CalvertHealth®

THE GUIDE to JOINT COMMISSION READINESS

Your Joint Commission RESOURCE

2023

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Our Mission

Calvert Health's trusted team provides Southern Maryland residents with safe, high quality health care and promotes wellness for a healthy community

Our Vision

We provide exceptional care and make a difference in every life we touch.

Compliance is everyone's responsibility!

"In any moment of decision, the best thing you can do is the right thing." – Theodore Roosevelt

In health care, we are surrounded by guidelines in the forms of laws, rules, regulations, mandates and directi
are all responsible for following these rules and protecting the organization, ourselves and especially our pat
To help us do that, we have set up policies and procedures to guide our behavior and actions, a Code of Con
provide an overview of acceptable behavior and basic guidance for important issues, and a Compliance Plan
measure and monitor how we are doing and promote proactive compliance with healthcare laws and regulat
requirements.

Our behaviors and actions are what define us as an organization. Following the rules/regulations (complianc
performing job duties in a way that avoids harmful and/or inappropriate activities (ethics) and doing the righ
the first time and every time (integrity) are all pieces of the puzzle. These pieces extend beyond us just doing
jobs and help to build proper compliance practice into everyday workflow setting the groundwork and expec
for a culture of compliance excellence across the organization.

Some ways to help create a culture of compliance excellence include:

1. Attend training/ retraining and education programs as needed.
2. Stay educated on compliance requirements for your area.
3. Know and follow the organization's policies and procedures.
4. Ask questions if you don't understand something.
5. Report compliance concerns.

A critical part of your responsibility to compliance, besides being compliant yourself, is to report something
you think may be a problem. You can report anonymously if you choose and there will never be any form of
retaliation for reporting a possible issue in good faith. Report any concerns of compliance violations immedi
using your chain of command, to a member of the Compliance Team, anonymously through our **Compliance
Hotline (410.535.8282)** or through the Compliance Concern online web form on the Intranet under the Com
tab.

If you are unsure as to whether an action is inappropriate or a compliance violation, contact a Compliance T
member. We are here to help!

Ways to Report Compliance Concerns:

- Compliance Hotline: Call 410.535.8282
- Anonymous Compliance Concern webform: Click here to report a compliance issue.
- Report directly to someone in your chain of command, the Chief Compliance Officer, or to a Compli
  Team member.

The Compliance Team:

Patrick Garcia
Chief Compliance Officer
Patrick.Garcia@Calverthealthmed.org
410.414.2795

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CHMC—A Primary Stroke Center

CalvertHealth Medical Center is a designated Primary Stroke Center by the Maryland Institute for Emergency Medical Services Systems (MIEMSS), recognizing that CHMC meets or exceeds the requirements set by the state for effectively treating strokes.

This designation assures stroke patients that CHMC is using the latest and most effective therapies and treatments to ensure the best possible outcomes. In addition, the designation also permits Emergency Medical Services (EMS) personnel to transport apparent stroke patients to CHMC over a non-designated center. To receive the designation as a Primary Stroke Center, Calvert's program went through rigorous application and survey processes in December of 2007. We completed the re-certification process in May 2018 and are due for re-certification in May 2023.

In August 2022, CalvertHealth Medical Center was awarded the *Get with the Guidelines Gold Plus* Award for the ninth consecutive year. CHMC also received recognition as Target Stroke Honor Roll Elite Award recipient. This award is given to hospitals who administer tPA to 85% of eligible patients in less than 60 minutes of hospital arrival. We also received the Target Type 2 Diabetes Honor Roll Award in 2022, which aims to ensure patients with type 2 diabetes receive the most up-to-date, evidence-based care when hospitalized with a stroke. CHMC strives to promote patient safety and provide the best, quality care we can for our patients. This award demonstrates our commitment to our patients and their outcomes. As an organization we are constantly striving to improve ourselves and the quality of our care.

EARLY STROKE IDENTIFICATION STRESSED: A stroke is a "brain attack" that cuts off vital blood flow and oxygen to the brain. It is the third leading cause of death and the leading cause of adult disability in the United States.

One of the available treatments for stroke patients at CHMC is the "clot-busting" medication t-PA (tissue plasminogen activator). This medication can only be administered within 4.5 hours of the onset of symptoms and only after the patient has been medically assessed and had a CT scan of the brain. Unfortunately, most people ignore the symptoms, and wait to see if they'll go away or wake up with the effects. Since time is of the essence, it is important to know the signs and symptoms of an acute stroke.

As healthcare workers, we must educate our community about the signs of stroke. Within the hospital environment, we must recognize the signs and call a Code Stroke (x8222) immediately.

10 Symptoms of Stroke

1. Confusion
2. Difficulty understanding
3. Dizziness
4. Loss of balance
5. Numbness
6. Severe headache
7. Trouble speaking
8. Trouble walking
9. Vision changes
10. Weakness

For any questions or concerns, please feel free to contact the Stroke Coordinator – Crystal Gray at Ext. 4759

Advanced Directives and MOLST

An **advance directive** is a document that allows patients over the age 18 to give the healthcare team direction about future medical care in the event of a medical emergency or catastrophic illness. These are examples of advance directives:

- ➔ Living wills
- ➔ Health Care Power of Attorney/Durable Power of Attorney

Medical Orders for Life-Sustaining Treatment (MOLST):
MOLST is a portable and enduring medical order form signed by a physician, nurse practitioner, or physician assistant. It contains orders about cardiopulmonary resuscitation and other life-sustaining treatments. A MOLST form must be completed for all individuals who want to change their code status or who are admitted to nursing homes, assisted living programs, hospices, home health agencies, and dialysis centers. It must be completed for hospital inpatients being discharged to another hospital or any of the above programs.

It is the hospital's responsibility to determine if a patient has, or wishes to make, an advance directive. Patients are asked about advance directives and MOLST forms when they are admitted and during their nursing assessments. Patients also receive a patient handbook, which contains information on advance directives. In addition, the hospital will assist patients who want to formulate an advance directive.

Process for Advance Directives (AD):
Does patient have an Advance Directive?

Yes ➔ A copy of the AD is placed in patient's record. A copy is required in order for staff to follow the patient's wishes (if the patient lacks capacity to make their own decisions or to appoint a healthcare agent to make decisions on their behalf.)

Admitting nurse asks if the patient has an advance directive, as part of the admission assessment process.
They can also check Meditech to see if one is

No ➔ If the patient does not have advance directives but wishes to formulate them, notify Case Management for assistance.

Communication of the Healthcare Team: SBAR & AIDET

SBAR: SITUATION, BACKGROUND, ASSESSMENT, & RECOMMENDATION
Studies across the nation clearly identify **communication failure** as the leading cause of adverse events. Members of the healthcare team are expected to communicate essential patient related information in a timely and effective manner. Use of "SBAR" is the process CHS has chosen to communicate. SBAR is a methodology to present information in a brief, organized manner, and avoid irrelevant information. It is especially useful to communicate information from one healthcare member to another when time is critical.

SITUATION: *Briefly* describe the situation
- ✓ Identify yourself and your unit
- ✓ Identify patient and unit if a patient is involved
- ✓ State the problem, when it happened/started, location and severity

BACKGROUND: *Briefly* provide background information specifically related to the current situation
- ✓ Briefly what led up to the issue
- ✓ Any other information that may be important to fixing the problem

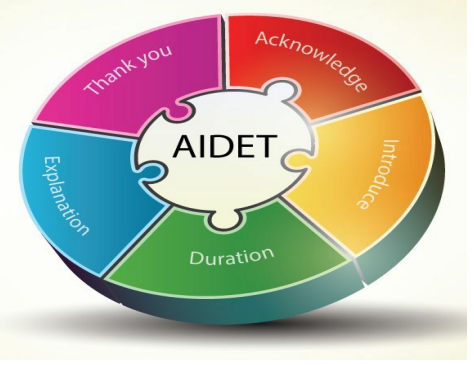
If a patient is involved:
- ✓ Admitting diagnosis and date of admission
- ✓ List of current medications, allergies, and IV fluids
- ✓ Most recent vital signs
- ✓ Key diagnostic results
- ✓ Code status
- ✓ Other pertinent clinical information

ASSESSMENT: Describe what is thought to be the problem. (i.e., "The problem seems to be cardiac." "I've given the patient the max dose of pain medication and she still rates her pain level at 9." "The pipe is gushing water and the floor is flooding.")

RECOMMENDATION: *Briefly* describe your recommendation; what you think needs to be done. (i.e., lab work, medications, and/or patient needs to be seen by the physician for further evaluation. Plant Ops needs to turn off the water, we need housekeeping help to clean up, we may need to help to find a different way to deliver the services we usually deliver until we can resume operations as usual)

AIDET: ACKNOWLEDGE, INTRODUCE, DURATION, EXPLANATION, & THANK YOU

AIDET ***is*** our way of communicating with patients, family, co-workers & physicians; using key words at key times. The goal of AIDET is to make CHS a better place; for employees to work, for physicians to practice and for patients to receive care. AIDET helps to reduce patient anxiety, increase trust and improve clinical outcomes. We all must commit to this practice. AIDET is a powerful form of communication that promotes compassionate and safe care. As such, it *is a* requirement, *not* a recommendation.



ACKNOWLEDGE:
- ✓ Greet the person by name
- ✓ Make people feel like welcomed This sets the tone for trust & shows that we care

INTRODUCE:
- ✓ Always tell people your name
- ✓ Tell people what your role is

DURATION: Be Specific
- ✓ Give a time expectation for how long something will take, or when something can be expected.

EXPLANATION:
- ✓ Describe what will take place, what the person can expect
- ✓ If you can, share the reason or background information that will help explain what is happening
- ✓ Use terms that most people can understand

THANK YOU:
- ✓ Thank people for choosing CalvertHealth and for trusting us with their care

Example 1: Good afternoon, my name is Sue. I will be the tech caring for you this evening.
The name on your chart is Samuel Jones. Should I call you Mr. Jones? Do you have a preferred name or nickname?
Let's first get you vital signs. This will take less than 5 minutes. The nurse told me that you had a fever earlier today, and that you got Tylenol, so let's check how your temperature responded.

Thank you so much. Is there anything else I can get for you before I leave the room?

Example 2: Good afternoon, Mrs. Jones, my name is Sue, and I am your respiratory therapist today. I understand you had some issues with breathing during the night, and your oxygen levels dropped. I talked to the doctor, who said she would come to see you in about an hour. In the meantime, I am going to increase the amount of oxygen you are getting, and I will come back in about 15 minutes to check you oxygen saturation again.
I want to thank you for being patient with us as we try to get you better and thank you for choosing Calvert Health.

Competency and Training

What is your role in the Hospital? How does your job contribute to patient care at CHS? What does your job description say? These are questions that EVERYONE should be able to answer. You should also be able to respond to questions related to:

- Your orientation to CHS and your job.
- Your supervision and performance evaluation.
- Your ongoing education.
- Your licensure, certification, credentialing, if applicable.

When Joint Commission Surveyors ask these questions, you can share these highlights with them:

- **Orientation: All newly hired employees complete both General Orientation and Departmental Orientation.**
  - Time Frame: The orientation period is six months for new employees.
  - General Orientation (for all newly hired employees) includes, but is not limited to: CHS's Mission, Vision, Strategic Plan, Code of Conduct (including Ethics & Corporate Compliance), Patient Rights & Patient Safety, Performance Improvement, Infection Control, Safety/Security, Specific Needs of Patient Populations that we serve (cultural, disabilities, age difference, etc.)
  - Departmental Orientation (Phase Two) gives an overview of skills and competencies that the

new employee will need to function effectively in his/her new department/worksite. This portion of orientation is essential in providing employees with the tools they will need to be successful in their individual departments.

- **Skill-based competencies are evaluated at the time of hire, at least annually thereafter, and when a current employee transfers to another position at CHS.**
- **Ongoing educational programs are provided at CHS.**
  - A wide variety of clinical and non-clinical courses are offered to staff throughout the year.
  - Access to literature, online learning modules, and other resources through various platforms that can be accessed through our intranet.
  - Literature research is available for assistance with hospital projects.

Clinical Privileges for Medical Staff: Medical Staff credentialing can be obtained in Meditech. It is also available by contacting the Medical Staff Office or the Clinical Coordinator.

Core Measures

Core Measures track compliance with various standards of care which has been shown to result in improved clinical outcomes for patients across our nation. Core Measures *are* best practices, based on the latest literature. The measures are carefully researched and scientifically proven to improve outcomes. Striving for, and maintaining the national benchmark in each category, is testimony to our patients and our community that we are committed to providing the highest quality care possible. Currently, CHMC participates in the following:

- ✓ Emergency Department (ED)
- ✓ Perinatal Care (PC)
- ✓ Sepsis (SEP)
- ✓ eCQM's- Electronic Clinical Quality Measures in the following areas:
  Perinatal Care, Stroke, Safe use of Opioids, and Venous thrombosis prophylaxis.

Clinical Staff are responsible for familiarity with these measures. Monthly multi-disciplinary meetings are held to review data and seek areas for improvement. Results are found in the Quality Section of the Intranet or on your PI Bulletin Boards. Unit directors will review pertinent outcomes with you during staff meetings.

Documentation in the Medical Record

If you are involved with direct patient care, proper documentation is a critical part of your job. Documentation provides a vital record of the episode of care. **It is ESSENTIAL** (and regulation) **to date, time, and sign all entries**. This includes ***ALL entries*** regardless of discipline (Medical Staff, Nursing, Rehab, Pharmacy, etc.). The medical record serves as a key mechanism for health care providers to communicate with each other. Make sure you know your department's documentation requirements, including:

- Non-approved abbreviations
- Time frames and/or frequency for documenting
- How patient documentation is kept confidential

The following is a list of challenging documentation standards. Keep them in mind and strive to adhere to the standards 100% of the time:

- No prohibited abbreviations in the record
- Telephone orders are timed, dated and signed as soon as possible
- Remember, verbal orders are ONLY to be used in emergent situations
- Functional status is assessed when warranted by the patient's needs or condition
- Pain is assessed & reassessed on all patients (within 1 hour) as needed. Results are to be documented

- Patient's history and physical examination, nursing assessment and other screening assessments are completed within 24 hours of inpatient admission
- If a history and physical (H&P) exam is performed within 30 days before admission, a durable, legible copy of this report is used in the patient's medical record and amended to reflect any changes that may have occurred.
- Before surgery, the patient's physical exam and medical history, any indicated diagnostic tests, and a preoperative diagnosis is completed and recorded in patient's medical record. It must be updated on the day of surgery. If over 30 days old, the H&P must be redone
- Any patient, for whom moderate or deep sedation or anesthesia is contemplated, must receive a pre-sedation or pre-anesthesia assessment
- When the operative report is not placed in the medical record immediately after surgery, a progress note is entered *immediately* (immediate post-operative note)

Emergency Management Codes

Emergency Preparedness Procedures are designed to direct you during emergencies such as fires, disasters, bomb threats or other emergencies. Each department has a CHS QUICK REFERENCE GUIDE so that it is readily accessible when needed. This guide can be used to answer questions from inspectors and surveyors.

It is everyone's responsibility to be familiar with their response requirements for these codes:

CODE RED	Fire and/or Smoke
CODE PINK	Infant or Child Abduction
CODE BLUE	Cardiac/Respiratory Arrest
CODE GREEN	Physically Combative Person(s)
CODE GOLD	Bomb Threat
CODE ORANGE	Hazardous Material Spills
CODE GRAY	Patient Elopement
CODE PURPLE	Security Emergency
CODE U	Radioactively Contaminated & Injured Patient
CODE YELLOW	Activate for Internal/External Disaster

- **ARMED AND DANGEROUS PERSON/ACTIVE SHOOTER:** An armed and dangerous person is a hostile individual who is armed with a weapon with the intent of causing harm to oneself or others. If you witness this situation, please do the following as quickly as possible: RUN, HIDE and FIGHT. As soon as it's safe to do so, Call 911 and x8222 to alert others and initiate a law enforcement response.

- Operators will alert security and establish communication with 911.

- Security will attempt to locate the armed and dangerous person and provide information to responding law enforcement officers.

- Continue your response until an **ALL CLEAR** is announced overhead.

Code Red—Fire and/or Smoke Emergency

- Hospital personnel in the immediate fire area shall:

  Rescue persons in immediate danger from fire.
  Activate alarm "pull box" **and** inform Communications Operator by telephone (x8222): give location, object burning, persons in danger, etc. Pull box to be activated for any fire or possible fire. **C**onfine the fire – close doors and windows.
  Evacuate persons. Extinguish the fire, if able to do so safely.
  NOTE: Initial evacuation will be for staff to move patients to a safe area on the same floor or level. A one-person blanket drag or MedSled Device, a hard plastic device used to pull a person over any terrain, is the transportation method of choice for non-ambulatory patients moving vertically or where beds cannot be used. Vertical evacuation (movement to a safe area on a different floor/level to exterior of building) is to be authorized by Incident Commander or designee or responding fire/police/rescue officer

- Staff **not in fire area** or responding to fire scene shall:
  a. Close all windows and doors.
  b. Clear hallways.
  c. Reassure and calm all persons.
  d. Avoid making unnecessary calls or use the paging system during the emergency

- To use a fire extinguisher, remember the following:
  Pull the safety pin
  Aim the nozzle at the base of the fire
  Squeeze the handle
  Sweep back and forth across the base of the fire

OTHER FIRE RESPONSE INSTRUCTIONS:

- Remain calm
- Clear the halls of any equipment
- Leave lights on
- Do not use elevators
- Restrict use of telephones to fire related issues
- Maintain usual routine and be alert for further instructions.
- Do not enter a smoke filled room unless *absolutely* necessary. If you must enter, crawl on hands and knees, and cover nose and mouth with a wet cloth.
- Leave doors closed if they are hot to touch. If no patients are inside, place a wet towel at the bottom of the door.

Medical Gas Shut-off:

Respiratory Therapists, Anesthesia and Imaging Services are authorized to shut off oxygen anywhere in the facility. Nurses, and Imaging Services Technicians can turn off oxygen in the areas they are designated to work. Maintenance can help determine the need to shut down the oxygen system, but patient outcomes are dependent on swift action of the clinical staff. Clinical staff must assess the patient need for oxygen and provide supplemental oxygen tanks, if needed, prior to the oxygen system being shut off. If evacuation becomes necessary, the Hospital Command Center will provide direction.
Only the fire Marshall can order medical gases be turned back on pending system inspection.

Code Pink—Infant or Child Abduction

The protection of infants and children is a proactive responsibility for everyone in the facility. All health care personnel should:

- Wear hospital identification badge at all times
- Inform all parents that children should not be taken away from them unless the employee presents proper identification
- Be observant of activities in and around the hospital.
- Report all suspicious persons/activities to Security.

WHAT TO DO IN THE EVENT OF A MISSING CHILD

All Employees	Nursing	Communications	Security
♦Immediately call **ext. 8222** in the event of an unlawful attempt to remove a child ♦**Be Observant** of physical appearance ♦All departments will assign staff to physically stand and observe at each dept. entrance and exit ♦Refer all media to public relations dept. or Administrator-On-Call	♦Ensure all newborns, infants and children are properly identified with proper hospital ID bands	♦Announce 2 times *Code Pink*, age and sex of child and dept. or area where event occurred. Repeat after two minutes then repeat announcement in fifteen minute intervals until canceled by Security ♦Notify Security via radio of the Code Pink ♦Relay information to Calvert Control Center as requested by Security	♦Report to area where suspicious person or activity has been reported. ♦Attempt to have all hospital exits closed. ♦Attempt to locate & recover infant/child ♦Have the Communications Operator **notify police immediately if the child has been removed from the facility** ♦Refer all media to public relations dept. or Admin on Call ♦Have the Operator announce "all clear" when appropriate

Code Blue—Respiratory/Cardiac Arrest

If you discover someone who has suffered cardiac or respiratory arrest, (they are unconscious and do not appear to be breathing), you should:

A. Initiate CPR and activate the Code Blue response team.
B. Push the Code Blue button in the patient room or dial x8222 to activate the Code Blue response team. Start and continue CPR until relieved by the Code Blue team.
C. Unit specific Code Blue processes will be reviewed with staff by their supervisor in specialty areas.
D. Exceptions are noted for the following areas:
   a. M.O.B. :
      i. Code Blue can be announced in MRI and Infusion by pushing the Code Blue button or by calling **ext. 8222**.
      ii. For Code Blue's occurring in the Medical Offices or Walgreens **call 9-1-1**.
   b. CMAC and Annex Building:
      ii. **Call 9-1-1** in the event of a Code Blue

Code Green—Physically Combative Person(s)

Code Green When an individual becomes violent and/or combative and additional personnel are required for the safe management of the person, a CODE GREEN will be initiated by **dialing ext. 8222.** The operator will immediately announce code overhead. In addition, the operator will notify QRT members by handheld radio or other available means.

- When the CODE GREEN announcement is made, Security and Quick Response Team (QRT) members shall respond immediately to the location of the incident.
- When the situation is under control and/or no further assistance is needed, the Communications Operator will be requested to initiate "CODE GREEN ALL CLEAR" via the overhead paging system. At least one security officer will respond to the location to ensure the safety of all persons, even if the CODE GREEN is cleared or canceled before their arrival

Code Gold—Bomb Threat

A bomb threat will be identified as "Code Gold". "Search and locate" efforts will be activated by direct announcement to individual departments by the person in charge of the search. Key hospital personnel will coordinate "search and locate" efforts under **the direction of CHS security.** Overhead paging is not done unless deemed necessary by the President or designee. All persons should remain calm, alert and should not mention "bomb threat" to the patients and public. The person receiving the bomb threat should stay on the call while a second person notifies the operator at ext. **8222**.

Receipt of a Bomb Threat:

1. Take notes (use Bomb Threat Checklist contained in the red Quick Reference Guide).
2. Ask the caller to repeat message and **record caller ID information if possible**.
3. Ask the caller for the location of the bomb and time of detonation if it is not provided.
4. Listen for background noises such as motors running, music, voices, aircraft, church bells, foghorns, and any voice, which may give a clue as from where the call is being made.

If you discover a bomb or suspicious item:

1. **Do *not* touch** or move the suspicious object. Secure the area.
2. Notify the Security Department, they will notify law enforcement for further investigation.

Code Orange—Hazardous Material

If you spill or discover a spilled chemical:

- Evacuate all people from the immediate area.
- Contain the spill.
- Restrict access to the contaminated area.
- Obtain the SDS (Safety Data Sheet) via the hospital intranet or call 1-800-451-8346 for a faxed copy. Follow clean up procedures as directed.
- If unable to clean the spill, dial Operator on **ext. 8222** and request a "Code Orange" activation.
- Notify department manager or clinical coordinator
- Available trained personnel will respond with spill tamer kits

Code Gray—Patient Elopement

If it is discovered that a patient who has been assessed by a physician and found to have diminished decision-making capacity, or is a mental health patient, who leaves or attempts to leave the hospital without complying with proper discharge procedures, this will be called an elopement. The patient shall be classified as missing and appropriate steps will be taken to investigate and determine their status and location.

1. Immediately after determining a patient is missing:
   a. The Charge Nurse will direct staff to search each patient room and all other areas of the unit. Obtain assistance from Security if needed.
   b. If the patient is not found, the Charge Nurse will activate a CODE GRAY by having the Communications Operator (**ext. 8222**) announce the CODE GRAY
   c. Communications Operator will announce CODE GRAY, including the floor or area of occurrence, and contact security via handheld radio.
   d. Security will:
      i. Assist with search of floor and all hospital areas as time permits
      ii. Request police assistance for off-campus search if needed
      iii. When the patient is located, immediately inform the patient's charge nurse or Clinical Coordinator and physician.
      iv. Encourage the patient to return to the floor (escort) and/or require them to return if ordered by a physician.
   e. Nursing Manager/Director and Security will direct activities of staff.
   f. When the patient is either located by staff or returns, the Communications Operator is to be notified to announce, "Code Gray, All Clear".
2. Record following information on the patient's medical chart:
   a. Circumstances preceding elopement
   b. Time patient last seen and by whom
   c. Clothing worn by patient
   d. Direction taken, if known
   e. Persons notified of elopement
   f. Follow-up actions completed.
   g. If patient was found or returned to room, when and how
   h. Patient's physical and mental status on return
   i. Date and time physician and family or caretaker was notified of all action
   j.

Code Purple—Security Emergency

When an immediate response from Security is needed (i.e. argument, patient attempting to elope, crime in progress, etc.), the following steps will be taken:

- Contact the Communications Operator at **ext. 8222** or press the code purple button (in units/departments where one is installed).
- Hospital Operator will
  - Overhead page "Code Purple" two times
  - Notify security officers by security radio
  - Notify security when code is cancelled
- Security officer will respond as requested to provide assistance.
- Security officer will document the event in the CHS safety net.
- Code Purple does not illicit the Quick Response Team.
-

Code U—Radioactively Contaminated & Injured Patient

Code U identifies any situation where a person who is believed to be radioactively contaminated is coming to or already at CHMC to be decontaminated and/or receive medical treatment.

- Code U will be activated by Administrator on Call after Emergency Department verifies that the contaminated patient is at or is en route to CHS by advising the Communications Operator.
- The Communications Operator will announce Code U and notify Security via radio
- Designated staff will respond to the Emergency Department or Radiological Emergency Area (REA) in the Hospital Decontamination Room to prepare for receipt of patient.
- Security, Plant Operations, Materials Management and Housekeeping personnel will prepare the REA by removing stored items and obtaining necessary supplies.
- The Communications Operator will repeat the Code U announcement 2 times or announce an "All Clear" upon instruction from Clinical Coordinator or Administrator on Call.
- Additional information or directions will be obtained by referring to the CalvertHealth Medical Center Treatment of Radioactive Contaminated Patients from the CHS Emergency Plans
-

Code Yellow—Activate for Internal/External Disaster

A **disaster** is an emergency situation of a magnitude that overwhelms the "normal emergency" resources available at CHS. The hospital's alert system is a 4-tiered approach based upon the magnitude of an incident. Specific criteria such as the impact on patient census, staff, facilities, and/or materials are used to gauge impact. **PLAN ALERT STATUSES**

- **ALERT STATUS 1:** Notification/Alert
  - Information is received indicating a situation or incident could have a potential or actual unusual impact on facility operations. Activated to maintain monitoring of event, situational awareness, and begin resource planning.
- **ALERT STATUS 2:** Minor Impact
  - An actual situation or event that is having a minor unusual impact on facility operation
- **ALERT STATUS 3:** Significant Impact
  - An actual situation or event that is having a significant unusual impact on facility operations
- **ALERT STATUS 4:** Catastrophic Impact
  - An actual situation or event that is having a catastrophic impact on facility operations

CODE YELLOW ACTIVATION PROCEDURE:

1. When the Administrator-On-Call has determined to activate the CHS Code Yellow Plan-Internal/External Disaster, the Operator will be notified and directed to announce a Code Yellow, and the Alert Status (1, 2, 3, or 4).

2. When the Code Yellow Plan is activated, each department or employee will refer to their Emergency Operations Plan or Quick Reference Guide.
3. The Operator will announce “Code Yellow- Internal/External Disaster”, Alert Status change when directed by Administrator-On-Call or CHS Incident Commander.
4. The Operator will be directed to announce “Code Yellow All Clear” when Code Yellow is terminated.

Supervisors of each department should fill out the Status Report Form within 15 minutes of the Code Yellow announcement and at any alert status change thereafter and deliver it to the Hospital Command Center.

Contact the Clinical Coordinator for any of the following:

- Electrical Power Loss
- Water Loss
- Medical Vacuum Loss
- Communication Loss (phones, pagers, etc.)
- Information Systems Down (MEDITECH, Allscripts, Network)

Failure Modes and Effects Analysis (FMEA)

CalvertHealth Medical Center is accredited by The Joint Commission (TJC) and is required to be in compliance with all standards set forth by TJC. In the Leadership Chapter, standard LD.03.09.01 EP 7, it states "At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment."

Within the Joint Commission requirements, selection of a topic include processes that have the greatest potential for affecting patient safety and must be based, in part, on information published periodically by The Joint Commission that identifies the most frequently occurring sentinel events and processes that pose high risk to patients.

FMEA is a systematic, proactive method for evaluating a process and identifying the parts of the process that are most in need of change. FMEA includes review of the following:

- Steps in the process
- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences of each failure?)

CHS uses FMEAs to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred. This emphasis on prevention may reduce risk of harm to both patients and staff. The FMEA process is particularly useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.

Examples of recent FMEAs done here at CHS are Management of EKGs, Specimen Collection and Administration of Continuous IV Fluids, Dialysis Scheduling, and the management of insulin pumps and continuous glucose monitoring within the facility.

HIPAA: Privacy & Confidentiality

HIPAA, Health Insurance Portability & Accountability Act of 1996, has 4 goals:

- Protect insurability of workers/families when they change/lose jobs.
- Simplify health care administration.
- Standardize electronic communication of patient health related information.
- Protect the privacy & security of individual health information.

Confidentiality of patient, employee, and business data is extremely important. You are held accountable for protecting the confidentiality of this information.

THINK ABOUT WHAT YOU SAY AND *WHERE* YOU SAY IT!

Here are some other things you should know:

- Log off **or lock your computer screen** when away from the computer
- Staff is required to sign a confidentiality agreement
- Computer passwords must NOT be shared -- users must sign off after using a computer
- Patient-specific information can only be discussed with staff that needs to know & will **NOT** be discussed in public areas like elevators, waiting rooms, the cafeteria, or corridors
- Voice volume should be modulated in areas where patient privacy is compromised
- Doors/curtains are pulled closed & patients appropriately covered during treatments and transport
- Knock on door and announce self before entering
- Physicians and staff use consultation rooms to discuss care with families

- Always double-check a fax number before faxing patient information
- Do not discard patient information in trash – must be shredded or placed in shred bins
- Do not download patient/confidential files onto non-CHS computers or media
- **Encrypt all emails with Protected Health Information that is being sent to non-Calvert Health .org email address by encrypting the message by using the word SECURE in the email subject line**
- Employees may not access their families' or their *own* medical records without going through the proper channels in the health information management department

Impaired Staff

Today's hectic lifestyles can present increased challenges and stress. Calvert Health System, through the LifeWorks Program, offers its employees exceptional tools and resources to help manage work and life demands; however, some staff may resort to alcohol and/or other substances as a means to cope with stressful situations. If you suspect a staff member is impaired while at work, notify your supervisor verbally or in writing. Please refer to the Drug Free Workplace Policy, HR 3-04. The following is a list of possible "indicators" of impairment:

- Irritability, depression, mood swings
- Irresponsibility, poor memory, poor concentration
- Unexplained accidents or injuries to self
- Neglect of family, isolation from friends
- DWI arrest or DUI violations
- Financial and/or legal problems
- Unkempt appearance, poor hygiene
- Trembling, slurred speech
- Bloodshot / bleary eyes
- Complaints by patients and staff
- Argumentative, bizarre behavior
- Noticeable dependency on alcohol or drugs to relieve stress
- Intoxicated at social events or odor of alcohol on breath while on duty
- Inappropriate treatment or dangerous orders
- Dwindling practice
- Excessive prescription writing
- Loss of interest in professional activities, social, or community affairs
- Difficult to contact or failure to return calls
- Missed appointments, unexplained absences
- Conducts patient rounds at irregular times
- Neglect of patients, incomplete charting, or neglect of other duties
- Unusually high doses/wastage noted in drug logs

Infection Control

We are all responsible for reducing the risks and spread of infections. The most important way to prevent infection is frequent **hand hygiene,** appropriate use of isolation precautions, and cleaning the environment. Here are some other things you need to remember about preventing infections:

- **DO NOT COME TO WORK with an infectious illness** (i.e., cough or rash with fever, conjunctivitis diarrhea; etc.)
- Get vaccinated for seasonal influenza each year and other circulating influenza viruses as recommended by the State Health Department
- Participate in the annual screening program for TB
- Use **"Standard Precautions"** with ALL patients regardless of their diagnosis
    - Wear Personal Protective Equipment (gowns, gloves, masks, face shields) to prevent occupational exposure
    - Use clean gloves when touching all body fluids, when performing venipuncture, and when handling any medication; especially when spiking IV fluids, IV medications, and blood bags.
    - Wear masks and protective eyewear when performing procedures which may splash or splatter
    - Always comply with Isolation precautions when posted on patient door (Contact, Enteric Contact, Droplet, Airborne, Protective, Special or any combination) and encourage/assist fellow staff members, family and visitors with compliance

- Perform Hand Hygiene
  - Know your department's hand hygiene compliance percentage
  - Use alcohol hand sanitizer BEFORE and AFTER patient contact, before donning and after doffing gloves, before and after any procedure, moving from a dirty area to a clean area on a patient, and after touching the patient's environment.
  - Wash hands with soap and water whenever visibly soiled, before eating and after using the restroom and when caring for a patient with Clostridium Difficile/infectious diarrhea or a potential bioterrorism agent.
  - Do **NOT** touch eyes, nose, and mouth unless hand hygiene has just been done! Wash hands after.
- Perform safe injection practices
  - One needle + one syringe = one injection
  - If using a single dose vial, discard after one use
  - Multi-dose vials must be labeled with the expiration date (28 days after opening, unless the manufacturer specifies a different, shorter or longer date) and **NOT** the open date
  - Use appropriate aseptic technique when withdrawing from multi-dose vial

Other Infection Control reminders:

- Sterile water and sterile normal saline for irrigation procedures are to be marked with the patient's name, date, and the end use date (24 hours after opening). These solutions are then single patient items and are to be discarded after 24 hours.
- Observe all required COVID-19 precautions
  - All staff are required to complete a health attestation statement prior to beginning their shift.
  - All staff must wear appropriate PPE when in a COVID positive or PUI room (Eye protection, N95 mask or PAPR, gown, gloves)
  - All staff must wear a surgical mask when in any patient care or patient-facing situation.
  - Other COVID related information can be found on the Intranet via the COVID-19 tab.
- **CLABSI**—Central Line Associated Blood Stream Infection
  - Limit use and duration of Central Venous Catheters
  - Keep dressing clean, dry and intact
  - Change dressing per hospital policy
  - Scrub the hub with alcohol for 30 seconds prior to accessing; *this applies to all medical insertion hubs*
  - Notify provider when access is no longer needed
  - All inpatients with an accessed central line are to have daily CHG bathing
- **CAUTI—**Catheter Associated Urinary Tract Infection
  - Limit use and duration according to hospital policy and approved indications only
    - Obstructions
    - Neurogenic bladder
    - Immobility due to trauma (hip, pelvic, femur fractures)
    - Strict I/O—ICU only
  - Remove on surgical post-op day 1, unless otherwise indicated
  - Notify provider when patient no longer meets indications for urine catheter
- **Prevent Blood borne Pathogen Exposure**
  - Wear PPE appropriate for the task. Wear eye protection and face mask for any procedure that has the potential for creating a splash, i.e. irrigating a urine catheter.
  - Engage safety devices after use to prevent occupational exposures
  - Discard all needles, sharps and broken glass IMMEDIATELY after use in approved puncture resistant needle boxes
  - Never bend, break, or recap needles

- When sharps containers are ¾ full, they should be removed by EVS, locked closed, and placed in the soiled utility room for pick-up. A new container should be placed in the room and secured.
- Get vaccinated against Hepatitis B
- Report all accidents or expires immediately to your department manager or clinical supervisor for directions on treatment and completing forms

- **Cleaning of the Patient's and Staff's Work Areas**
  - Cleaning the environment is everyone's responsibility to ensure safe care is given.
  - High-Touch Areas, such as keyboards, counter tops, IV poles, other patient equipment, should wiped with appropriate cleaning cloth at least once each shift. Tray tables for patients should be wiped before each meal.
  - Multi-patient use items, like stethoscopes and vital sign machines and cuffs, should be wiped clean between each patients' use.
  - Don't put dirty equipment in a clean patient's room. Any equipment that has been located in storage for an extended period should be wiped down to remove any dust that may have collected prior to placing in a patient's room/area.

What to do if you get an exposure/needle stick: In the event an employee has an exposure to body fluids, either through the skin (needle stick) or onto the mucous membranes (mouth, nose or eyes), or prolonged skin contact with a large amount of blood or body fluids:

- Provide first aid
  - For splash, flush eyes/mucous membranes with lots of water – Minimum 5 minutes
  - For needle stick, cut or wound, wash the exposed body part with soap and water for 1 minute
  - Remove soiled clothing being careful to avoid contact with mucous membranes, wash the area well, and change into clean clothing.
- Notify your supervisor and Employee Health as soon as possible
- Complete employee accident report in the Safety Net within 24 hours of accident
- Report to Employee Health M-F 8am – 4pm. If after-hours an employee needs emergency treatment, contact the clinical coordinator.
- Notify Employee Health Nurse at **ext. 8110** even if medical treatment is not needed.
- Medical treatment should be sought immediately after an exposure, so if medication to prevent HIV is needed, it can be started in the 2-4 hour window.

Informed Consent

When a patient seeks treatment at the hospital, the patient or his/her legal representative is asked to sign a general consent form that indicates he/she is seeking medical treatment at CHS. In addition, certain procedures/treatments require a special consent for:

- Operations/surgery
- Other invasive procedures not covered by the general consent
- Administration of anesthesia
- Administration of blood and blood products
- Procedures requiring conscious sedation

In order to meet the requirements for INFORMED CONSENT, the provider must explain the operation or procedure, the benefits, risks, and alternatives to the patient, as well as the benefits and risks of those alternatives and the likelihood of the patient achieving his or her goals. **The practitioner performing the operation and/or invasive procedure is responsible for obtaining AND documenting the informed consent in the patient's medical record.** Nursing staff can be supportive by witnessing a signature on the consent form or by notifying the proceduralist if the patient has further questions but is ***NOT*** responsible for educating the patient as to the risks, benefits, etc., of the procedure.

For more information on informed consent, refer to CHS policy, GA-006.

Joint Commission Accreditation Process

The Joint Commission (TJC) accredits several health care organizations/programs in the United States. To maintain accreditation, CHMC must undergo an on-site evaluation by a Joint Commission team at least every three years. Our next full survey will be no later than September **2023**. TJC opens the survey window 18 months prior to the due date. TJC defines such a large window (18 months) to encourage organizations to be in a state of continuous readiness.

Joint Commission surveys are UNANNOUNCED…so a surveyor could walk in at any time. Upon first arrival, surveyors will likely report directly to the information desk [but may report to a department] and notify you of the survey team's arrival. **This is what to do when Joint Commission surveyors report to the information desk or your department to announce their arrival. PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY.**

1. Welcome the surveyors to CalvertHealth Medical Center with a smile. ☺
2. Ask them to have a seat in the waiting area and to remain there until a designated representative comes to greet them.
3. **IMMEDIATELY** notify Administration and the director of the department of The Joint Commission Surveyors arrival and where they are waiting.

It is essential to maintain a constant state of compliance with Joint Commission's patient safety standards. **Keep in mind, we do these things, not because of TJC, but because it is the RIGHT THING TO DO FOR OUR PATIENTS!** It is **important** you **know the Joint Commission standards** that impact your department as they contribute to the quality of care and services delivered.

Criteria used to evaluate our compliance with the standards include

- **Consistency:** TJC requires **ONE** consistent level of care. This means that our hospital's policies & procedures must be consistent throughout **ALL** areas.
- **Integration:** Joint Commission surveyors want to see an **INTERDISCIPLINARY** approach and tools that encourage interdepartmental coordination & effective communications among *all* staff involved.
- **Collaboration:** Collaboration means that each staff member in the organization draws on the knowledge of his/her coworkers to improve the quality/safety of patient care. Joint Commission evaluates CHMC on our ability to **WORK TOGETHER** to provide a framework for problem identification & resolution and enhancing our capacity for effectively implementing/sustaining positive change.

Sample staff questions might include:

- What is the mission of your organization?
- How do you handle patient hand-offs to assure the safe transfer of care?
- What is your process for honoring Advance Directives?
- What is the plan of care for this patient?
- How do you communicate with other members of the healthcare team?
- What are the universal/standard precautions?
- What is your process for wasting narcotics?
- What is your role in a fire alarm?
- How do you participate in performance improvement activities? What has improved lately and why?
- What is your department doing to comply with National Patient Safety Goals?
- What is your position and how would someone know you are competent to perform your job?
- How is staffing on your unit? Is there any mandatory overtime? Are there vacancies?

Hints to MASTER Surveyor Questions:

- **Be proud of your work!** Remember this is what you do every day. This is an opportunity to acknowledge the good job you always do!!
- Be honest. Don't panic. Relax. Take a deep breath – then answer the question.
- Show that you are friendly, helpful, and willing to participate in the survey.

- Speak with enthusiasm and confidence about your job.
- If you don't know the answer to a specific question, know where the answer can be found. For example, refer to a policy or procedure manual, a supervisor or manager, or other resource.
- Ask for clarification if you're not sure what the surveyor is asking. Ask the surveyor to repeat or reword the question.
- Demonstrate team participation in the interviews. Everyone should be prepared to contribute.
- Focus on your unit's PI (Performance Improvement) projects; show pride in your work. Show your department's PI bulletin board to the surveyor.
- Help out if a co-worker seems to be "stuck" or unsure how to answer a question.
- **Don't** offer extra information. Simply answer the question at hand.

TRACER METHODOLOGY

TJC uses a method for determining how well standards are met by tracing patients through our organization. Surveyors will visit patient care areas and trace a patient's experience through the continuum of care. During the tracer, surveyors will interview staff members, providers, and patients/significant others to determine how well standards have been met. Where the patient has been in the organization…the surveyor will go. Our Quality Management Department conducts frequent Mock Tracers. Take advantage of those opportunities and participate! It will help you feel more confident during the actual survey.

Joint Commission Readiness Checklist

Use this checklist on a routine basis to assure continuous compliance!
Performance Improvement & Safety

- ☐ Department bulletin board is up to date (PIQS report, CHMC Safety & Compliance Officers, Equipment & Environmental Disinfectant Guide, Annual Report, HCAHPS, Hand Hygiene Compliance, RACE/PASS Poster, NPSG's, and the Strategic Plan & Goals. In addition, make sure to display your Department's PI-Safety report, newsletters…). You can find updated hospital materials at SharedDrive (S): > Public Access > Bulletin Boards
- ☐ Staff ID badges on with NPSG badge buddies
- ☐ Staff need to know:
  - What the ***department*** has done in the last year to improve quality & safety
  - What the ***hospital*** has done in the last year to improve quality & safety
  - How the department is complying with National Patient Safety Goals

Clinical Documentation

- ☐ Pain assessment performed
- ☐ Pain scale and pain goal is used and documented
- ☐ Care plan is up to date and interdisciplinary
- ☐ Patient's preferred language is documented and used
- ☐ Patient has an order for restraints which is correct and complete
- ☐ Suicide screen is complete, there is an order, checks are completed, and the patient's room is safe
- ☐

Infection Control

- ☐ Staff perform hand hygiene **before and after** patient care – washi in, wash out
- ☐ Patient who should be on isolation precautions have appropriate sign posted and have appropriate PPE available
- ☐ Staff/visitors wear PPE as appropriate
- ☐ Linens, patient room, and bathroom are clean
- ☐ Disinfect equipment as appropriate according to the Manufacturer's Instructions for Use (MIFU)

Crash Carts

- ☐ Make sure all checks have been done & are properly locked
- ☐ Is it plugged in? Has the defibrillator been checked unplugged as well as plugged in?
- ☐ Is anything expired?
- ☐ Verify accurate date/time on defibrillator
- ☐ Ensure cart is free of dust/debris
- ☐ Do you have the supplies/equipment for the appropriate age groups?
- ☐ Laryngoscope blades and handles wrapped

Medications

- ☐ All sharps secured and can ONLY be accessed by authorized individuals
- ☐ All glucometer bottles dated appropriately
- ☐ Check expirations dates
- ☐ Check multi-dose vials for dates and expirations
- ☐ Check for proper storage & control of medications (no medications unattended/unsecured)
- ☐ Check for cleanliness of pill crushers
- ☐ Know how to access the hospital formulary
- ☐ Staff need to know:
  - o Proper procedure for narcotic wasting
  - o How to report an adverse drug reaction [ADR] & medication event/error report
  - o High Risk Medications
  - o Look Alike Sound Alike Medications
  - o Department's medication event/error results & prevention strategies

Patient Rights/Responsibilities

- ☐ Use & confidentiality of patient sign-in sheets/logs
- ☐ Computer screen location/visibility to passers-by
- ☐ Instructions for Non-English-speaking patients
- ☐ Keep patients covered, especially during transport
- ☐ Compliance with patient confidentially during conversations, particularly in public areas
- ☐ Informed Consent procedures-NO signed consents before conversation with provider
- ☐ Advanced Directives status
- ☐ How to register a complaint

Environment of Care

- ☐ Clean department in good repair
- ☐ Hallway free of clutter
- ☐ Equipment in good repair and checked by Biomedical in last 12 months
- ☐ Oxygen tanks are safely stored & handled
- ☐ Location of emergency oxygen shut-off valve, who can shut it off, & how/when this is done
- ☐ Fire extinguisher expiration date
- ☐ Emergency Exit signs present & illuminated
- ☐ Fire doors fully close properly
- ☐ No doors propped open or blocked
- ☐ SDS information access [Call 1-800-451-8346 for faxed copy of SDS when needed.]
- ☐ 18" ceiling rule
- ☐ Tissue test on pressurized rooms (Endo, OR, Dirty Utility, and Clean Utility)

Miscellaneous

- ☐ NO PROHIBITED ABBREVIATIONS
- ☐ **ALWAYS** verbally validate Name and DOB when delivering care.
- ☐ **All** entries in the medical record (*includes all disciplines*) are signed, dated, **and timed**
- ☐ Telephone and Verbal orders authenticated as soon as possible, restraint/seclusion orders within 24 hours
- ☐ Assessments timely & care plans individualized/complete
- ☐ Department employee files up to date & readily accessible
- ☐ Employees know how to access Policies/Procedures and Medical Staff Privileges

- ☐ Employees know where to find and utilize the Manufacturer's Instructions for Use (MIFU's)
- ☐ Use good hand hygiene and disinfect equipment appropriately
- ☐ No expired food
- ☐ Microwaves are clean

Use this checklist on routine basis to assure continuous compliance!

Medication Management

Everyone plays a role in making our medication process safe. The following are highlights of some of the standards for medication management that most commonly impact physicians/clinical staff at CHMC.

- The pharmacists are an excellent resource for drug information. They are happy to assist staff with any questions.
- All medications on/off a sterile field REQUIRE labeling, which includes Drug name, dosage, date. This requirement applies to departments such as Surgical Services, Radiology, Endoscopy, Pain Management, Family Birth Center, Wound Center, and areas where small procedures are performed.
- **Prohibited abbreviations may not be used**

DO NOT USE	Intending Meaning	PREFERRED
xx.0mg	Trailing Zeros	Trailing zeros is not acceptable. Conversely, leading zeros are acceptable.
> and <	Greater than or less than	"Greater" or "Less than"
IU	International Unit	Int. Unit
MgSO4	Magnesium Sulfate	Spell out
MS or MSO4	Morphine	Spell out
OD, OS, OU	Right eye, Left eye, Both eyes	Spell out
QD or qd	Daily	Spell out
QID or q.i.d.	For times a day	Q6H or 4X day
QOD or q.o.d.	Every other day	Spell out
U or u	Unit(s)	Spell out
X3D	For 3 days of 3 doses	X 3 days or X 3 doses

ORDERS

- All orders must be clear, complete, legible, dated and timed. Medication orders are either entered by Computerized Physician Order Entry (CPOE) or handwritten in emergency situations and computer down times. Any unclear orders will be questioned and must be clarified. Frequency of any illegible orders will be tracked and reported to medical staff.
- A complete medication order includes the drug name, the metric mass or concentration, the dosage form, the route of administration and the schedule. A "PRN" order must specify a parameter for use ("PRN itching", or "PRN fever greater than 101"). "Resume Coumadin" is an incomplete order because it does not contain all necessary elements.
- Blanket orders (such as "continue home meds" or "resume pre-op orders", or "resume meds") are prohibited. Each medication must be individually considered by the clinician and ordered only if there is clear clinical indication. Upon transfer between units or from one level of care to another, all medication orders must be reconciled. and all orders must be reviewed for accuracy and appropriateness during transfer.
- There should be a clearly documented diagnosis or indication for every medication ordered. At the time of admission and again at the time of discharge, the medication list should be reviewed by the attending physician and all unnecessary medications discontinued.

DOSING

- The hospital uses a standard dosing time schedule for all medications (e.g., "daily" meds at 1000, "four times daily" meds at 0600, 1200, 1800, 2359, etc.). Standard dosing times apply except for antibiotics and some additional medications which are continued from the time of the first dose. If the clinical condition of the patient warrants a "STAT" medication, the order should be brought to the attention of the patient's nurse or nursing supervisor by the ordering physician to ensure prompt administration to the patient.
- Prior to dispensing, all ordered medications are reviewed for appropriateness with respect to known allergies, height/weight dosing, drug interactions, duplication, dose range, and renal function. Any medication deemed possibly incomplete or inappropriate by the pharmacist will be clarified. Pediatric medications, for patients 12 years and younger, are ordered in mg/kg dosing. The order will be clarified by the pharmacist if medications are not written correctly.

HIGH ALERT MEDICATION/LOOK ALIKE SOUND ALIKE

- Particular attention is paid by the pharmacy to medications with high risk for toxicity or dosing errors such as chemotherapy drugs, pediatric weight-based dosing, or renal function dosing. High alert medications are reviewed prior to dispensing by procedures outlined in the High Alert policy. Medications designated as High Alert include the following: TPN, PCAs, IV Insulin, Heparin drips, Chemotherapy, high dose, and bolus: thrombotics (tPA and Tnkase), Labor and Delivery "high dose" magnesium, PCEA-Patient Controlled Epidural Analgesia, U-500 Regular Insulin, and Cisatracurium infusion (ICU only). Look-alike sound-alike medications such as those with similar sounding names (Humulin & Humalog; Cefazolin & Cefoxitin; and Clonidine & Klonopin) also receive close scrutiny. Look-alike sound-alike medication lists and high-Alert medication lists are available on the nursing units.
- Premixed IV admixtures of medications and IV fluids will be used if commercially available in order to assure standardized dosing and eliminate risk of compounding errors.
- Wasting of any unused controlled substance must be witnessed by two professionals licensed to prescribe, dispense, or administer controlled substances, i.e. licensed provider, nurse, or pharmacist. They must be returned to the Pyxis if unused or wasted in the controlled substance pharmaceutical waste bins located in each unit. Fentanyl patches are to be cut and disposed in the controlled substance pharmaceutical waste bins located on each unit.

PAIN MEDICATION

- When ordering pain medications, do not use range orders. Do use pain scale for titration. "Morphine 2-4 mg every 3-4 hours prn" is incomplete and unclear. "Morphine 2 mg IV every 3 hours prn Moderate pain 5-7, Morphine 4 mg every 3 hours PRN Severe Pain 8-10 is acceptable. Any range order received by pharmacy will be clarified per policy BEFORE administration.
- Assessment of effectiveness will be reassessed and documented within 60 minutes of administration of all IV, IM, and PO pain medications.
- If a patient requests pain medication and Tylenol is ordered for fever; you may not administer "Tylenol for fever" order for pain management. The provider will need to be contacted for appropriate orders.
- Nursing will administer the prescribed pain medication at the stated dose, route, and frequency. When the patient has multiple orders for pain medication to be given based on pain score, the nurse should administer the medication and dose that correspond to the reported score.

  Example:
  Ibuprofen 800 mg PO Q8H PRN for mild pain (1-4)
  Percocet 1 tab PO Q4H PRN for moderate pain (5-7)
  Percocet 2 tabs PO Q4H PRN for severe pain (8-10)
  Patient's pain level is a 6, you will administer Percocet 1 tab for pain

- If a patient complains of pain at an intensity for which you do not have a medication ordered, the provider will need to be contacted to obtain new orders.
- If a patient requests a higher dose of medication than what corresponds to the current orders, the provider will need to be contacted to obtain new orders.

  Example:
  - Patient orders for Ibuprofen 800 mg PO Q8H PRN for mild pain (1-4)
  - Percocet 1 tab PO Q4H PRN for moderate pain (5-7)
  - Percocet 2 tabs PO Q4H PRN for severe pain (8-10)
  - The patient has a pain score of 5 but is requesting 2 tabs of Percocet. This **cannot** be administered without getting a new order from the physician to change the current Percocet order.

- A patient may request a lower dose medication than what corresponds to the current pain scale. In this case, the nurse may administer a lower potency dose at the patient's request.
  Nurse will document the medication/dose that they are administering on the correct medication order on the MAR. You will then document a pain comment to reflect the inconsistency of the pain score and the medication/dose given.

  ***Pharmacy is available for consultation for pain management for patients who have been unsuccessfully controlled despite attempts to adjust the regimen by the provider. In many cases, simple medication adjustments can be made by the provider to control pain and a consult may not be needed. ***

FORMULARY

- The Medical Executive Committee (MEC), upon recommendation of the Pharmacy Director and the Medication Usage & Safety Team (MUST), establishes the hospital formulary. Requests for changes to the formulary should be submitted on the Formulary Request Form. Changes to the formulary will be made by MUST using evidence-based criteria, current standards of care and best practices
- Automatic therapeutic substitutions will be made by the pharmacy according to the formulary and hospital policy. All automatic substitutions are reviewed and approved through the MUST committee If an automatic substitution is clinically contraindicated, the provider must write "Do not substitute" following the order in the comments and indicate the clinical reason the automatic therapeutic substitution should not occur.

ADVERSE DRUGE REACTIONS/MEDICATION EVENTS

- An Adverse Drug Reaction (ADR) is any unintended, undesired, or unexpected effect of a drug in doses recognized in accepted medical practice. Any ADR that is significant enough to prompt a change in therapy must be reported. Reporting is done by any clinician knowledgeable in the patient's care (MD, RN, or RPh) by completing a Safety Net Report. If ADR is clinically significant, it should be reported to MedWatch (by pharmacist) and reported at MUST.
- Medication Error: A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use. The CHMC Department of Pharmacy Services considers medication errors to fall into one of the four major categories:
  - Medication prescribing errors
  - Medication transcription errors
  - Medication dispensing errors
  - Medication administration errors
- Medication event form/online reporting: A medication event is reported via Safety Net. It is accessible via the Intranet at CHMC. An error may be electronically submitted by any staff member at CHMC. The medication event is then sent to managers and directors involved with the error.
- Medication alerts such as recalls, or new black box warnings are transmitted to Medical Staff when necessary, by e-mail or memo. The attending physician of any patient in the hospital who may be currently receiving such a drug is to be notified immediately by the pharmacy to determine what course of action is in the patient's best interest.
- Medication events and adverse drug reactions are monitored through the hospital's Medication Usage & Safety Team. Any trends involving physicians go to Medical Staff department chairs and Med Exec for review.

ANTICOAGULATION SAFETY

Anticoagulant medications, such as warfarin (Coumadin), Heparin and enoxaparin (Lovenox), have the potential to cause significant adverse reactionsand require special tests, dosage adjustments, and patient education. Newer anticoagulant medications (Factor Xa Inhibitors and direct thrombin inhibitors), such as rivaroxaban (Xarelto), apixaban (Eliquis) and dabigatran (Pradaxa) are also monitored by the Clinical Pharmacist. Education is provided by pharmacy staff, dietitians, health care providers, and outpatient anticoagulant clinic when appropriate.

Opioid Stewardship

National statistic reveals that from 1999 to 2015, more than 180,000 people died from overdoses related to prescription opioids. Concerned about the potential dangers for opioid prescriptions, the Centers for Disease Control (CDC) in March 2016 issued new guidelines for opioid use.

The Opioid Stewardship team focuses on the importance of medication safety with regards to opioids and utilizing best practices for safe and effective pain control while decreasing the potential for dependence. The stewardship team includes many members from multiple disciplines. During the past few years, they have worked on the following initiatives:

- Developed prescribing guidelines in line with CDC recommendations- Inpatient and Outpatient
- Limit discharge prescriptions of opioids to 3-7 days (tracking and trending provides)
- Utilize oral agents prior to IV agents
- Avoid opiates and benzodiazepine combination
- Avoid long-acting medication such as MSContin or Oxycontin
- Patient and Family education
- Physician and Staff Education
- Alternative to Opioid Guidelines available to staff and patients
- Narcan Kits available to patients who come in with overdose
- Peer counselor support available in collaboration with Health Department
- Strengthening referral base for patients with Substance Use Disorder
- Utilization reports of controlled substances
- Continued review of opioids throughout the organization

All patients are assessed for pain.

- Physical and psychosocial assessments include:
  - Description of pain: character, frequency, location and duration, and intensity.
  - Intensity can be assessed by using one of the following:
    - Scale of 0-10
    - Wong Baker face pain scale
    - FLACC score: **F**ace, **L**eg, **A**ctivity, **C**ry, **C**onsolability
- Identify the patient's goal for his/her pain (what is the acceptable level of pain?)
- Patients assessed to have no pain are instructed to report the occurrence of pain
- Pain must be assessed & documented *prior to* giving pain medication and **reassessed** to determine the patient's response to the medication. Reassessments are done **within one hour of med administration** (intravenous, oral, intramuscular and subcutaneous)
- Policy states that **ALL** patients' and their pain is to be reassessed at discharge
- Involve your patients and their families in the treatment plan
  - This is proven to yield better results for patients
- Use all available written, educational materials (such as the one on the right) when teaching patients about pain management.


CalvertHealth

MANAGING YOUR PAIN

Comfort and Pain Management

Acute Versus Chronic Pain

Describing Your Pain

Forms of Pain Management

Treatment Options

Medication Side Effects

REMINDERS

PHONE
410-535-4000
301-855-1012

CalvertHealth

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This educational brochure is available for our patients

Antibiotic Stewardship

The introduction of antibiotics to medical practice drastically changed patient outcomes - once deadly infections could now be easily treated. Overuse and inappropriate use of antimicrobials have resulted in resistant pathogens threatening the ability of healthcare professionals to successfully treat infections.

- Over 2,000,000 people are infected with resistance bacteria each year[1]
- 23,000+ deaths annually are caused by antibiotic resistance in the US[1]
- 20-50% of antimicrobials prescribed in US hospitals are either unnecessary or inappropriate[2]
- Overuse increases risk of developing antimicrobial resistance
- Exposure to unnecessary therapy may result in side effects or adverse drug events
- Increase risk of *C. difficile* infections

Antibiotic stewardship and infection control plans help slow the emergence of resistant pathogens while optimizing patient outcomes.

- Antimicrobial stewardship is defined as "coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration."[3]
- Stewardship programs can optimize treatment, improve quality of patient care, reduce adverse events associated with antimicrobial use, reduce hospital rates of *C. difficile* infections, and decrease healthcare costs.[4]
- The Centers for Disease Control and Prevention (CDC) outlines seven core elements of antimicrobial stewardship programs (ASPs):[4]
    - Leadership commitment
    - Accountability of program outcomes
    - Drug expertise (pharmacy involvement)
    - Implementing recommended actions
    - Tracking and monitoring antimicrobial use and resistance
    - Reporting on antimicrobial use and resistance
    - Education

CalvertHealth Medical Center established an Antibiotic Stewardship Program in 2014 which includes members from multiple health care disciplines. Its mission is to ensure that every patient receiving antimicrobials, be provided optimal therapy. The stewardship program engages in multiple initiatives to improve antimicrobial use, monitor local resistance, and educate.

- Generate and distribute annual antibiograms
- Educate patient and staff on antibiotic use and resistance
- Develop protocols to treat various infectious diseases
- Utilize surveillance software for infection prevention and antimicrobial stewardship interventions
- Targeted interventions to de-escalate antibiotics when appropriate
- Report to Medication Usage and Safety Team (MUST)
- Participate in multidisciplinary task force for improving antibiotic utilization
-

References

1. Centers for Disease Control and Prevention. Antibiotic/Antimicrobial Resistance. (Updated Jan 2017). Accessed Feb 17, 2017. https://www.cdc.gov/drugresistance/
2. Centers for Disease Control and Prevention. Get Smart for Healthcare. (Updated Dec 2016). Accessed Feb 17, 2017. https://www.cdc.gov/getsmart/healthcare/index.html
3. Society for Healthcare Epidemiology of America, Infectious Diseases Society of America, Pediatric Infectious Diseases Society. Policy Statement on Antimicrobial Stewardship by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and the Pediatric Infectious Diseases Society (PIDS). *Infect Control Hosp Epidemiol* 2012; 33(4):322-327
4. Centers for Disease Control and Prevention. Core Elements of Hospital Antibiotic Stewardship Programs. Atlanta, GA: US Department of Health and Human Services, CDC; 2014. http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html

Oxygen Safety and Storage

STORAGE

Please note: These guidelines change from time to time. All storage must be labeled indicating the ***type*** of tanks that can be stored in the rack, so please refer to those signs AND the Oxygen Cylinder Duration Chart that is posted in each oxygen holding area BEFORE you choose a tank to transport your patient.

CalvertHealth uses the following system:

RED MEANS STOP!

RED SIGN = EMPTY TANKS

These tanks contain less than or equal to 500 psi of oxygen and the needle indicator will be in the red zone. Do not transport your patients using these tanks!

GREEN MEANS GO!

GREEN SIGN = IN USE/FULL TANKS

These tanks contain greater than 500 psi of oxygen and the needle indicator will be in the white or green zone. Always check how much psi is left in the tank and refer to the oxygen cylinder duration chart

- All EMPTY tanks are replaced by Respiratory Therapy. Please call x4892 or x4897 if you need assistance.
- The Oxygen Cylinder Duration Chart provides the calculations for tank duration in hours based on the liter flow prescribed to your patient so that you can safely choose the correct tank for transport.
- If you see oxygen stored incorrectly, please correct it!

SAFETY

Contrary to popular belief, oxygen itself is not flammable, but it accelerates the heat and flames of a fire. It is a colorless, odorless gas that is often prescribed to patients with certain cardiovascular diagnoses. The universal color of an oxygen cylinder is GREEN. Oxygen is safe to use, provided you follow the suggested guidelines:

- Always place a cylinder in a stand, storage cart, stretcher or wheelchair to be used. When not using an oxygen tank, place it back in the correct storage cart.
- Always shut off a cylinder when not in use.
- Always separate FULL/IN USE cylinders from EMPTY cylinders according to the guidelines listed above.
- Always transport an oxygen cylinder in a wheeled cart, wheelchair, or stretcher. Do not carry it down the hallway by the handle.
- Never leave a cylinder standing up on its own or on top of a stretcher. This could fall and injure someone!
- Never keep more than 12 cylinders in an area. This excludes those deemed "IN USE" in a rolling caddy.
- Never store an oxygen tank at the bedside in a patient's room for trips to the restroom, etc.

Oxygen Safety is everyone's job!

If you see a potential problem, please call Respiratory Therapy.

Patient Advocacy

PATIENT ADVOCATE: Being in the hospital can make people feel anxious and overwhelmed. If patients or family members have questions or concerns that their doctor or another member of their team has been unable to address, then the Patient Advocate is available for support. The Patient Advocate can be reached at ext. 4623 for assistance with any of the following:

- Questions about patient rights and responsibilities
- Clarification of hospital policy or procedure
- Concerns regarding the direction or quality of patient care
- Help in voicing a concern or grievance
- Assistance accessing needed services or resources

ETHICS COMMITTEE: Medical care can be complex and confusing and can touch on many of our important values and ideals. CalvertHealth has an Ethics Committee to provide a forum for the consideration of the full range of ethical issues confronting our hospital and its patients, including cases involving life-threatening conditions, options for medical care/treatment, and end-of- life issues. To discuss an ethical issue related to care, contact Integrated Care Management at **ext. 4858** during normal business hours or the Administrator on call after hours & weekends.

PASTORAL CARE: The admission assessment identifies spiritual and cultural needs of the patient and triggers a referral to the Chaplain when necessary. For religious or spiritual needs during daytime hours Monday through Friday, contact the Clergy Office at **ext. 8249**. For after hours, the hospital operator can help you reach the applicable denomination.

COMPLIANCE OFFICER: "Are we doing the right thing the right way?" If you ever have questions about this, contact the Corporate Compliance Officer at **ext. 8282**.

DOMESTIC VIOLENCE: Is your patient a victim of violence? Call our Social Work Department at **ext. 8148** for assistance.

Inpatient Assessment

All patients admitted to CalvertHealth Medical Center undergo an assessment before care begins. This assessment can take many forms and involve many people. The assessment is just the starting point, but because it identifies needs and treatment goals for an episode of care, all care providers should carefully document assessments and be prepared to discuss our process with a surveyor.

- **WHO may initially assess patients?** A physician, nurse, social worker, therapist, dietitian, and other licensed staff.

- **WHEN is the initial assessment performed?** Initial assessments are done on presentation, on admission, and at the first outpatient visit (or before clinical procedures or treatment).

- **WHAT is included in the assessment?** Physical evaluation, medical history, psychological status, spiritual needs, learning readiness and needs, nutritional and functional status, and discharge needs.

- **Does initial assessment address physical, psychological, and social status?** Yes. The assessment is completed by the nurse as soon as possible, but within 12 hours. Dietary, rehabilitation, and discharge-planning criteria are assessed at this time. These screening criteria are used to trigger alerts to the appropriate departments for determination if further assessment is warranted.

- **HOW are assessments done?** Physical examinations, diagnostic tests and results, review of records of previous hospitalizations as appropriate, patient and family interview.

- **WHERE is the assessment documented?** In the written or electronic health record

- **What are the requirements for the medical staff?** A licensed independent practitioner with appropriate privileges completes a history and physical within 24 hours. Consultations are requested, as appropriate, based on the need for further assessment.

- **How often do we reassess?** We reassess our patients every shift at a minimum. We also reassess patients based on time elapsed, response to treatment, a significant change in patient condition, or an entry into a new care setting. Ultimately, the needs of the patient determine ongoing assessment.

Patient Care Plan

Results of patient assessment are used to develop the patient's plan of care. The care plan is an interdisciplinary process that may include but not limited to, physical therapy, a dietician, and case management, and should address the patient's most important issues. The care plan should be ***individualized*** to meet the unique needs of the patient. Care plans must include goal dates.

Some of the tools we use to plan, provide, and monitor patient care:

- Admission protocols/orders
- Policies and Procedures
- Communication during rounds & change of shift
- Documentation in the medical records
- Nursing protocols
- Interdisciplinary rounds

Patient Education

Teaching patients and families about their illness, the expected recovery phase, and medications are some of the topics you can expect to cover while in the hospital. We also focus on safety measures while in the hospital, such as preventing further health related problems. We encourage patients to be engaged in their care, to ask questions and to be their own advocate when it comes to their health care. Education is one of the staff's most important roles and each patient has their own teaching plan based on their own needs.

Patients should receive education about their health care in a language they speak and understand. As patients arrive to the hospital, they are asked about their preferred language. The patients preferred language can be found on their face sheet.

Teaching is INTERACTIVE & INTERDISCIPLINARY.

Successful teaching requires that we assess each patient for their own individual learning needs as well as assess the learning process. Below is the focus of those assessments;

- Evaluating a patient's or family's ability to learn.
- Recognizing any cognitive, emotional, cultural, or financial barriers to learning that might exist.
- Presenting information that is clear, concise & easily understood to patients and families.
- Evaluating the effectiveness of the teaching & reinforcing the information provided.
- Documenting patient education materials provided.

interpreter (VRI) system. Staff can also request an interpreter. These special needs should be assessed immediately upon presentation to the hospital, and assistive devices accessed as quickly as possible. Contact the Clinical Coordinator for assistance.

Patient Rights and Responsibilities

PATIENT RIGHTS:

Maryland Patient Bill of Rights:
Every hospital patient, support person and/or surrogate decision-maker has the right to:

· Receive considerate, respectful, and compassionate care;
· Be provided care in a safe environment free from all forms of abuse and neglect, including verbal, mental, physical or sexual abuse.
· Have a medical screening exam and be provided stabilizing treatment for emergency medical conditions and labor;
· Be free from restraints and seclusion unless needed for safety;
· Be told the names and jobs of the health care team members involved in the patient's care if safety is not a concern;
· Have respect shown for the patient's personal values, beliefs, and wishes;
· Be treated without discrimination based on race, color, national origin, ethnicity, age, gender, sexual orientation, gender identity or expression, culture, physical or mental disability, religion, language, or ability to pay;
· Be provided a list of protective and advocacy services when needed;
· Receive information about the patient's hospital and physician charges and ask for an estimate of hospital charges before care is provided and as long as patient care is not impeded;
· Receive information in a manner that is understandable by the patient, which may include:
Sign and foreign language interpreters;
Alternative formats, including large print, braille, audio recordings, and computer files; and
Vision, speech, hearing, and other temporary aids as needed, without charge;
· Receive information from the patient's doctor or other health care practitioners about the patient's diagnosis, prognosis, test results, outcomes of care, and unanticipated outcomes of care;
· Access the patient's medical records in accordance with HIPAA Notice of Privacy Practices;
· Be involved in the patient's plan of care;
· Be screened, assessed, and treated for pain;
· Refuse care;
· In accordance with hospital visitation policies, have an individual of the patient's choice remain with the patient for emotional support during the patient's hospital stay, choose the individuals who may visit the patient, and change the patient's mind about the individuals who may visit;
· Appoint an individual of the patient's choice to make health care decisions for the patient, if the patient is unable to do so; Make or change an advance directive;
· Give informed consent before any nonemergency care is provided, including the benefits and risks of the care, alternatives to the care, and the benefits and risks of the alternatives to the care;
· Agree or refuse to take part in medical research studies and/or clinical trials, without the agreement or refusal affecting the patient's care;
· Allow or refuse to allow pictures of the patient for purposes other than the patient's care;
· Expect privacy and confidentiality in care discussions and treatments;
· Be provided a copy of the Health Insurance Portability and Accountability Act Notice of Privacy Practices; and
· File a complaint about care and have the complaint reviewed without the complaint affecting the patient's care.

Additional Patient Rights:
· Have a family member or representative of the patient's choice and the patient's own physician notified of admission to the hospital;
· Be told in advance about the plan for discharge or transfer to another level of care;
· Participate in the consideration of ethical issues that arise during the hospital stay;

· Be notified of the existence of any business relationship among the hospital, educational institutions, other health care providers, and/or payers that may influence treatment and care;
· Be provided care in an environment free of harassment and exploitation;
· Receive treatment without regard to socioeconomic status; and
· A written copy of the patient rights.

PATIENT RESPONSIBILITIES:

Every hospital patient, support person and/or surrogate decision maker has the responsibility to:
· Provide accurate and complete information, including name, address, and date of birth, phone number, social security number, insurance carrier and employer when required.
· Provide accurate and complete information about health, medical history, and medications, including over the counter medications.
· Follow the plan of care and ask questions.
· Talk to the provider if there are concerns about following the treatment plan.
· Accept outcomes if the plan of care is not followed based on lifestyle choices.
· Show respect and consideration for others.
· Follow hospital rules and safety regulations.
· Be in control of behavior, unless unable to control behavior due to a medical condition.
· Be mindful of noise levels, privacy, and number of visitors.
· Refrain from behaviors that are aggressive, hostile, and sexually inappropriate, including threats of verbal abuse, physical attacks, and indecent exposure.
· Provide a copy of an Advance Directive if one is available.
· Leave valuables at home.
· Select a capable caregiver for discharge planning.
· Meet financial obligations.

Performance Improvement

In keeping with our four main strategic goals, we target several projects for improvement every year. As employees, it is important that you not only know your department's improvement goals, but also the goals of our organization. All goals are ultimately related to the quality of care and safety of our patients. Progress related to projects such as Core Measures and patient experience surveys (HCAHPS) can be found on the intranet in our hospital's ***PI Quality and Safety Report***. It is your responsibility, as an employee of this organization, to be informed about the goals and objectives for improvement and be able to articulate those plans at both the department and organization level.

Performance Improvement & Staff Participation

Staff participates in continuous performance improvement activities through:

- Staff meetings
- Bright Ideas program
- Attending in-service training programs
- Participation on committees, process improvement teams, etc.
- Collecting data and monitoring activities in their work areas
- Continually looking at ways to improve care and services
- Active involvement in Shared Governance; Safety Huddles; Safety Coach Program

Performance Improvement Data Collection

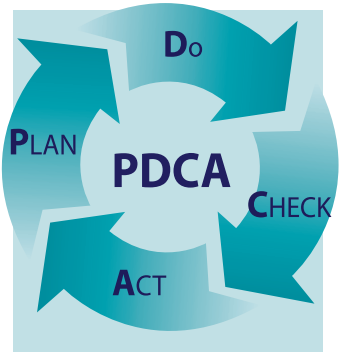
Data is collected in a number of ways at CHS; through electronic health record (EHR) reports, safety net reports, satisfaction surveys and PI/QA (performance improvement and quality assurance forms), etc. CHS also uses software such as Vizient and Business and Clinical Analytics (BCA) to collect and help analyze data. As staff you can help improve data collection reliability by documenting thorough and accurate details within the EHR. It is necessary to monitor and improve processes through data collection to ensure our services result in positive quality outcomes.

PDCA Process for Performance Improvement

Continuous Process Improvement: The ultimate goal at CHS is to demonstrate *ongoing*, improvement in the performance, quality, and safety of the health services provided through the organization.
We use the PLAN-DO-CHECK-ACT (PDCA) methodology to achieve and document these improvements. The PDCA methodology is both a simple and powerful tool in our quest for continuously improving what we do. Essentially, we come up with a hypothesis (a change we think will improve our outcomes or safety), we put that change in place, and then we "check" to see if we were right by looking at data. Those subsequent data points drive how we "act." We may choose to continue with the plan, add another change, or decide to completely start from square one. It's an ongoing cycle of improvement.

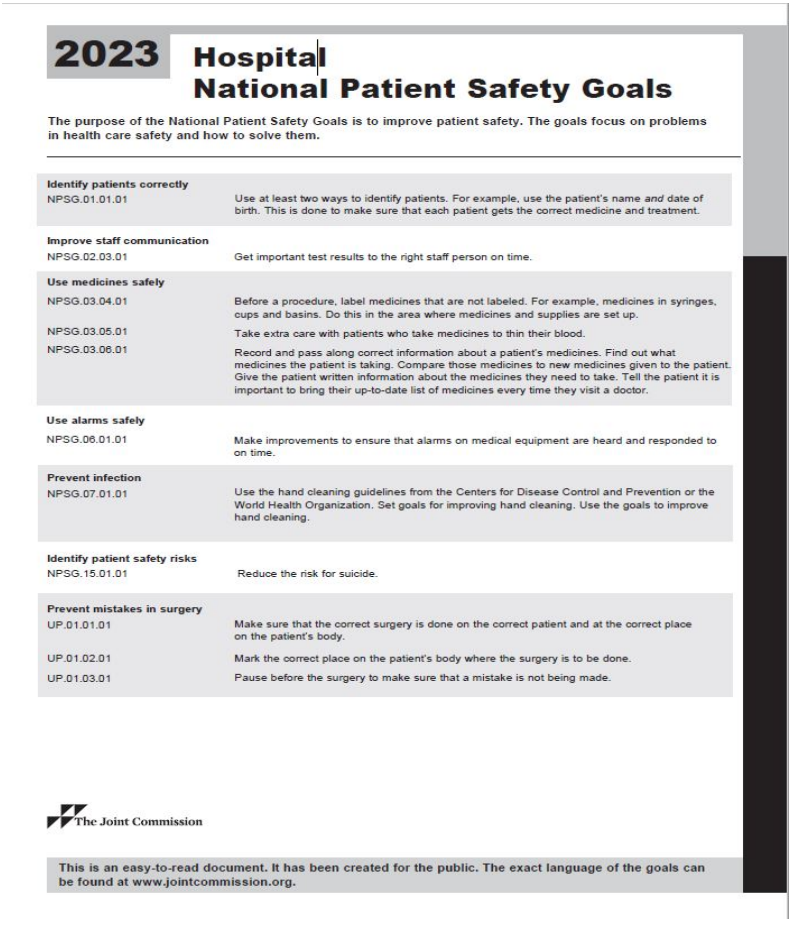
Plan-Do-Check-Act—PDCA

Cycle	Description
Plan	Question the capacity or capability of a process. Pose theories on how to improve the process and predict measurable outcomes.
Do	Make Changes on an experimental, pilot basis.
Check	Measure outcomes compared to predicted outcomes.
Act	Implement the changes on a broad scale.



National Patient SafetyGoals (NPSG)

National Patient Safety Goals are a series of specific actions that accredited organizations are required to take in order to prevent medical errors such as miscommunication among caregivers, unsafe use of infusion pumps, and medication mix-ups. A panel of national safety experts has determined that taking these simple, proven steps will reduce the frequency of devastating medical errors.



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. Give the patient written information about the medicines they need to take. 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

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.

Red Panic Values and Critical Findings

RED PANIC VALUES at CHMC are **LABORATORY** and **CARDIOPULMONARY** test results that may significantly change patient outcome and treatment; where urgent notification and response is important.
CRITICAL FINDINGS at CHMC are **RADIOLOGY** findings/results that may significantly change patient outcome and treatment; where urgent notification and response is important.
🗐 For additional information, please refer to **Panic Value Test Results for Red Panic Values & Critical Finding Policy, GA-100**

Laboratory will notify the unit via telephone of **RED PANIC VALUE** results. Results must be given to nurse caring for the patient. Results must be written down by the RN/LPN, and then read back to testing department to verify.

🡻

RN/LPN will notify practitioner within one hour of receipt. If needed, practitioner may be interrupted from their duties. Acknowledgement by practitioner is required.

🡻

RN/LPN is responsible for documenting **RED PANIC VALUE** notification in patient record, including:

1. time of receiving results from Lab
2. time of practitioner notification

TEST	Red Panic Less Than	Red Panic Greater than	Units
Blood Gas:			
pH	7.3	7.6	mm/Hg
pCO2	15	60	mm/Hg
	(if pH not 7.35-7.45)		
pO2-arterial	50		mm/Hg
pO2-capillary	30		mm/Hg
Glucose	60	400	mg/dl
Hematocrit	21		%
Hemoglobin 0Day-1Mnth	10	23	g/dl
Hemoglobin >1Mnth	7	20	g/dl
Potassium 0-59Y/O	2.8	5.7	mEq/L
Potassium >60Y/O	3.0	5.7	mEq/L
Sodium	120	160	mEq/L
Lactic Acid		3	mmol/L

Critical Findings for Radiological Studies include, but are not limited to:

- ✓ Pulmonary embolism (PE)
- ✓ Tension Pneumothorax
- ✓ Mal-placement of ET Tube
- ✓ Cerebral hemorrhage or infarction
- ✓ Ectopic pregnancy
- ✓ New/progressing aortic dissection/aortic aneurysm
- ✓ Acute or significantly enlarging pneumothorax
- ✓ Free intraperitoneal air (pneumoperitoneum)
- ✓ Acute saddle pulmonary embolism
- ✓ Acute aortic aneurysm, Ruptured aortic aneurysm
- ✓ Traumatic aortic tear or other vascular injury/extravasation
- ✓ Traumatic organ or urinary bladder injury

- ✓ Free air under the diaphragm/ruptured viscera
- ✓ Testicular or ovarian torsion
- ✓ Spinal cord compression
- ✓ Acute or significantly progressive intracranial hemorrhage
- ✓ Large territory acute brain stroke or hemorrhagic stroke
- ✓ Large mass with significant mass effect or herniation
- ✓ Depressed or basal skull fracture
- ✓ Acute dural venous thrombosis

- ✓ Abnormal tube/line positions that are compromising the patient

- ✓ Perforated appendicitis or diverticulitis
- ✓ Ischemic Bowel disease and/or portal venous air
- ✓ Acute spinal fracture
- ✓ Epidural hematoma or abscess

- ✓ Mets to spine with extrinsic or impending cord compression
- ✓ Cord Tumor or infarction

- ✓ Arterial occlusion
- ✓ Placental abruption
- ✓ Suspected battered child syndrome
- ✓ Deep Vein Thrombosis (DVT)

Encourage Patient/Family Involvement in Safety

Patients & families will do better if they are active participants in their care. The following are some ways we involve our patients & their loved ones in their care:

- We ask, in our satisfaction surveys, how we can improve quality and safety
- We provide information in our Admission Packet on how to report concerns
- We encourage our patients to discuss their concerns with us while they are here so we can address them timely
- We engage patients and family members via our patient advisory council
- We utilize our Get Well Network to encourage patients to report concerns
- We educate our patients on important safety issues, such as:
    - The importance of keeping a complete list of home medications in your purse or wallet
    - Purpose & side effects of medications
    - How to prevent falls

Reduce Risk of Patient Falls & Injury

Inpatient Falls

- Timely assessment/reassessment, interventions and frequent rounding are essential to preventing falls
- Use the appropriate falls risk assessment tool (Morse/Humpty Dumpty or Edmonson) to identify those at risk for falls
- Document education of patient and family including the importance of calling for assistance with ambulation and transfers.
- Use yellow arm bands, yellow socks, and door magnets/label to identify patients at risk for falls
- Attempt to anticipate patient needs by frequent toileting and keeping essential items within arm's length
- Use appropriate monitoring equipment, such as bed alarms, chair alarms, and video monitoring
- Provide CalvertHealth Fall Brochure to patients and family members
- Ensure beds, stretchers and wheelchairs are locked and bed is in lowest position.
- Place assistive devices within reach of patient
- Frequently orient patients to their surroundings and staff
- Ensure environment is free from spills, clutter, cords, and unnecessary equipment and that lighting is adequate.

Outpatient Falls

- All patients are to be treated as a fall risk
- A fall protocol is implemented for all patients
- Provide CalvertHealth Fall brochure to the patient and family
- Frequently orient the patient to surroundings, including any call device and bathroom locations
- Ensure bathroom and exit doors are clearly marked
- Keep all the patient areas clean and unobstructed
- Ensure all rooms within CHS are well lit and lights are in working order

- **IF A PATIENT FALLS:**
  - Provide appropriate care for the patient!
  - Complete the post-fall assessment and head injury post fall assessment (when applicable)
  - Complete a Safety Net report and inform your department leader or Clinical Coordinator
  - Forward a copy of the completed Post Fall Huddle Form (Inpatient or Outpatient) to the Performance Improvement Office
  - If you have any questions call Thomas Grantland in Quality Management at ext. 4512

Practice these fall-prevention tips everyday:

- Keep aisles, stairs, and walkways free of clutter
- Close cabinet drawers when they're not being used
- Turn on lights before entering a room and report burned out bulbs ASAP
- Always use handrails on stairs and take one step at a time
- Clean up or report spills immediately
- Heed "caution – wet floor" signs and walk around
- Take only what you can carry comfortably, make sure you can see over the load
- Slow down when walking on wet or slippery surfaces, take small steps, & keep a hand free for balance
- Keep harnesses and other fall-protection equipment in working order--use them correctly
- Wear the right shoes for the job and keep soles clean for better traction
- If you experience a fall immediately report it to your supervisor and ensure that a Safety Net report is completed

STAT Team (Rapid Response Team)

Our STAT Team is a Rapid Response team which is comprised of the Clinical Coordinator, a Respiratory Therapist and a provider from the Hospitalist team. Our STAT Team responds quickly to a patient's bedside when activated and provides rapid assessment and care.

Any member of the healthcare team can initiate a STAT team response if any of the following criteria is met or they have significant concerns about a patient's condition.

- HR: >140 beats per minute or <40 beats per minute
- RR: >28 breaths per minute or <8 breaths per minute with noted distress
- BP: Systolic blood pressure <90 mmHg and not responding to medications or interventions
- SpO2: Maintaining <90% despite oxygen supplementation
- Acute changes in mental status: Loss of consciousness, seizures or any other notable changes in LOC

✓ **By early assessment and intervention, we can potentially avoid a bad outcome**

Be proactive, activate the STAT team by hitting the orange STAT Call button on the wall terminal or dial x8222!

Restraints & Seclusion

Patient safety is our primary concern, occasionally restraints or seclusion is needed to protect the patient, the staff, and/or to prevent disruption of treatment. Restraint & Seclusion have the potential for producing serious consequences, such as physical or psychological harm, loss of dignity, and even death. Because of the associated risks and consequences of their use, hospitals are increasingly exploring ways to decrease the use through effective preventive strategies or alternatives. Our goal is to minimize their use and, when needed, utilize the least restrictive method required to meet the patient's needs. **To determine the appropriate restraint needed, refer to the Restraint & Seclusion Policy; GA-066**

Root Cause Analysis (RCA)

CHS is actively involved in developing and implementing systems designed to prevent adverse events. When an adverse event or near miss occurs, the Quality and Risk Management department may conduct a Root Cause Analysis (RCA). This is a systematic process to determine fundamental system deficiencies leading up to the event. The RCA identifies risks and system vulnerabilities so actions may be taken to improve patient safety.

Steps of a RCA may include interviewing, organizing an interdisciplinary team closely involved in the event, studying the event, and identifying any contributing factors. Process and system improvements are identified based on causative factors and an action plan is developed. Implementation and monitoring of the corrective actions identified in the RCA is shared as feedback to all affected individuals.

As an employee you may be asked to participate in an RCA to take positive action to prevent future adverse events. Your insight and feedback are essential to the success of an RCA. RCAs are a non-accusatory, non-punitive and confidential approach to identifying system improvements to reduce risk and keep our patients safe.

Safety and How to Report Issues

Safety/Quality

If you have a concern about safety or quality of care at CHS, bring your concerns and suggestions to the attention of your supervisor. Your input is very important. If you feel your concerns have not been addressed thoroughly, you may report your concerns to the Quality and Risk Management Department by calling ext**.** 8117 or by completing a report in the Safety Net. In addition, any employee who has concerns about safety or quality also has the option of contacting The Joint Commission to report these concerns. Of course, we would prefer you to FIRST discuss your concerns to try to work them out with CHS. No disciplinary action will be taken against an employee who contacts The Joint Commission.

CHS Hotline-Anonymous Reporting is an option

Use the CHS Hotline (**ext. 8282**) to report (you need not provide your name):

1) Safety issues
2) Corporate compliance issues
3) Privacy issues

Adverse Event and Near Miss Reporting

- ✓ Complete Safety Net reports for incidents not consistent with routine clinical care or hospital procedure, which adversely affects or threatens the health, life, safety, or comfort of patients, staff, volunteers, or visitors.
- ✓ Reports should also be submitted for "near misses" or "good catches." Proactive reporting of these types of events is crucial for early detection and review of potentially serious issues **BEFORE** they reach any individual.
- ✓ All adverse events should be reported/documented immediately; at least by the end of your shift.
- ✓ **REPORTS ARE CONFIDENTIAL AND SHOULD NOT BE REFERENCED IN THE PATIENT'S MEDICAL RECORD** or filed in the patient's medical record.
- ✓ Information in the report should be factual, professional, objective (avoiding personal opinions) and provide as much detail as possible.
- ✓ Reports are used to identify actual and potential safety concerns, monitor for trends and improve overall safety.

🗐 **See Policy GA-051; Reporting of Adverse Events and Near Misses**

Sentinel Events

Sentinel Event: A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:

- ✓ Death
- ✓ Permanent harm
- ✓ Severe temporary harm and intervention required to sustain life.

Such events are called "sentinel" because they signal the need for immediate investigation and response. The terms "sentinel event" and "error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

Examples of Sentinel Events:

- ✓ Discharge of an infant to the wrong family
- ✓ Abduction of any patient receiving care, treatment, or services
- ✓ Unanticipated death of a full-term infant
- ✓ Hemolytic transfusion reaction involving major group incompatibilities
- ✓ Surgery on the wrong patient or wrong body part
- ✓ Inpatient suicide, or suicide within 72 hours of discharge
- ✓ Unintended retention of a foreign object in an individual after surgery or other procedure
- ✓ Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- ✓ Severe neonatal hyperbilirubinemia
- ✓ Rape, assault (leading to death, permanent harm, or severe temporary harm) or homicide of a staff member, licensed independent practitioner, visitor or vendor while on-site at the healthcare organization, or while under the supervision/care of the organization.
- ✓ Staff witnessed sexual contact or sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact.
- ✓ Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED) leading to death, permanent harm, or temporary harm of the patient.
- ✓ Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of care.
- ✓ Any intrapartum (related to birth process) maternal death.
- ✓ Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm.

IMMEDIATELY notify your supervisor upon identifying a ***potential*** sentinel event. Your supervisor is responsible to immediately notify the Associate Vice President of Quality & Risk Management or designee. **The attending physician is responsible for notifying the patient/significant other of any serious unexpected outcome after consultation with Risk/Quality Management.**

What are staff responsibilities regarding a Sentinel Event?

- Provide care for the patient
- Notify attending physician of event if he/she is not present
- Immediate verbal notification should be made to appropriate department director/manager, Administrator on-call and Associate Vice President of Quality and Risk Management
- Complete an incident report
- Obtain and preserve evidence, such as take photographs or lock up equipment involved in event
- Risk Management will review case to determine if a sentinel event has occurred
- Participate in the investigation event to determine the root cause, as requested

  - ➢ If a sentinel event has occurred, a root cause analysis will be conducted, and a corrective action plan will be developed. **Root Cause Analysis (RCA)** is the process to analyze & determine the root cause (underlying errors, deficiencies, and problems) in a process/procedure that allowed or caused the event to occur.

  - ➢ See **Sentinel Event Policy GA-72** for further information.

Service Recovery

SERVICE RECOVERY is the process of making things right after something has gone wrong with the healthcare experience. It's doing all that we can—in a sincere way that satisfies the customer—when service has failed. It might be a long waiting time, delivering the wrong meal, or having a procedure canceled. Studies show that 75% of the people that complain will do business with us again if we fix the problem. If we fix the problem QUICKLY, the rate jumps to 95% and these individuals become our most loyal customers. Everyone at CalvertHealth can be a Service Recovery STAR by following these steps:

S Show concern & LISTEN carefully. Introduce yourself and make good eye contact.

T Take ownership of the issue to the end. Do not drop the ball.

A Apologize, regardless of who's at fault…more importantly, do not blame any person/department!

R Resolve the problem so it does not happen again to anyone else. Use our Service Recovery Tool Kits when appropriate. Tool kits are available through Patient and Family Services at ext. 4523

Staff Rights

Staff Rights: If you are an employee with clinical responsibilities and wish to be excluded from providing or participating in some aspect of a patient's care based on your religious, moral, ethical, or cultural beliefs, you should complete the Religious, Ethical, and Cultural Values & Beliefs request form. The form is located on the intranet and should be forwarded to your supervisor and Human Resources. A determination will be made as to whether the request is justified and can be reasonably accommodated; however, please note you are responsible for providing appropriate patient care until alternate arrangements can be provided. Please refer to Employee Religious, Ethical, and Cultural Values and Beliefs Policy, HR 1-03.

Staff Injury

Employee safety is EVERYONE'S responsibility. As an employee, you should exercise safety precautions in the function of your job, to prevent injury and to reduce associated costs. It is important that you report all accidents to your supervisor immediately. It is our goal to ensure that if an employee sustains an injury at work, they receive the appropriate follow up as promptly as possible to ensure a speedy recovery.

In the event an employee sustains an injury while at work:

- Notify your supervisor immediately.
- Notify Employee Health at ext. 8110 immediately during office hours, for afterhours please email or leave a message
- Complete an Employee Incident Report within 24 hours in Safety Net, regardless whether you seek treatment or not. This is not optional if you get injured on the job you must report it, do not wait and see if it gets worse before filing incident reports.
- You may seek treatment in the Emergency Department or Urgent Care if needed, please notify Employee Health that you were seen. Before you can see your own medical provider you will need a claim number from Employee Health. All work notes are to be sent to Employee Health.
    - Time Off or Restricted Duty: If the employee is given time off or is returning to work with restrictions by the Emergency Room Provider or their own medical provider, notify Employee Health immediately. All light duty must be approved by Employee Health.
    - Not reporting work related injuries within 24 hours is a violation of our Standard of Conduct policy HR3-01& HR5-08

The Gold Seal of Approval™

The CHS Regulatory Compliance Committee developed this booklet for our employees, medical staff, and volunteers.

It is accessible on our INTRANET.

DEVELOPED: 2002
REVISED: 6/05, 6/06, 6/07, 4/08, 01/10, 3/11, 7/11, 1/13, 6/14, 7/15, 3/17, 12/18, 1/20, 3/23