons who administer medications but are not staff members (i.e. the patient who is self-administering) receive training and appropriate information about: nature of the medication, how to administer medications (frequency, route and dose), the expected actions and side effects of the medications to be administered, and how to monitor the effects of the medications.

- Before administering a medication, the provider or appropriate health care professional administering the medication advises the patient, or if appropriate, the patient's family about any potential clinically significant adverse reaction, and/or other concerns about administering a new medication.

- Place documentation of above information in the EMR.

How are patient education materials approved for use at Capital Health?

The Patient Education Review Committee reviews and approves patient education materials.

What other resources are available to assist staff as they educate their patients?

Capital Health has a computerized patient education system including Krames, Cerner and Lexicomp which contains both drug and health information. This information is appropriate for patient use and written at an appropriate reading level. Medication information is available in multiple languages. Patient care material is available in English and Spanish. The Patient Channel from the Wellness Network covers a variety of topics. Additional patient resources include a consumer health section in both campus libraries and Capital Health website. Community Health Education Department offers numerous outpatient education resources i.e. health fairs, speakers bureau, and health screenings.

What if the patient is non-English speaking and you need to use the Cyracom Language Line?

Document in the patient's chart that you used these services as well as the interpreter's identification number. Documentation must also include the specific topics on which you educated the patient.

If the patient is non-English speaking or LEP (limited English proficiency) and you use the Capital Health approved Language Bank staff, document in the patient's chart that you used these services as well as the interpreter's name and the specific topics on which you educated the patient.

What Staff Education Resources are Available at CH?

- Health Science Library on both campuses and available on the Library Services Site
- Educational Material available on the CH Intranet (CapitaLink)

- Capital Health Policies: Patient Care, Administrative, Human Resources, Infection Prevention, Emergency Response, Corporate Compliance, and departmental policies on-line.
- Online newsletters
- Approved on-line resources
- Unit-based clinical nurse specialists and educators
- The Department of Clinical Education (DCE)
- Cerner – EMR patient care education source
- Lexi-Comp is an Internet based medication and patient care reference source
- Mosby is the official reference manual for Capital Health nursing procedures
- UpToDate is an evidenced based clinical support resource (Capitalink – Application tab)
- Comprehensive Hospital Package from EBSCO includes:
    - Medline Full-Text
    - CINAHL Full Text
    - Psychology & Behavioral Sciences Collection
    - Health Business Elite
    - 95 Full-Text books
- Cochrane Collection, Dynamed Access Medicine (25 Full-Text core medical textbooks), Stat!Ref (more than 20 full-text medical and nursing textbooks)
- SDS chemical list (Safety Data Sheets)
- CE Direct online continuing education for nurses
- The Provider Unit for continuing nursing education contact hours

Legibility

The definition of legibility may be subjective to a degree, but the criterion for readability is simple: a notation can either be clearly and easily read or not. Your legibility is a critical issue in documentation, and is addressed in healthcare regulations and accrediting standards.

What implications does my handwriting have at Capital Health?

- Poor handwriting techniques lead to misunderstandings and can contribute to errors in patient care i.e. medications.
- Illegible entries trigger a series of telephone calls or polling other coworkers to discuss what an entry might say. This results in significant loss of time and subjective interpretation that may not be accurate.
- Clear medical record entries may be the most important evidence in defense of a claim if Capital Health and/or you are involved in litigation.
- Provides necessary documentation in support of reimbursement of service

Tubing Safety Alert

Policy: Management of IV Access (Peripheral and Central, 11582485 (I:6)

On a national basis, it has been reported that patients have died as a result of wrong tubing connections.

Examples of wrong connections are:

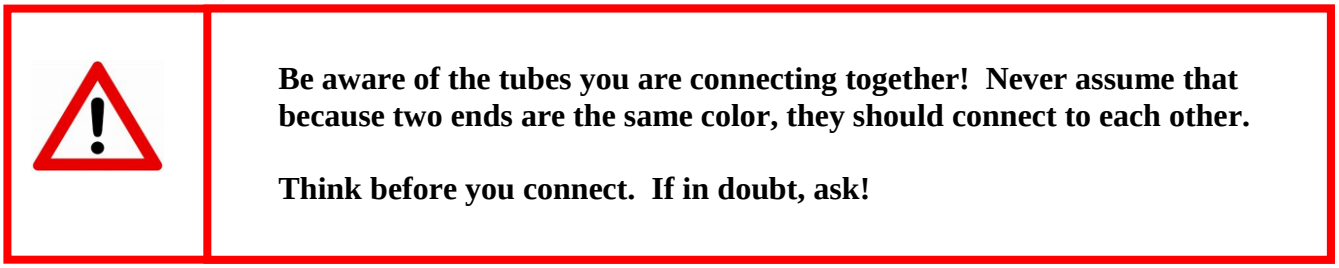
- IV fluids connected to tracheostomy inflation ports
- Connecting automatic blood pressure tubing to IV ports
- Sequential compression stockings connected to IV ports
- Attaching oxygen to re-transfusion devices
- Spiking enteral feeding sets with IV tubing and then mistakenly infusing through IV lines

Clinical staff should inform non-clinical staff, patients and their families that they must get help from clinical staff whenever there is a real or perceived need to connect or disconnect devices or infusions. Patients and families should be educated **not to** connect or adjust tubing and notify professional staff of any concerns.

Any tube that has a port is potential for wrong connection. When connecting tubing, it is important to follow where each tube ends. Never assume that because two ends are the same color, they should connect to each other. **"Think before you connect. If in doubt, ask."** Recheck connections and trace all patient tubes and catheters to their sources upon the patient's arrival to a new setting or service as part of the hand-off process.

For high risk catheters such as epidurals and arterial lines, as well as tracheostomy inflation ports, label the catheters.

Examples of potential problems are:
- Oxygen extension tubing that will fit over a needless connector
- IV fluids that can connect to nasogastric anti-reflux filters
- Fluids that can be connected to a tracheostomy cuff



Hand-Off Communications

Policy: Hand-Off Communications, 10267889 (PC: H: 5)

Hand-off communication is defined as any time one health care provider transfers responsibility of a patient's care to another. Additionally, communication between health care providers without transfer of care but requiring input to help manage the patient's care will be termed a hand-off communication.

All verbal and electronic hand-off communication utilizes the S-BAR (situation, background, assessment, recommendation) format to provide accurate information about a patient's care, treatment and services, current condition and any recent or anticipated changes.

The information communicated during hand-off is accurate in order to meet patient safety goals.

The clinical documentation systems are the mechanism by which patient information is obtained for use in hand-off communication by LIPs, residents, nurses, and other health care providers while in the hospital setting.

Attributes of effective hand-off communication:

1. Hand-offs are interactive communications allowing for the opportunity for questioning between the giver and receiver of patient information.
2. Hand-off includes up-to-date information regarding the patient's care, treatment and services, condition, and any recent or anticipated changes.
3. A process for verification of the received information, including repeat-back or read back, as appropriate.
4. An opportunity for the receiver of the handoff information to review relevant patient historical data, which may include previous care, treatment, and services.
5. Interruptions during handoffs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

Situations that require hand –off communication include:

- Shift-to-shift staff changes
- LIPs transferring complete or on-call responsibility of a patient.
- Temporary responsibility for staff leaving the unit for a short period of time
- Anesthesiologist report to post anesthesia recovery nurse
- LIP and nursing hand-off from emergency department to inpatient units
- Nursing unit to diagnostic area
- Discharge to different hospitals, nursing homes, rehab centers, and home health care
- Handoffs of critical laboratory and radiology results
- Nurse to observer for all levels of observations
- PACU to floor nurse post-operatively

Pain Management

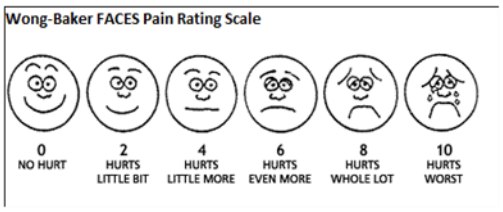
Policy: Management of Pain Across the Lifespan, 10754861 (ADM:TX:0024)

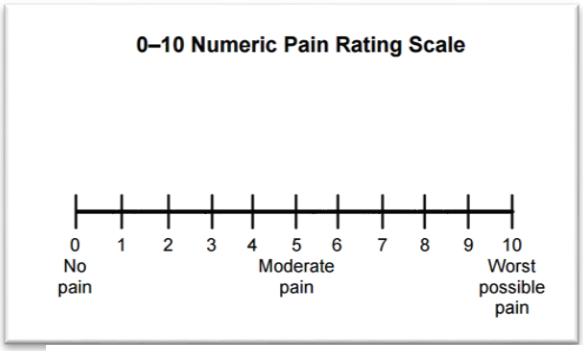
Definition of Pain: "Pain is whatever the experiencing patient says it is, wherever it is stated to be located, and existing whenever the experiencing patient says it does," says Margo McCaffrey, RN.

Pain Assessment: The single most reliable indicator of the existence and intensity of pain and any resultant distress is the patient self-report. Discuss with patient pain management goal(s). Pain goal setting supports pain management and helps increase patient satisfaction.

Pain Assessment Tools:

- Numeric Pain Index (NPI) or Visual Analog Scale
- Pain Assessment in Advanced Dementia Scale (PAINAD)





Visual Analog Scale (VAS) 1

– Pain assessment is documented in the form of a fraction (5/10 or 3/5). The use of these scales is based on the patient's ability to give a self-report of pain. NICU/NBN uses NIPs, Critical Care uses CCPOT for sedated patients, and pediatrics uses FLACC scale.

Pain Assessment in Advanced Dementia Scale (PAINAD)

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

Behavior	0	1	2	Score
Breathing Independent of vocalization	• Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	• None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	• Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	• Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	• No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
			TOTAL SCORE	

– (Warden et al., 2003)

– The Pain Assessment in Advanced Dementia Scale (PAINAD) is used for patients who are confused and unable to rate their pain using the numeric or faces scale.

– The nurse uses the scale appropriate at the time of assessment to rate the patient's pain for Mild, Moderate or Severe.

Assessment Frequency:

– On admission, an initial comprehensive pain assessment is required
– At least every 8 hours minimum, check department policy for specific timing
– PRN
– Any new onset of pain requires a comprehensive assessment

Re-Assessment:

To be completed at appropriate intervals following the administration of analgesics and/or other pain relieving therapies.

– Within 60 minutes after IV medication intervention.
– Within 60 minutes after oral or other routes of intervention (cold compresses, meditation, etc.)
– Reassessment may occur more frequently as determined by the patients' clinical condition.
– If patient is sleeping at time of assessment, document "sleeping."
– If the patient does not achieve acceptable pain relief, contact LIP.

Documentation:

Admission Assessment Forms
Vital Signs with Pain Scale
Multidisciplinary Progress Note
Flow sheet, pain management section
Multidisciplinary Care Plan including pain goal

PRN / STAT AND ONE-TIME Medication Administration Record

When documenting pain related to the administration of medication, the patients reported pain score must match the ordered indication for pain (example: patient is ordered Dilaudid 1mg IV every 2 hours prn severe pain. Patient reports pain 9/10 on the numeric pain scale. It is acceptable to administer this dose for this report of pain)

Levels of Observation (LOO)

Policy: Levels of Observation and Video Monitoring, 11610374 (PC:L:2)

PURPOSE:

To promote the safety of patients at risk for harm or injury by assigning to an individualized Level of Observation (LOO). To provide guidelines for the implementation of the appropriate LOO.

LEVELS OF OBSERVATION FOR **SUICIDAL** PATIENTS:

1. One-to-One Observation
2. Continuous Visual Observation
3. Intermittent Observation/Q15 minute Checks

LEVELS OF OBSERVATION FOR NON-SUICIDAL PATIENTS:

1. One-to-One Observation
2. Continuous Visual Observation
3. Intermittent Observation/Q15 minute Checks

4. Telesitter Video Monitoring

One-to-One Observation:

- Applies to the following clinical areas for SUICIDAL and non-suicidal patients:
    - Emergency Departments (ED)
    - Screening Center
    - Inpatient Mental Health
    - Adult and Pediatric Inpatient Areas
    - In any other patient care area: The patient is not left alone and is taken to the ED or returned to the area of origins appropriate and as soon as possible for further evaluation
- *The only acceptable LOO when a patient presents with suicidal ideation and/or evaluation and/or clinical assessment determines that the patient is at imminent risk of self-harm*
- This is the most restrictive and highest level of observation.
- Patients that are at imminent or high risk of harm or injury to self must be monitored at this level
- One qualified staff member is assigned to observe the patient at a distance that ensures the patient's immediate safety at all times and during all activities with no physical or visual barrier between them.

Continuous Visual Observation:

- Applies to only the following area for SUICIDAL patients:
    - Inpatient mental health
- Applies to the following areas for non-suicidal patients:
    - EDs
    - Screening Center
    - Inpatient Mental Health (patients may not be clustered)
    - Adult and Pediatric Inpatient Units
- This LOO can only be implemented after the patient is evaluated using a validated assessment tool and/or clinical assessment and found not to be at imminent danger or harm
- Patients who are not imminently at risk of harm or injury to themselves or others, but potentially could be, may be placed on this level of observation.
- The patient remains within eyesight of one qualified staff member at all times and during all activities with no physical or visual barriers between them.
- This LOO may be used for non-suicidal patients when it is possible to cluster patients so one qualified staff member can monitor more than one patient at a time

Intermittent Observation/ Q Minute Checks:

- Applies to the following clinical areas for SUICIDAL patients:
    - Screening Center
    - Inpatient Mental Health
- Applies to the following areas for non-suicidal patients:
    - Screening Center
    - Inpatient Mental Health
    - Adult and Pediatric Inpatient Units
- This LOO can only be implemented after the patient is evaluated using a validated assessment tool and/or clinical interview
- This is the least restrictive level of observation
- It is appropriate for patients who are potentially at risk of harm or injury who require an intermediate level of care

- Patients assigned to this level of observation is physically visualized by a qualified staff member at a minimum of every 15 minutes

Telesitter Video Monitoring

- Applies to Adult and Pediatric Inpatient Units
- The Telesitter Video Monitoring system is a nursing intervention that is used when appropriate to ensure patient safety. It is initiated based on nursing assessment and recommendation and does not require a provider order.
- Telesitter is not used with acutely ill psychiatrically decompensated patients

Process for Implementing a LOO:

If the nursing and/or screening assessment of a patient indicates a patient may be at risk for harm to themselves they are immediately placed in a One-to-One Observation. The provider is contacted for a One-to-One order and the patient is evaluated, using a validated assessment tool as soon as practical

The reasons that a patient may be placed on a level of observation may include:

1. Suicidal thoughts or suicide attempt prior to admission
2. Repeated non-lethal self-injury attempts (e.g. skin cutting, biting, picking, intentional ingestion of foreign bodies)
3. Homicidal, violent, or dangerously aggressive behavior (patient may be monitored by security staff)
4. Acute onset of psychiatric symptoms
5. Elopement behaviors
6. Risk for injury due to medical condition and/or declining cognitive function (e.g. high falls risk, interfering or non-compliant with medical treatment)
7. Continued unauthorized self-administration of personal medications (prescription or illegal drugs)

CONSIDERATIONS FOR *SUICIDAL* PATIENTS

- A search is conducted under appropriate conditions to secure all dangerous items, including but not limited to, sharps, glass items, and metal utensils. When clinically indicated a search is conducted prior to the patient's arrival to the receiving unit
- Dangerous and potentially dangerous items are removed
- Patients are searched and changed into hospital gown. Personal items are removed, labeled and stored in the appropriate area.
- Staff should only take necessary items and equipment into rooms and ensure they take all items and equipment with them when they leave the room
- Paper garbage bags should be used instead of plastic
- A "crisis diet" is ordered so the patient only receives paper products, finger foods, and no utensils
- Family/visitors must report to the nurse's station and/or to the department clinical staff before visiting the patient. Family/visitors are informed that potentially harmful items are not to be given to the patient. All items and packages brought by visitors are searched for contraband.

PROCEDURES FOR ALL CATEGORIES OF PATIENTS:

- Notify the nursing office when a patient is placed on a LOO the RN needs to explain to the patient:
  - Reasons for the level of observation.
  - Expectations for discontinuation of the observation.

- This monitoring includes the bathroom privilege if they are on one-to-one with arms-length or eyesight observation.

- All visitors to high-risk patients must check in at the nurses' station before visiting the patient. Family/visitors are informed that potentially harmful items are not to be given to the patient. Any objects or packages brought to the patient by visitors are searched.
- The observation aide *must* receive report from the nurse or charge nurse **before** entering the room to observe that patient.
  - The primary RN documents the type of LOO, patient's behaviors, patient interactions, and the evaluation of continued need for the LOO at least once a day
  - At every change in level of care, the LOO currently in place is maintained upon arrival to the receiving unit. As soon as practical, the patient is reevaluated using a validated assessment tool and or clinical interview to determine the appropriate LOO.

Documentation:

A. When a patient is placed on any LOO, the staff member assigned to the patient documents the patient's activities/behaviors on the Observation Record every 15 minutes.

B. Every <u>four</u> hours, the RN, LPN, or the Mental Health Counselor documents the patient's behaviors, patient interactions, interventions, and the evaluation of continued need for the level of observation in the clinical documentation record.

C. Documentation of the education given to the patient regarding the expectations for discontinuation of the observation is recorded in the clinical documentation record.

D. If the individual responsible for maintaining the Observation Record requires a break or is asked to assume another function, the RN is notified and the Observation Record is given directly to another staff member to ensure uninterrupted monitoring and continuous documentation.

E. Hand-off communication is documented when a patient on any LOO leaves the unit for medical testing or other procedures.

DISCONTINUATION:

Provider driven LOO:

When the team and/or RN feels the patient's condition has clinically improved to the point where the individualized level of observation could be discontinued (or reduced to a less acute level of observation), they notify the provider and obtain an order to discontinue.

RN driven levels of observation:

- When the RN feels the patient's condition has clinically improved; the RN may decrease or discontinue the LOO.
- When the LOO is related to a falls risk, the guidelines for discontinuing that level of observation is followed according to the Fall Safety Program policy.

IMPORTANT FACTS

When the staff member monitoring a patient(s) on a LOO needs a break or is asked to assume another function, the following is done:

- Inform the RN.
- Give the Observation Record **directly** to the relieving staff person to ensure uninterrupted monitoring and continuous documentation.

- The person relieving the observer get report about the patient(s) from the RN.
- **NOTE:** Family members **MAY NOT** monitor patients.
- Confidentiality:
  - Do not discuss the patient with anyone that is not directly caring for them.
  - If family members have questions about this direct them to the RN.

OFF-UNIT TESTING

Patients on a LOO that leave the unit for testing are accompanied by unit staff.

- Security may accompany the patient if deemed necessary by the provider or the RN.
- Hand-off communication is used when a patient on any LOO leaves the unit for medical testing or other procedures.
- Make sure the reason for the LOO is entered in patient's record and handoff communication tool.

TELESITTER VIDEO MONITORING

Initiated based on nurse assessment and recommendation following the TVM Screening Algorithm and does not require a provider order.

If a LOO is ordered by a provider for a patient who meets the criteria for TVM, the nurse informs the provider of the monitoring option. If an agreement to utilize the video monitoring system as appropriate is received, the nurse will document it and an order to discontinue the LOO is obtained.

AT START-UP:

- Make sure the correct patient information is given to the TeleSitter Observer:
  - Room number
  - Patient name
  - Diagnosis
  - Behavior
  - Nurse and nurse phone number
  - Back-up phone numbers
  - Camera number
  - Patient's Language
- Give Patient/Family Education.
- Enter appropriate documentation in EMR.
- Plug in cart and wait for camera to set itself (takes about 2 minutes and you will see it turning in the dome.)
- Communicate with TeleSitter Observer via AvaSys audio to make sure sound is adequate both ways. Confirm that view into room is adequate as well and have TeleSitter introduce self to patient (if appropriate.)
- Confirm with TeleSitter that privacy light and chime are working in sync. TeleSitter will test this from monitor station. RN in the room will confirm that light and chime are responding and will explain to patient what this means (if appropriate.)
- If privacy is needed or if patient is being removed from room (for test, walk, etc), RN/NA to call TeleSitter to request privacy.
- When privacy is no longer needed or patient is returned to room, call TeleSitter to request re-initiation of monitoring.

MONITOR POINTS TO REMEMBER TO TELL PATIENTS AND FAMILIES:

- The TeleSitter does not record
- The TeleSitter has a privacy mode and we use this when you need privacy
- The TeleSitter Observer can always see you but can not always hear you. Please continue to use your call light if you need something.
- If the TeleSitter Observer talks to you, you can answer and they will hear you.
- When the yellow light is on, that means the TeleSitter Observer can see into this room. When the yellow light is off, that indicates the privacy mode is activated and the TeleSitter Observer can not see into the room.
- The TeleSitter Observers are Patient Companions

Clinical Staff Responsibility:

A. Assesses that the patient is appropriate for TVM (see "Patient Inclusion & Exclusion Criteria for TeleSitter Video Monitoring").
B. Consults with the nurse manager or designee concerning the recommendation that the patient be monitored using the TVM system.
C. Obtains TeleSitter monitoring equipment. If unable to locate one, notifies Administrative Coordinator.
D. Contacts Clinical Patient Observation Technician in Logistics and provides a report on the patient including information on diagnosis, behaviors, reason for monitoring, mobility, assistive device, etc.
E. Facilitates initial introduction of Clinical Patient Observation Technician to patient in the room (if appropriate).
F. Communication is entered in the clinical documentation record to include:
  a. TeleSitter Monitoring – Continuous
  b. Reason for monitoring
G. Notifies patient and visitors that TVM is implemented to promote patient safety.
H. Documents patient education in the patient clinical documentation record.
I. Reassesses patient at least every four hours for the need to continue TVM.
J. Responds in a timely manner when notified of patient concerns by the Clinical Patient Observation Technician or the STAT Alert Alarm.
K. Notifies Clinical Patient Observation Technician:
  a. If patient privacy is needed.
  b. When patient is removed from room.
  c. When TVM can be discontinued

Discontinuation of TeleSitter Monitoring:

A. Discontinuation is a nursing clinical judgment and is based on patient activity and clinical necessity.
B. A patient is deemed safe when there is no need for TVM (i.e. no longer displaying withdrawal symptoms, no longer restless, no longer at risk for elopement, appropriate behaviors).
C. Once discontinued:
  a. Notify Clinical Patient Observation Technician of patient and room location being discontinued.
  b. Notify Environmental Services (EVS) of discontinuation, room location and the need to clean the equipment.
D. Clinical Patient Observation Technician clears notes from software and notes on log the time and date of discontinuation.

Cleaning:

A. The device is disinfected after each patient use by cleaning with a hospital approved disinfectant following relevant infection control protocol.

B. For painted metals and plastics - ordinary dirt, smudges and water soluble stains can be removed with mild soap and water.
C. EVS cleans the TeleSitter hardware in the patient room, then covers with plastic bag and moves it to the main nurse's station on the respective unit.
D. Nursing unit personnel returns equipment to designated storage location.

Medication and IV Safety

Policy: Medication, 12077088 (PC:M:1)

- Medication safety is the responsibility of everyone that prepares and/or administers medications at Capital Health
- All in-patients and outpatients must have an Identification Band which is checked prior to administration of medications.
- Always use two (2) patient identifiers. Patient name and birth date.
- Do not use dangerous and unapproved abbreviations in the medical record.
- Allergies are recorded in medical record according to policy and are recorded on all written or electronic medication administration records.

All medications are ordered via Computerized Physician Order Entry (CPOE) or written on the Physician Order Form legibly, clearly, and verified as complete with the:

1. Name of the patient
2. Age and weight of the patients, or other dose calculation requirements, where applicable in the patient record
3. Date and time of the order
4. Drug name preferably generic name
5. Dose
6. Dosage form or strength/concentration when applicable, ("range" orders are not accepted)
7. Dosage route
8. Frequency of administration
9. Quantity and/or duration, when applicable
10. Specific instructions for use, when applicable
11. PRN medications require written indication
12. LIP/designee signature
13. Medication orders for neonates and pediatric patients must be dosed on a dose per kg basis
14. When primary medications are discontinued, dependent medications also discontinued. (i.e. PCA morphine with naloxone PRN)
15. Medications need to be started as soon as possible on the day they are ordered, unless specified otherwise
16. Pre-operative antibiotics are to be administered within one hour of incision

Zeros and Decimal Points:

Use leading zeros 0.1 not .1

- Use whole numbers 1 not 1.0
- Do not use trailing zeros 1 not 1.0

- Leave a space between each part of the order when transcribing the order
- 500 mg not 0.5 gm
- Drug 40 mg po bid not drug40mgpobid

Profiling Medications

- All medications are profiled by Pharmacy
- Profile to be checked prior to administration of a new medication

Exceptions -

- Life threatening situations, i.e. Code Blue and in areas where an LIP is routinely present to control use, i.e. ED
- When medication orders require additional information regarding questions of therapeutic duplication, they are clarified by a Registered Pharmacist
-

Medication Orders

- Orders are re-evaluated and re-ordered (written or via electronic ordering system) when a patient goes to and from the operating room under general/regional anesthesia and when transferred into or out of critical care. Pre-approved admission, pre-/post-op or pre/post-procedure orders or protocols are used in certain patient care areas. This step calls for multidisciplinary commitment to patient safety and risk reduction.
- Medication orders are re-evaluated for patients who have a change in level of care, to or from intensive care units.
- What needs to change?
    - ✓ All pre-op, pre-procedure, prior to change in level of care orders are to be discontinued
    - ✓ All orders are to be reordered (electronic or paper) by the LIP. (Pre-printed, standing orders are acceptable if individualized to the patient and signed.) Any written order requires a written signature.
- Discontinue pre-op orders on MAR, using a written "To OR" A set of post-op orders must be written
- Transfer in or out of ICU/CCU/Telemetry requires transfer orders
- Pre/post procedures require pre- and post-procedure orders (cardiac cath, pacemaker insertion)

Pharmacy Hold

- Pharmacist notifies unit when need for clarification from physician is indicated
- "Pharmacy Hold" written in ink and bold print in date section on MAR

1. When medication orders require additional information regarding questions of dosage, drug interactions, allergies, route incompatibility, etc, Pharmacy contacts the Provider for further clarification. The Registered Pharmacist:
    a. Notifies the nursing unit that the order in question is on "Pharmacy Hold" and the reason.
    b. Contacts the prescribing provider.
    c. Receives the telephone order, writes it on the physician order form or enters into the electronic ordering system, and delivers the original to the nursing unit using appropriate campus-specific mechanisms.
    d. Calls the nursing unit (areas not using automated MAR) to remove the "Pharmacy Hold" if the order is to remain as originally written.

- Licensed Health Care Practitioner (LHCP) on unit rewrites order as it is clarified (as a new order) if paper MAR

Verbal Read Back

- For telephone orders and situations where the LIP cannot write the order
- What do you do?
    - ✓ **Need patient's full name and complete order**
    - ✓ **RN writes down the order**
    - ✓ **RN reads the order back to the LIP**
    - ✓ **RN used the verbal read back stamp and completes the required information**
- Physician authenticates the order

Controlled Substances

- Require the signature of 2 RNs to witness, waste and dispose
- Waste recorded in Pyxis/Omincell
- All forms (patches, pills and IV including PCA) are disposed in the approved controlled substance disposal container located in medication rooms

If any questions on disposal of hazardous medications, refer to patient care policy PC: P: 50 Pharmaceutical Waste Disposal – policy contains list of all medications that must be disposed of in hazardous waste containers

High Alert Medications

- Mixed by pharmacy, except in emergencies, Standard concentration premixed infusion where available
- Require 2 RNs to verify appropriateness and accuracy and each nurse will independently check orders using the seven rights of medication administration, calculations, and pump settings.
- Double check occurs prior to initiating an order and when hanging a new bag of medication and with any dosage change

Do's and Don'ts

Do

- Do contact Pharmacy if patient has difficulty swallowing (substitute liquids or chew tabs)
- Do document the site of an injection
- Do know why you are giving a medication
- Do educate the patient and provide written approved patient education materials

Don't

- Do not crush time-release or enteric-coated medications
- Do not give heparin and Lovenox together over time
- Do not cut corners when giving meds (No shortcuts!)

IV Fluid Orders Include:
- Type of solution
- Amount
- Rate of infusion (KVO, TKO orders are not valid)
- Duration
- Date of order
- LIP signature

IV Bags Need Changing?
- Change one at a time
- Double check independently high-risk medication bags
- Change per pharmacy expiration if specified, otherwise**, no fluid is to hang for more than 24 hours.**

All IV medications and fluids administered on a smart infusion pump are to be programmed using the guardrail safety system. They should never be programmed in a basic infusion unless not listed in the drug or fluid library. If not listed, notify your nurse manager. IV pumps are required for the following infusions:
- Pediatric patients
- Central lines
- Critical Care drugs
- Electrolytes (such as K, Ca, Mg)
- Blood products
- Peripheral Parenteral Nutrition (PPN)
- Intradialytic Parenteral Nutrition (IDPN)

Medications at the Bedside
- No medications are left at the bedside
- No needles or syringes unlocked at the bedside
- If Isolation - specific order written by physician, i.e. inhalers at bedside - must be under LHCP control
- Refer to M1 policy for list of pharmaceutical items that necessitate their storage at the bedside when indicated by the patient's clinical condition

Medications from Home
- All medications brought in by the patient are to be sent home
- When medications are sent home with a caretaker (18 years or older), document the name of the caretaker in the medical record. Controlled substances are never sent home with a caretaker.

  Exceptions:
  - ✓ Investigational - Pharmacy will dispense to unit at times needed for administration
  - ✓ Special Order Meds - Pharmacy must identify and label before use

Sending Medications Home
- LIP prescribes medications to be sent home with the patient
- Nurse notifies QRM/Social Service/Case Management as appropriate for determination of indigent needs
- Pharmacy dispenses the medication to LIP
- LIP dispenses medication directly to the patient at time of discharge

- Do not send left over meds home with patient

Patient/Family Education
- Educate patient about each medication
- Document all patient education
- Patient education is ongoing during the hospital stay
- Discharge education is also necessary
- Provide written materials as much as possible

Code Team
- Pharmacy will assist with medication administration during a code
- "Restate" all verbal orders during the code prior to administering drug.
- A critical care nurse responding to code blue brings a Rapid Sequence Intubation (RSI) box of medications for use by anesthesia or CRNA when intubating a patient.

Rapid Sequence Intubation (RSI) Box
- Found in a sealed box on critical care units' refrigerator, ED and Pediatric Emergency Department
- Label on box identifies caution with drug
- Ventilation support must be in use when administering these medications

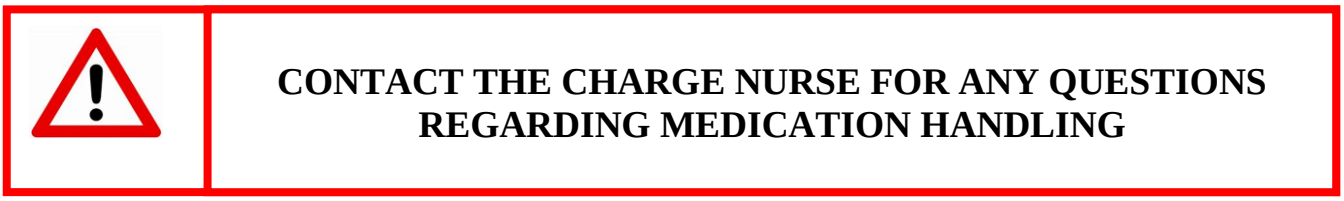
Reporting Medication Errors- Safety Reporting System
- Complete a safety report for untoward side effects and adverse reactions to meds
- Complete a report for any med-related incident
- Complete a report when an error occurs
- Complete a report when an error is found
- The computerized system of reporting is quick and easy to use. Remember patient safety is our goal.

Handling Medications by Non-licensed Staff
- When medications arrive in a pneumatic bullet; promptly remove the medications from the bullet to ensure that medications are secured within the nursing unit.
- Inspect the package for damage, breakage, leakage of medication.
- Report immediately any suspected issues to the Charge Nurse.
- If other staff are entering the medication room at the same time; check that this person is authorized to enter the room.

<u>Who is authorized to access the storage area in the medication room?</u>
Authorized staff actively involved in medication management or patient care such as prescribing, dispensing, delivery, administration or blood draws for labs/point of care testing are allowed access to the storage area in the medication room.
- Transfer medications from the pneumatic tube to the assigned bin in the Medication Room ASAP.
- Ensure that the medication door is locked when you leave the room.

Remember:
- DO NOT open medications/take medications out of the bag during transport.
- DO NOT put medications in your pocket during transfer.
- DO NOT perform another task prior to taking meds to the medication room.

- DO NOT take medications directly to the patient's nurse or patient room.



SECTION XIII: ADVANCED CLINICAL TOPICS ONLY

Flushing Intermittent Medications via Infusion Pump in Adults

Policy: Medication, 12077088 (PC: M: 1)

Policy Statement: When piggyback medications are ordered in the adult population and no IV fluids are ordered, either NSS or D5W (same as the medication is mixed in) is hung and programmed on the pump to infuse a volume of 30 ml at the rate the antibiotic or medication infused.

Procedure:
If patient has antibiotics or other secondary medications ordered and are administered intermittently with no main IV fluids ordered, the following guidelines should be followed:

1. Identify base fluid that medications are mixed in
2. Obtain bag of same IV fluid, in smaller quantity to last 24 hours... i.e. 100ml NSS or 250 NSS, depending on number of meds to be administered. If some meds are mixed in NSS and another is mixed in D5W, you will need 2 line setups.
3. Set up flush as primary infusion (Choose either D5W flush or NSS Flush) in the Alaris fluid library. Set rate at same rate as secondary medication is prescribed. Set VTBI to 30ml
4. Next, program secondary medication to be delivered as per label. Note volume will reflect if fluid has been added by pharmacy. Program accordingly.
5. When Secondary medication is finished the primary will take over for the remaining 30ml already programmed.

Injection Safety Practices: Using Single-Dose and Multi-Dose Vials

Policy: Medication Vials: Multiple-Dose and Single-Dose, 10609424 (PC: M:3)

Single-dose vials

- Use single-dose vials only once for a single patient, with a single syringe and a single needle
- If a single-dose vial is entered more than once during a procedure; use a new needle and a new syringe for each entry.
- Use all contents within 1 hour.
- Once a single-dose vial has been used, throw it out, even if there are leftover contents.

Multi-dose vials

- Only vials clearly labeled as multi-dose can be used more than once.
- Use multi-dose vials only on one patient, where possible.
- Use a new needle and new syringe for each entry into the vial.

- Do not leave needles in the vial's rubber septum between uses.
- Don't forget to date the vial once it has been opened! Beyond-use dates should be 28 days from the date the vial was opened, unless otherwise specified by the manufacturer.
- Store multi-dose vials outside the immediate patient treatment area.

For all vials:
- Make sure to wipe the vial's rubber septum with alcohol pads and let the alcohol dry completely before putting a needle through. The rubber septum is not sterile, even if the vial has never been opened before.

IF YOU ARE NOT SURE WHETHER A VIAL IS OKAY TO USE,
DO NOT USE IT!
WHEN IN DOUBT, THROW IT OUT

Anticoagulation Management

Policy: Anticoagulation Management, 10296041 (PC:A:18)

Goal: To reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Rationale: Complex dosing, monitoring, and variable patient response pose risk for patient harm. Standardization of care with patient involvement through education can reduce these risks.

Requirements:
Hospitals must set up management plans, and written policies and protocols allowing for individualized care when using anticoagulants.
Baseline and ongoing monitoring of therapy to include a baseline INR for all patients initiated or re-initiated on warfarin (Coumadin®) is required prior to giving the first dose. The hospital must include provisions for the involvement of dietary services for education and management of diets on warfarin patients. Education of staff, prescribers, and patients and/or families is required on an ongoing basis. Specific medication management requirements are the use of programmable pumps for IV infusions and use of unit dose or unit of use products where available. Performance improvement measures must be put in place to monitor the use of anticoagulants and related protocols continually.

Anticoagulation at Capital Health:
Anticoagulants are considered high-risk medications. The Anticoagulation Management Policy (A:18) outlines the protocols and procedures in place at Capital Health to meet the standard. The policy includes explanation of the Weight Based Heparin Protocols, medication specific monitoring of other anticoagulants, anticoagulant reversal guidelines, and requirements for patient education as well as an outline of performance improvement responsibilities. Anticoagulants used at CH include:
<u>Injectable:</u>
unfractionated heparin (UFH), enoxaparin (Lovenox®), fondaparinux (Arixtra®), bivalirudin (Angiomax®), and argatroban

<u>Oral:</u>
warfarin (Coumadin®), rivaroxaban (Xarelto®), apixaban (Eliquis®), dabigatran (Pradaxa®),

Additional anticoagulants not on formulary at Capital Health include edoxaban (Savaysa®) and betrixaban (Bevyxxa®).

Monitoring of anticoagulation therapy is critical to ensure both effective and safe care. These medications impact how quickly a patients' blood will coagulate to prevent clots or manage patients with existing clots. The degree to which a patients' coagulation status is affected by anticoagulant therapy can vary due to patient or medication related factors. Close monitoring of labs, and clinical signs and symptoms must be done to avoid excessive anticoagulant effect resulting in adverse effects, such as bleeding. Additionally, heparin based agents (including enoxaparin), may cause a significant drop in platelet counts.

In 2013, changes mandated by Medicare included the need to monitor for drops in platelets that are sometimes seen when using heparin based products. Heparin Induced Thrombocytopenia (HIT) with or without thrombosis is seen rarely but is a serious reaction and warrants avoidance of any future heparin product exposure. A HIT assay can be sent out per provider order to confirm heparin as the cause of the reaction and a positive confirmation requires heparin to be added to the patient's allergy list. Our protocols include the process of notifying prescribers when the platelet count drops by 30% from baseline after initiation of a heparin based product (heparin or enoxaparin) so that appropriate decisions can be made related to potential HIT.

Newer oral anticoagulants, referred to as DOACs (Direct Acting Oral Anticoagulants), have become a mainstay of therapy as an alternative to warfarin for many indications. Examples of these at Capital Health include rivaroxaban (Xarelto®), apixaban (Eliquis®) and dabigatran (Pradaxa®), These agents differ in that there is no monitoring parameters for efficacy as there are for older anticoagulants (ex. INR for warfarin, PTT for heparin). Clinical signs and symptoms of bleeding or clotting are the only true monitoring parameters. These newer agents should never be used concomitantly with injectable anticoagulants due to their rapid therapeutic onset (2 to 4 hours) compared to warfarin (>= 5 days). Reversal options for anticoagulants can be found in policy A:18 and may include direct antidotes, supportive care measures, or a combination of both. Each agent differs in the amount of time required for effects to wear off. When patients on anticoagulation are scheduled for procedures, the prescriber or designee must provide orders if and when to stop and restart anticoagulation or if reversal is required in relation to the procedure.

The clinical protocols for treatment and monitoring of anticoagulants are adopted from the American College of Chest Physicians (ACCP) Evidence Based Guidelines for clinical practice published in the journal CHEST or other guidelines for specialty medical practice. These guidelines outline the best evidence for antithrombotic and thrombolytic therapies based on the clinical data available for each clinical scenario. Dosing strategies for a chosen anticoagulant generally vary depending on the clinical indication. Upon placing an order for an anticoagulant in Cerner CPOE, the prescriber is required to specify the indication to allow for the ability to evaluate selected dosage regimens.

Anticoagulation Education provided to patients is to be documented in the electronic medical record to include the specific topics of education covered based on the anticoagulant ordered. Education may be provided by nursing, prescriber, pharmacy or Food and Nutrition Services.

Sepsis Recognition and Intervention

Policy: Sepsis Recognition and Intervention, 12490511 (PC:S:28)

Capital Health System follows the Centers of Medicare and Medicaid (CMS) guidelines for the identification and treatment of sepsis. Per CMS definition, sepsis exists along a continuum of severity:

- **Sepsis**: presence of two or more SIRS criteria and a suspected or confirmed infection
- **Severe Sepsis**: sepsis *plus* evidence of organ dysfunction (unrelated to chronic condition or medication)
- **Septic Shock**: severe sepsis *plus* persistent hypotension or initial lactate greater than or equal to 4.0mg/dL

Patients with Severe Sepsis and Septic Shock are required to receive timely interventions, as defined by the care standards/guidelines. Information regarding required interventions, along with forms utilized for Severe Sepsis and Septic Shock can be found with the policy – Sepsis Recognition and Intervention (S:28).

Definitions:

Systemic Inflammatory Response Syndrome (SIRS)	
Non Pregnant Criteria	**Pregnant 20 weeks through Day 3 Post Delivery**
Temperature: > 38.3 C or < 36.0 C (> 100.9 F or <96.8 F)	Temperature: > or equal to 38 C or < 36.0 C (> or equal to 100.4 F or <96.8 F)
Heart Rate (pulse): > 90	Heart rate (pulse): > 110
Respirations: > 20 per minute	Respirations: > 24 per minute
White Blood cell count: > 12,000 or < 4,000 or > 10% bands	White blood cell count: > 15,000 or < 4,000 or >10% bands

Organ Dysfunction, evidenced by one of the following:	
Systolic blood pressure (SBP) < 90 mmHg or mean arterial pressure < 65 mmHg	Systolic blood pressure (SBP) < 85 mmHg or mean arterial pressure < 65 mmHg
Systolic blood pressure decrease of more than 40 mmHg	Systolic blood pressure decrease of more than 40 mmHg
Acute respiratory failure as evidenced by a new need for invasive or invasive mechanical ventilation	Acute respiratory failure as evidenced by a new need for invasive or invasive mechanical ventilation
Creatinine > 2.0 mg/dL	Creatinine > 1.2 mg/dL
Urine output < 0.5 mL/kg/hour for two consecutive hours	Urine output < 0.5 mL/kg/hour for two consecutive hours
Total Bilirubin > 2 mg/dL (34.2 mmol/L)	Total Bilirubin > 2 mg/dL (34.2 mmol/L)
Platelet count < 100,000	Platelet count < 100,000
INR > 1.5 or aPTT > 60 sec	INR > 1.5 or aPTT > 60 sec
Lactate > 2 mmol/L (18.0 mg/dL)	Lactate > 2 mmol/L (18.0 mg/dL) Note: Do not use lactate obtained during active delivery defined as documentation of uterine contractions resulting in cervical change (dilation or effacement) through delivery or childbirth

Patients within all adult emergency, inpatient, triage, and observation areas are screened by the registered nurse (RN) continuously for sepsis utilizing the St. John's Sepsis application in the electronic medical record (EMR). The St. John's Sepsis algorithm generates SIRS and Sepsis Discern Alerts based on patients vitals in the EMR.

1. A SIRS Discern Alert generates if a patient meets three SIRS criteria. Nurses in the emergency triage, observation, and inpatient units alert the appropriate provider of the SIRS alert and document in the EMR.
2. A Sepsis Discern Alert generates if a patient meets two SIRS criteria and one organ dysfunction.

a. Nurses in emergency and critical care areas notify the provider coordinating care for the patient directly for further evaluation. The nurse documents this notification.
b. Nurses in the inpatient and observation units call a Medical Alert-Rapid Response Team and notify the provider as well as obtains appropriate resources.
c. Nurses in the Obstetrics (OB) utilize the OB/Postpartum Systemic Inflammatory Response Syndrome (SIRS) screening tool to evaluate patients for sepsis. If a patient receives a score of 4 or more, the nurse notifies the OB provider, who then determines if sepsis is a concern.
    i. If the OB provider determines the patient is not at risk for sepsis, the OB provider documents their findings and no Medical Alert-Rapid Response Team is called.
    ii. If the OB provider identifies that the patient is at risk for sepsis, a Medical Alert-Rapid Response Team is called.
    iii. If the SIRS score is greater than or equal to 4, the RN notifies the OB provider, and if the OB provider is not readily available, the RN may initiate a Medical Alert-Rapid Response Team

Sepsis interventions for severe sepsis and septic shock, known as the 0-3 Hour Bundle and/or the 3-6 Hour Bundle, are started and timed based upon the patient's presentation time (the earliest time that the patient meets all clinical criteria OR that the provider documents the presence of severe sepsis and/or septic shock). Interventions are required to occur within specific timeframes.

- **0-3 Hour Bundle Includes**:
    - Initial lactate
    - Collection of blood cultures
    - Administration of antibiotics
    - Administration of 30ml/kg of IV NS or LR *is required within three hours of lactate greater than or equal to 4, initial hypotension, or patient has documented septic shock by the provider
        - The provider can give a smaller volume of crystalloid fluid (if the rate ordered is greater than 125 ml/hr)
        - The documentation must indicate the volume given in place of a 30 ml/kg and the reason why the full 30 ml/kg is not being administered (example: heart failure)

- **3-6 Hour Bundle Includes**:
    - Repeat lactate if initial result greater than or equal to 2
    - Initiation of vasopressor if patient has persistent hypotension following fluid administration. This must be assessed within 1 hour following administration of a 30 ml/kg or following the designated smaller volume (if the full 30 ml/kg bolus is not being administered and the proper documentation is present)
    - Provider Documentation of a Focused Reassessment for Sepsis following fluid resuscitation for patients with septic shock

For additional review, refer to policy referenced above.

Antimicrobial Stewardship

Policy: Antimicrobial Stewardship, 10267853 (PC:A:26)

Given antimicrobial's increased risk for severe adverse effects, bacterial resistance, and C. difficile infections, a multidisciplinary approach is imperative to guide antimicrobial use and optimize patient care.

Capital Health has an Antimicrobial Stewardship Committee that is co-led by an ID physician and pharmacist, and includes members from other departments such as Infection Prevention, Administration, Medicine, Pharmacy, Microbiology, Nursing, and more.

Some of the committee's objectives are to evaluate antimicrobial usage and C. difficile infections, implement guidelines/protocols/policies to guide prescribing, and educate practitioners on multiple levels.

However, appropriate antimicrobial is a responsibility that extends system-wide to all types of healthcare professionals.

- Licensed Independent Practitioner's (LIP) role:
  - Diagnosing infection and determining if it's a viral, bacterial, or fungal cause
  - Selecting empiric therapy based upon most likely pathogen and local susceptibility patterns
  - Monitoring culture results and de-escalating antimicrobials appropriately
  - Establishing a treatment plan and duration of therapy

- Nursing's role:
  - Preventing the spread of infection through appropriate triage and isolation
  - Documenting accurate antibiotic allergy and allergic reaction to guide therapy
  - Obtaining cultures properly and prior to antibiotic administration if possible
  - Administering antibiotics and drawing labs appropriately
  - Following algorithm for early identification of C. difficile infections
  - Monitoring of microbiology results for resistance to currently ordered antibiotics
  - Alerting LIP of any culture results or adverse events
  - Identifying patients who meet criteria for IV:PO conversion

Conclusion:
- Almost up to 50% of antibiotics are prescribed either unnecessarily or inappropriately.
- Exposure to antibiotics with broader spectrums put patients in danger for bacterial infections with higher resistance patterns and less antibiotic treatment options.
- Longer duration of antibiotics significantly amplifies the risk for C. difficile infections and bacterial resistance.
- Fluoroquinolone use has been associated with an increase risk for MRSA, and quinolone-resistant gram-negative bacilli, ESBL producing organisms, and CRE.
- Given limited antimicrobial options for treatment of extremely-resistant pathogens, it is important to remember that more is NOT always better.

Clinical Institute Withdrawal Assessment for Alcohol and Protocol (CIWA)

Policy: Early Identification of Alcohol Withdrawal Syndrome, 10296015 (PC:A:9)

Purpose: To improve the care of the patient with AWS (Alcohol withdrawal syndrome) by identifying the diagnosis in the early stages and prevent its progression into Delirium Tremens (DTs).

CIWA PROTOCOL: Medication is administered based on CIWA-Ar score

The **Clinical Institute Withdrawal Assessment (CIWA-Ar)** score

- A 10 item scale to assess alcohol withdrawal (max score 67)
  - Mild alcohol withdrawal score *less than* 15
  - Moderate alcohol withdrawal score 16-20
  - Severe alcohol withdrawal score *greater than* 20
- AWS can begin within 1-4 hours of last drink
- DTs can begin within 1-2 days of last drink
- A nurse can score a patient at risk for AWS with CIWA without a physician order
  - If score is *greater than* 10, call the physician to evaluate for AWS and initiate CIWA protocol

Assessment: CIWA-Ar scale initiated by one of the following triggers: initial diagnosis related to alcohol, physician assessment, nursing assessment, or CADC consultation. The nurse who assesses a score of ten (10) or above using the CIWA-Ar scale calls the physician for evaluation and possible implementation of the AWS – CIWA protocol if not already ordered.

Only non-delirious patients are appropriate for CIWA.

Procedure:

- CIWA-Ar scoring in electronic medical record (EMR) or downtime order form is used to document the score of the patient.
- Reassess and re-score every 2 hours while the score remains below 10.
- VS and CIWA-Ar scale hourly when medicated until CIWA-Ar is less than 10 for 3 consecutive measurements. Neuro checks every 4 hours until CIWA is less than 10.
- Then CIWA-Ar and VS every 2 hours x 24 hours then every 4 hours until specified otherwise.
- **Provider orders PO Benzodiazepine-Valium or Ativan.** If NPO, the provider will order IV dosing.
- ***Call provider if:***

  - *CIWA-Ar score is 10 or greater after 3 consecutive doses of medication*
  - *Score of 20 or greater*
  - *Score rises by more than 10 points from the initial dose of medication or previous assessment*
  - *Vomiting or passing blood/coffee grounds*
  - *Seizure activity or difficult to arouse*
  - *Vital Signs are:*
    - *HR greater than 120/minute*
    - *SBP greater than 160 or less than 100*
    - *DBP greater than 100 or less than 60*
    - *RR greater than 30/minute or less than 10/minute*
    - *Temperature greater than 38°C (100.6°F)*

**** When CIWA-Ar score is less than 10 for 72 hours contact the provider for discontinuation of protocol.****

Remember a consult is required for the **Certified Alcohol and Drug Counselor (CADC)** to assess the patient.

Consultation with the CADC/LCADC is now an **automatic** part of the protocol and is pre-selected on the order set.

Delirium Tremens (DTs) are upgraded to ICU for management of DT protocol. Alcohol Withdrawal Syndrome (AWS) is different from DTs.

Symptoms of DTs: confusion, disorientation, severe agitation, and/or hallucinations.

Safe Use of Opioid Analgesics

Opioid analgesics rank among the highest incidence of adverse medication events. Causes for adverse events have been cited to include lack of understanding of potency differences among opioids, prescribing and administration of multiple opioids or concomitant CNS depressant agents on a single patient and inadequate monitoring of patients receiving opioids. Joint Commission Sentinel Alert number 49 was published in August of 2012 and outlines strategies to avoid opioid related adverse occurrences. The FDA has more recently adopted aggressive strategies to reduce the incidence of harm related to use of opioid analgesics.

Strategies include:

- Screening patients for risk of respiratory depression. Higher risk patients may include:
    - Sleep apnea/ sleeping disorder/ morbid obesity/ snoring
    - Risk increases with age (2.8 times over age 60, 5.4 times over age 70, 8.7 times over age 80)
    - No recent opioid use
    - Post surgical (particularly upper abdominal or thoracic surgery)
    - Longer times receiving general anesthesia
    - Increased doses or those with opioid dependence
    - Use of other sedating drugs (including multiple opioids)
    - Pre-existing pulmonary or cardiac disease or major organ failure
    - Thoracic or other surgical incisions that may impair breathing
    - Smokers
- Assessing patient history and screening for opioid tolerance, abuse or adverse events
    - Upon admission the nurse assesses for any opioid drug use, examples in the medication reconciliation and interdisciplinary admission may include:
    - Codeine
    - Fentanyl (ACTIQ, DURAGESIC)
    - *Heroin*
    - Hydrocodone (HYSINGLA, LORTAB,)
    - Hydromorphone (DILAUDID,)
    - Morphine (MS CONTIN, , ROXANOL)
    - Oxycodone (PERCOLONE, PERCOCET, OxyCONTIN, ROXICODONE, XTAMPZA, Oxaydo)
    - Oxymorphone
    - Tramadol (ConZip, Qdolo, ULTRAM, ULTRACET)
    - Methadone (Methadose)

    - Controlled substance prescription history is tracked at the state level and can be accessed via the New Jersey Prescription Monitoring Program (Clinical Tools menu on Capitalink and as a direct link through the Capital Health EMR (https://newjersey.pmpaware.net/login)
        - Registration required (free to healthcare professionals)
    - Use caution in initiating opioids on patients who do not chronically use opioids (opioid-naïve)
    - Allow adequate time for a therapy to work before increasing dosages
- Use a multi-modal plan with pharmacologic and non-pharmacologic options to manage pain. Ex:
    - Scheduled (around the clock) administration of NSAIDS, acetaminophen, gabapentin/ pregabalin, lidocaine topical patch to lower baseline pain levels
- Tailor dosing based on patient's tolerance and severity of pain
- Longer acting medications (ex. OxyCONTIN, MS Contin, Duragesic patch) are utilized for patients with chronic pain who have pain at baseline and use pain medications at home routinely to minimize the need to use as needed medications
    - Long acting pain medications have a slower onset of pain relief and are not useful in an as needed manner, but provide consistent pain relief for many hours after administration
    - Fentanyl patches (Duragesic) have an onset of roughly 6 hours and importantly can have lingering effects for up to a day or longer once patch is removed
- Breakthrough (as needed) pain medication orders can be utilized to manage pain that manifests in the time frame between **regularly scheduled pain medication administrations**
    - Breakthrough pain orders should **not** be ordered as a 4th level of as needed pain medication (ex. mild, moderate, severe, breakthrough) as this does not meet the ISMP definition for breakthrough pain
    - As needed (prn) medication orders must be specific to a level of pain (ex. mild, moderate or severe pain) and only 1 medication can be ordered for a given level of pain
        - Ex. cannot have 2 options for mild pain or moderate pain, etc.
        - Having more than one option for a given level of pain creates a situation where the nurse has to choose which option to give and is acting outside their scope of practice by doing so.
        - It is acceptable to have 2 options for a level of pain if there is a prescriber defined variable for when to give one versus the other (ex. ibuprofen PO for mild pain and ketorolac IV for mild pain if patient is NPO)
    - Make efforts to administer regularly scheduled pain medications on time to reduce the need to use as needed doses due to late or missed maintenance doses
- Capnography monitoring is available to detect signs of overdosage before it becomes an emergent situation (standard with PCA orders)
- Prospective prevention of common adverse effects of opioids such as constipation should be practiced by initiating patients on laxative / stool softener combinations when using opioids (ex. polyethylene glycol, docusate, senna, bisacodyl). As needed laxatives are often not sufficient.
- Misuse of opioids may also occur when a patient who chronically uses opioids is not prescribed opioids requisite to their needs. Unless obtunded or patient has altered metal status, chronic (tolerant) opioid users should be maintained on opioid therapy to avoid withdrawal and/or the need for "catch up" opioid dosing which can lead to over dosage due to multiple doses of opioids in a short duration of time
- Use conversion scales to determine equianalgesic dosages when converting from one opioid to another (See Pharmacy Therapeutic Handbook on Capitalink)
    - Remember to decrease the dose of the new opioid by roughly 30% of the calculated equianalgesic value to account for incomplete cross-tolerance

Managing Pharmaceutical Waste

Policy: Pharmaceutical Waste Disposal, 10602021 (P:50)

Hazardous Waste (Black Disposal Bins)

- Certain pharmaceutical wastes generated in patient care areas and in the pharmacy are considered "hazardous waste "by both the US Environmental Protection Agency (EPA) and New Jersey Department of Environmental Protection (NJDEP). Black disposal bins are located on patient care areas with signage listing the hazardous waste items for disposal in bin. Bins are to be locked and kept closed.

- **Drugs are classified as hazardous when they possess any of the following characteristics:**
    1. *Genotoxicity:* ability to cause a change or mutation in genetic material
    2. *Carcinogenicity*: ability to cause cancer in animals, humans, or both
    3. *Teratogenicity*: ability to cause defects in fetal development or fetal malformation
    4. *Reproductive toxicity*: fertility impairment
    5. *Organ toxicity at low doses*: evidence of serious organ or other toxicity
    6. Structure and toxicity profiles of new drugs that mimic those of existing drugs that are hazardous by the above criteria

SECTION XIV: Initiatives and Accreditations

Early Heart Attack Care (EHAC) Program

Purpose: To meet the regulatory education requirements for the Capital Health Chest Pain Center – Hopewell.

What is a Heart Attack?

A heart attack occurs when a vessel supplying the heart muscle with blood and oxygen becomes completely blocked. The vessel has become narrowed by a slow buildup of fatty deposits, made mostly of cholesterol. When a clot occurs in this narrowed vessel, it completely blocks the supply of blood to the heart muscle. That part of the muscle will begin to die if the individual does not immediately seek medical attention.

One of every 3 deaths in the US in 2013 was from heart disease, stroke and other cardiovascular diseases, while heart disease and stroke were the No.1 and No.2 killers worldwide. Early recognition of heart attack symptoms can save lives. If recognized in time, treatment can occur before the heart is damaged. 85% of heart damage occurs within the first 2 hours of a heart attack.
Modifiable risk factors that can influence your risk for developing coronary artery disease include: elevated levels of serum cholesterol, low-density lipoprotein cholesterol, and triglycerides; lower levels of high-density lipoprotein cholesterol; and the presence of type 2 diabetes, cigarette smoking, obesity, a sedentary lifestyle, hypertension, and stress.

It is important to know the signs and symptoms of a heart attack and that not everyone has the same symptoms. People may or may not experience any or all of the following symptoms:

- Nausea
- Chest pressure, squeezing or discomfort
- Pain that travels down one or both arms
- Jaw pain
- Fatigue
- Anxiety (feeling of impending doom)
- Back pain
- Shortness of breath
- Feeling of fullness
- Perspiration or cold sweat
- Indigestion
- Dizziness or lightheadedness

These symptoms may come and go until finally becoming constant and severe. Signs and symptoms can occur hours or weeks before the actual heart attack.

<u>Heart attack symptoms can be different between men and women:</u>

- Men normally feel pain and numbness in the left arm or side of chest, but in women, these symptoms may appear on the right side.
- Women are less likely to seek immediate medical care and are more likely to die.
- Women may feel completely exhausted, drained, dizzy or nauseous.
- Women may feel upper back pain that travels up into their jaw.
- Women may think their stomach pain is the flu, heartburn or an ulcer.

Not all patients present with typical or classic symptoms; in an atypical presentation, the signs and symptoms are different. How?

The patient may not complain about pain or pressure in the chest. Be alert for the following:

- A sharp or "knife-like" pain that occurs with coughing or breathing.
- Pain that spreads above the jawbone or into the lower body.
- Difficult or labored breathing.

What should you do if you have any signs or symptoms of an early heart attack?

If you are at home: Call 911 to activate Emergency Medical Services
If you are at the Hospital at RMC or Hopewell, dial "8888" on any hospital phone to activate the RRT (Rapid Response Team); state to the operator "RRT" and location of the emergency.

Learn more and sign our EHAC Oath electronically at *http://www.capitalhealth.org/medical-services/chest-pain-center*

Baby-Friendly Hospital Initiative (BFHI)

Capital Health is a Baby-Friendly ® Facility.

Baby-Friendly® facilities seek to protect, promote, and support breastfeeding as the biological norm, and human milk as the optimal source of infant nutrition. At Capital Health, this means we provide the highest level of clinical breastfeeding support through hands on consultation and education throughout the postpartum period. We also use human donor milk in our NICU for premature babies – a practice that is considered life saving – and on 3M for babies that need extra support.

The Baby-Friendly® Hospital Initiative is a partnership between UNICEF and the World Health Organization that assists hospitals in giving parents the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies. Hospitals that follow the "Ten Steps to Successful Breastfeeding" can apply for designation as a Baby-Friendly® facility. Capital Health has the prestigious distinction of being one of the first Baby-Friendly® hospitals in NJ: first in 2012, and then again with our re-designation in 2017. Capital Health will seek its third designation in 2022.

As a complement to the practice guidelines provided by the "Ten Steps to Successful Breastfeeding," the International Code of Marketing of Breast-Milk Substitutes is an additional tool to protect breastfeeding. In alliance with the Code, Baby-Friendly® Hospitals do not provide free samples of infant formula to new families and do not promote those products in the facility. We do this by ensuring the ID badges we wear, the trainings we attend, and the magazines we provide in our waiting rooms are free from advertising that violate the Code.

As an employee, you could encounter lactating patients in almost every setting. So while you do not need to be a Baby-Friendly® expert, you should be familiar with the Ten Steps, as well as how to find Capital Health's Newborn and Infant Feeding policy, which is located in the Patient Care policy section on CapitaLink.

Many Capital Health staff do work directly with lactating patients, whether in the postpartum setting, or in places like radiology, pharmacy, housekeeping, the ED, and Pediatrics. It is essential that employees know how to provide or seek out the support for those patients that protects their ability to breastfeed.

Some of you may currently be lactating, or may be at some point during your employment. It is important that you know that Capital Health supports your federally and state protected rights to pump your milk for your baby or child. We have pumping areas at Hopewell and RMC, and it is your right to reasonably use them.

Staff in all departments may have a lactating coworker or employee, so it is also essential that you understand and adhere to those rights on their behalf.
If you have questions about how to support your lactating patients or coworkers, our Lactation team is here for you 7 days a week (609-303-4163).

The *Ten Steps to Successful Breastfeeding* are*:*

1. Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.
    a. Have a written infant feeding policy that is routinely communicated to staff and parents.
    b. Establish ongoing monitoring and data-management systems.
2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.
3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast-milk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
8. Support mothers to recognize and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, artificial nipples (teats) and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

Provisions of the International Code of Marketing of Breast-Milk Substitutes require:

1. No advertising of breast-milk substitutes to families.
2. No free samples or supplies in the health care system.
3. No promotion of products through health care facilities, including no free or low-cost formula.
4. No contact between marketing personnel and mothers.
5. No gifts or personal samples to health workers.
6. No words or pictures idealizing artificial feeding, including pictures of infants, on the labels or product.
7. Information to health workers should be scientific and factual only.
8. All information on artificial feeding, including labels, should explain the benefits of breastfeeding and the costs and hazards associated with artificial feeding.
9. Unsuitable products should not be promoted for babies.
10. All products should be of high quality and take account of the climate and storage conditions of the country where they are used.

SECTION XV: Appendix

Gender Inequity Laws

Right to be Free of Gender Inequity or Bias in Pay, Compensation, Benefits or Other Terms and Conditions of Employment.

FEDERAL LAW

Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on, among other things, an individual's sex. Title VII claims must be filed with the United States Equal Employment Opportunity Commission (EEOC) before they can be brought in court. Remedies under Title VII may include an order restraining unlawful discrimination, back pay, and compensatory and punitive damages.

The Equal Pay Act of 1963 (EPA) prohibits discrimination in compensation based on sex. EPA claims can be filed either with the EEOC or directly with the court. Remedies under the EPA may include the amount of the salary or wages due from the employer, plus an additional equal amount as liquidated damages.

Please be mindful that in order for a disparity in compensation based on sex to be actionable under the EPA, it must be for equal work on jobs the performance of which requires equal skill, effort, and responsibility, and which are performed under similar working conditions.

There are strict time limits for filing charges of employment discrimination. For further information, contact the EEOC at 800-669-4000 or at www.eeoc.gov.

NEW JERSEY LAW

The New Jersey Law Against Discrimination (LAD) prohibits employment discrimination based on, among other things, an individual's sex. LAD claims can be filed with the New Jersey Division on Civil Rights (NJDCR) or directly in court. Remedies under the LAD may include an order restraining unlawful discrimination, back pay, and compensatory and punitive damages.

Another State law, N.J.S.A. 34:11-56.1 et seq., prohibits discrimination in the rate or method of payment of wages to an employee because of their sex. Claims under this wage discrimination law may be filed with the New Jersey Department of Labor and Workforce Development (NJDLWD) or directly in court. Remedies under this law may include the full amount of the salary or wages owed, plus an additional equal amount as liquidated damages.
Please be mindful that under the State wage discrimination law a differential in pay between employees based on a reasonable factor or factors other than sex shall not constitute discrimination.

There are strict time limits for filing charges of employment discrimination. For more information regarding LAD claims, contact the NJDCR at 609-292-4605 or at www.njcivilrights.gov. For information concerning N.J.S.A. 34:11-56.1 et seq., contact the Division of Wage and Hour Compliance within the NJDLWD at 609-292-2305 or at http://lwd.state.nj.us.

AD-290 (1/14) New Jersey Department of Labor and Workforce Development nj.gov/labor

Acknowledgment Form – VOLUNTEERS Only

Capital Health

2023-2024

MANDATORY EDUCATION HANDBOOK FOR NON EMPLOYEES & VOLUNTEERS

Documentation:

This is to acknowledge I have received, reviewed the Volunteer Training Manual/Generic Non- Employee Mandatory Education Book and taken the Annual Exam. Furthermore, believing Capital Health has need of my service as a volunteer I agree to:

- Be punctual and conscientious in the fulfillment of duties and accept supervision graciously.
- Conduct myself with dignity and consideration for others.
- Endeavor to make my service of the highest quality.
- I understand and shall abide by all the Health Insurance Portability and Accountability Act (HIPAA) regulations.

STATEMENT OF CONFIDENTIALITY

I understand and agree that in the performance of my duties at Capital Health, I must hold patient, employee, committee, peer review, and all other business operation information in confidence. This includes any confidential information I may come across in the line of duty or inadvertently, regardless of how it is presented to me (hard copy, verbal, audio, and which is electronically generated or stored). I also understand Capital Health information is only accessible to fulfill the obligation needed to plan, provide, complete, and document service provided.

I further understand any violation of confidentiality of information may result in termination of internship/affiliation and/or legal action.

_____
Date

_____
Print Name Signature

_____
Home Address City State Zip

_____
Home Phone Cell Phone