Initial Orientation Essentials

This **Essentials** Packet is intended to provide an overview of important information on values and general safety guidelines at Mad River Community Hospital (MRCH). Details of current hospital procedures, policies, and manuals are accessible by employees via hospital computers on the **Intranet**, the MRCH internal website. You are encouraged to access and become familiar with the **Intranet** and its policies/procedures. Policies, manuals, and forms can be found on the **Intranet** under "Policies" using the "Policies & Procedures Search Engine." (Below, items found in the "Policies" section of the Intranet either are enclosed in quotation marks or are in italics. This document may be useful to you over the long run for turning to policies as issues arise.)

Must be completed before beginning work

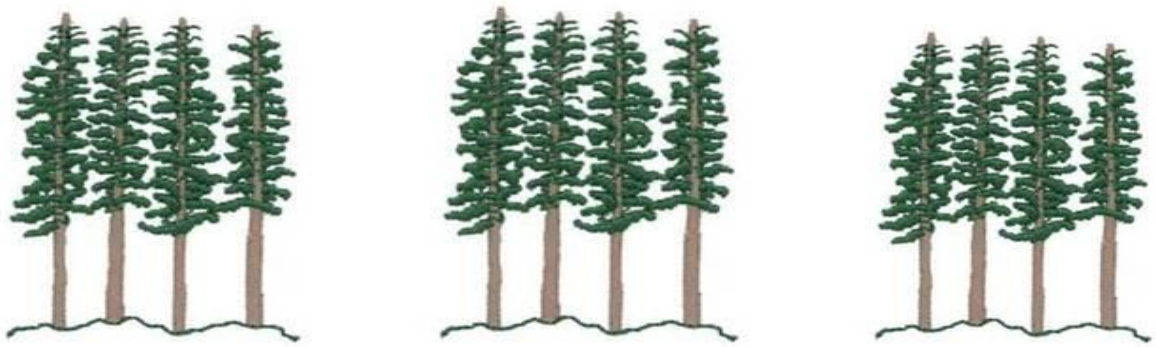
All employees of Mad River Community Hospital are required to complete the Initial Orientation **Essentials** prior to their first day of work if they have not attended a formal New Employee Orientation (NEO) session.

Directions:

1. Please read the self-learning "Essentials" module thoroughly (below).
2. Complete the Quiz (circle or complete the correct answers).
3. Submit the completed quiz to the Staff Development Office.
4. Schedule to attend the first possible NEO and NNO (if applicable).

Thank you

Suellen Lowry, Staff Development Clinical Educator (MRCH x 3117)
Cheryl Furman, Staff Development Administrative Assistant (MRCH x 3119)



Essentials

Mission

The patient is our first concern. We will do everything in our power to exceed the expectations of our patients and our community through quality-care services, attention to detail, honest communication, and positive attitude. All physical facilities, skills of personnel, and management are geared at all times to the needs of the patient. The hospital has an obligation to provide those it serves with the best possible care through the best possible resources.

Vision

Our QUEST is to become California's leading and most innovative community health center.
We COMMIT to providing excellent care to patients.
We PLEDGE always to respect and care for those who choose us for wellness, health care, employment, or as a place to practice the art and science of medicine.

Quality Care / Customer Service

- **Compassion:** We provide an environment that is caring and conducive to healing the whole person physically, emotionally, and spiritually. We respect individual needs, desires, and rights of our patients.
- **Quality:** We believe in continuous quality of care and performance improvement as the foundation for preserving and enhancing health-care delivery. Effective communication and education of our patients, staff, and the community we serve are essential elements of this process.
- **Comprehensiveness:** We are committed to an integrated health-care delivery system that encompasses a full spectrum of health-care delivery. This continuum of care encompasses all aspects of an individual's health-care needs across the lifespan.
- **Cost effectiveness:** We offer quality health care that is accessible and affordable.
- You are encouraged to read the MRCH booklets "Standards of Excellence" and "Guide to Quality Care and Patient Safety," available via HR and Staff Development.

Safe Practices

- MRCH is committed to providing a safe environment for patients and staff. In order to achieve this, all staff must be observant for processes and systems that need to be revised (and perhaps submit a work order to Plant Ops or Biomed).
- All hospital employees are responsible for patient safety. If you see someone who needs help or may seem ill, ask if they need help. Ensure the patient's safety and call for medical assistance if needed (e.g. Rapid Response Team).
- According to the "Risk Management Plan," MRCH establishes a culture of safety in part through implementing policies and procedures that follow requirements of National Quality Forum initiatives, CMS, HFAP, and CDPH.

Patient Rights

Per the "Patient Rights" policy, patients have rights, including the following: the right to have family members and providers notified about their admission; know names of staff caring for them; make decisions about their care; have reasonable responses to reasonable requests; appropriate assessment and effective management of pain; designate visitors (though the facility can place reasonable restrictions on visitation, "Visitation" policy); reasonable continuity of care; and information about reasons for transfers and options following discharge. Patients are given a copy of their rights.

Cultural Awareness

We work in a culturally diverse setting. Know your own beliefs and be respectful of the beliefs and practices of others. The best way to find out about a person is to ask that person without judgment or criticism.

Interpreters

For interpreter services, MRCH uses Pacific Interpreters, LanguageLine Solutions (24 hrs/day). Interpreter services are offered at no charge ("Interpreter/Translator Services" policy).

Age-Specific Concerns

As detailed in the "Age Specific Competencies" policy, we consider the patient's age in identifying special needs for care. Patients may have specific needs due to transitioning across the life span. Elderly persons, for example, may have poor skin integrity resulting in extra diligence to avoid pressure injuries and skin tears.

HIPAA (Health Insurance Portability and Accountability Act of 1996)

We value the confidentiality of our patients and information systems. All personnel are obligated to protect patient privacy rights, including information in any forms of communication, such as electronic, paper, or oral.

- Protected Health Information (PHI) is any health information that can be tied to an individual. E.g.: diagnoses, treatment, and prescription information, etc., as well as demographic information such as name, birth date, contact information, and identification numbers.
- PHI is given only to those who have an appropriate and authorized need for it. Therefore, PHI cannot be shared without authorization from the patient, except for treatment, payment, or health-care operations (TPO) purposes.
- HIPAA is important, and penalties for violations are significant. If you are uncertain or have questions, ASK your manager, supervisor, and/or health information management/medical records staff. "HIPAA" policies provide further information.

Advance Health Care Directives (AD)

An AD (e.g., power of attorney) means written instructions pertaining to health-care measures when incapacitated.

- Per the "Advance Directives" policy, patients must be advised of their rights to participate in medical decisions and to formulate an advance directive (AD). If a patient has an AD, it is placed in the chart.
- If patients request information on an AD, this should be addressed expeditiously; Social Services can be helpful.
- Patients also can execute a temporary AD that only applies to the current hospitalization.
- It is important to document that patients were offered the opportunity for an advance directive.

Patient Grievance / Patient Experience Officer

- We do everything in our power to address and resolve patient concerns. If necessary, patients utilize the chain of command, including talking with supervisors/managers or the Patient Experience Officer, so the management team may assist in resolving grievances.
- As discussed in the "Complaint/Grievance Policy," MRCH has an established process for prompt resolution of patient grievances and will inform each patient or patient representative who to contact to file a complaint/grievance.

Patient Identification

All patients must be identified by a proper armband. Per "Patient Identification" policy: "Identification of patients, throughout the organization, is verified by name and date of birth. The specific identifiers are verified with the patient or their representative prior to placing an armband on any patient, prior to obtaining blood samples, and prior to medication," as well as other activities.

Patient Wristbands

According to the "Wristband Color Codes" policy, various color-coded bands are placed when needed and left on at all times.

• **White**: Identification w/o transmission-based precautions • **Green**: Identification with transmission-based precautions	• **Purple**: DNR • **Red**: Allergies • **Yellow**: Fall Precautions • **Red/White/Numbered**: Blood Band

To avoid confusion, and with patient permission, social cause wristbands should be removed.

Abuse Recognition and Reporting

- All health-care workers are mandated reporters of suspected abuse/neglect of children, the elderly, or dependent adults. Abuse can be physical, emotional, financial, or sexual.
- Staff are also required to report suspected violence/assault.
- Abuse, neglect, or assault is reported by the employee to the appropriate agency. Appropriate agencies must be contacted immediately when abuse is suspected. A written report must be sent ASAP and within two days of discovery. Social Services needs to be informed for follow up as appropriate.
- An Occurrence Report must be completed.
- The "Abuse/Neglect Recognition and Reporting" policy has further information, including s/s of abuse or assault.

Quality Assessment and Performance Improvement

Quality assessment and performance improvement (QAPI) are everyone's responsibility. Learn about your unit's QAPI goals.

- For improvement, we use the **FOCUS** model: Find a process to improve. **O**rganize a team that knows the process. **C**larify current knowledge for the process. **U**nderstand causes of process variation. **S**elect the process of improvement.
- Steps that identify a Performance Improvement Opportunity are used as many times as needed -- **PDCA cycle** - Plan, Do, Check, Act. "Do the right thing -- Do the right thing well."
- The "Quality Assessment and Performance Improvement Program" policy has more information.

Occurrence / Adverse Event Reporting

The completion of Occurrence Reports is important for risk management and QAPI.

- Occurrence Reports (yellow form) will be completed at the time of an incident. Occurrence Reports are made for any unusual incidents (such as patient or visitor falls), whether there is an injury or not.
- Per the "Occurrence Report" policy, the process is non-punitive, and Occurrence Report data are confidential.
- In the Occurrence Report, be *detailed* -- so people can know what occurred and what may have contributed to the event (e.g., dim light). Also, please add factual outcome information if you have it. In part, include the patient/visitor name, your name (on reverse side of form), and the date/time of occurrence.
- Per the "Adverse Event Policy," an adverse event involves a serious injury or ongoing threat of a serious injury or death -- for a patient, personnel, or visitor. **These events must be reported to the supervisor and administration ASAP**. (And please complete an Occurrence Report.)
- Adverse event examples include, but are not limited to, patient abduction, discharge of an infant to a wrong person, patient suicide, hemolytic reactions, or wrong site surgery.

Compliance

The Compliance program assists the hospital to develop effective internal controls that promote adherence to federal and state law and program requirements of federal, state, and private health plans. The program advances the prevention of fraud, abuse, and waste while at the same time furthers quality care for patients ("Compliance Program Overview" policy). High ethical standards need to be followed in all areas, including accurate billing.

- MRCH has a Chief Compliance Officer (Pamela Floyd, x4918) with an open-door policy and a Compliance Confidential Hotline, which staff, patients, and others can call with concerns, 707-825-4909.

Compliance, continued

- Employees must immediately report to the Compliance Officer any suspected or actual violations (whether or not based on personal knowledge) of applicable law or regulations by MRCH or any of its employees. Under no circumstances shall the reporting of any such information serve as a basis for retaliatory actions against any employee making the report.

Code Red Response (Fire)

R-Remove and/or Rescue Patients and Visitors	**Extinguisher:** **P**-Pull (may need to break tie)
A-Activate Alarm and Call Code Red, dialing **3911** during day or 5**5** at night	**A**-Aim
C-Close Doors, Confine Fire	**S**-Squeeze
E-Evacuate & Extinguish if possible	**S**-Sweep

NOTE: Locate the fire extinguishers and alarm pull box closest to your work area. And make sure you know how to remove the extinguishers from their wall brackets. The "Code Red/Fire Plan" contains more information.

Oxygen Safety

Oxygen supports combustion. The "Safety, Oxygen Fire Precautions" policy contains additional details.

- Petroleum-based products should be not used in the nares or to lubricate or clean oxygen equipment.
- O2 tanks should be stored in well-ventilated areas and secured (no overturns).
- Keep potential ignition sources (e.g. frayed wiring) away from oxygen – and report safety hazards.
- Per the "Code Red/Fire Plan" policy, during a fire, Plant Ops and the Administration are notified. Plant Ops "[t]urn[s] off Oxygen/Medical Gases only as directed by the House Supervisor or the Arcata Fire Department. **Shutting off medical gases could endanger patients**." Plant Ops also notifies Cardiopulmonary.
- If a portable oxygen cylinder is needed, please call Cardiopulmonary. Use caution when transporting patients with oxygen. Always use oxygen tank holders, or lay the tank horizontally to prevent a cylinder fall until a holder is available. No rolling or dragging cylinders.
- If applying an oxygen mask, be aware this can cause patient anxiety, and please provide education and comfort.

Radiation Safety

- Degree of radiation exposure depends on three factors: Time, Distance, and Shielding. Read signs on doors; if there is a radiation sign, enter room cautiously and only when safe to do so. MRI and ultrasound are not sources of radiation.
- The extremely strong MRI magnetic field will interact with metallic items (if they are ferromagnetic) and turn them into *potentially deadly missiles*. 24/7, do NOT enter the MRI unit without clearance, by specially trained MRI staff, to do so.
- For more information, there are radiation and MRI safety policies in the *Environment of Care* and *Radiology* manuals.

Infection Control

(The *Infection Control Manual* [on MRCH Intranet] has many useful infection control policies.)

Per CDPH, Healthcare-Associated Infections (HAI) are the *most common complication of hospital care*. The Chain of Infection should be broken (e.g., through hand hygiene, use of PPE, isolation, health-promoting practices such as vaccines, etc.).

Hand hygiene is the most important intervention to stop HAI.

- World Health Organization (WHO) "**My 5 Moments for Hand Hygiene**": Before and after touching a patient, before clean/aseptic procedure, after body fluid exposure risk, after touching a patient's surroundings (before moving on).
- Even proper removal of gloves does not eliminate the significant risk of hand contamination from "back spray" (microbes jumping back onto hands), tears, etc., which is one reason hand hygiene must also be done always.
- Per CDC, *alcohol-based products* are most effective for removing microbes on hands. Also per CDC, alcohol-based products do not cause antibiotic resistance and are less drying than frequent use of soap and water. Rub enough on **all areas of hands.**
- Wash hands with *soap and water*, **rubbing for at least 15-20 seconds**, when hands are visibly dirty, after possible exposure to certain pathogens such as C. diff. or norovirus, before eating, and after using restroom.

Always use **Standard Precautions** with **all patients** (hand hygiene and PPE in situations with body fluid exposure risk). Body fluids include items such as blood, mucous, and urine. **Transmission-based Precautions** (plus standard precautions) are used for patients with known or suspected infections.

- Personal Protective Equipment (PPE) -- e.g., gloves, gowns, goggles, masks, respirators – protect staff (and others) from exposure to infectious materials. Choose PPE based on the type of anticipated exposure.
- **Isolation categories are Airborne, Droplet, and Contact**. Signs on an isolation door will instruct about the use of PPE. Patients requiring airborne precautions (for TB, varicella, measles, etc.) may be admitted to negative air flow rooms, and staff use respirators.
- **Bloodborne Pathogens**: Pathogenic organisms that are present in human blood and can cause disease in humans, including but not limited to Hep B, Hep C, and HIV ("Bloodborne Pathogen Exposure Control Plan" policy). Health-care workers can be exposed to blood through **sharps injuries**, plus **mucous membrane or broken skin** exposures (e.g., splashes into eyes).
- If **exposed to a patient's body substance**, report this immediately to manager/supervisor. Evaluation will occur in ED and follow-up treatment coordinated. Per the "Employee Needlestick/body substance exposure plan," sites of potential exposure to a bloodborne pathogen are washed with soap and water; mucous membrane exposures are flushed with water.

Infection Control, continued

- **Susceptible staff**, such as **non-immune** and **pregnant staff**, need to notify their managers that they should try to avoid entering rooms of patients in isolation if it may put such staff at risk (e.g., patients with chicken pox, rubella, etc.) ("Room Assignment for Transmission Precautions," "Standard and Transmission Based Precautions" policies).

Infectious organisms can live on **surfaces**, including dry surfaces, for hours, weeks, or months (e.g., Strep, E. Coli). So *clean surfaces and equipment between patient use* -– and perform hand hygiene after touching surfaces or equipment.

Environment of Care (and please note the *Environment of Care Manual* on Intranet)

- Report **unsafe conditions** to your manager, director, or supervisor immediately, and fill out work order(s) and Occurrence Report(s).
- Hospital grade plugs must have three prongs. Never use extension cords without Plant Ops' permission. Never pull plugs out of the wall socket by the cord. Report frayed cords, remove them from work area, and attach a note describing defect.
- Do not use defective/damaged equipment; remove from work area if portable. Medical equipment failures or damages: place note specifically describing defect; fill out and send work order to BioMed.
- Ensure all life-saving equipment is plugged into emergency red outlets, or outlets labeled "emergency," (to have emergency power from the hospital generator during electrical system failure).
- Plant Operations may be called after hours through the House Supervisor for any utility system failure (e.g., ventilation, water/sewer, gas leaks, etc.). The "Utilities Systems Management Plan" describes other actions when there is a disruption in utilities.
- If disruption of overhead paging and telephone service occurs, use available cell phones (House Supervisor, Administration, etc.). Plant Operations will use walkie-talkies.
- When informed of sewer and/or water system failures, limit toilet use (usually to one/dept.) and use bottled water. Conserve available water.
- Safety Data Sheets (often called "MSDS") provide safety/first-aid information and clean-up procedures for spills or exposures involving hazardous materials (hazmats). The MSDS database is available via the Intranet. Once you have accessed the particular hazmat, look at the pdf. Copies of MSDS may be available through the House Supervisor or Plant Ops in the event of a computer network failure. Plant Operations and/or Environmental Services will be responsible for clean up of large spills or leaks. The "Hazardous Materials and Waste Management Plan" policy contains further information.

Emergency and Disaster Response

Please see final, attached page (page 9).

Security

Per the "Security Management Plan," all staff, volunteers, vendors, and contractors MUST wear appropriate picture identification on their upper torso at all times. If an ID badge gets lost, notify Human Resources immediately.

- Four words helpful in maintaining hospital security: "May I help you?"
- Report all security issues to the manager/House Supervisor immediately (and please complete an Occurrence Report).
- A security guard is on duty after hours.
- For safety, roadway barriers, such as cones placed when the helipad is in use, must be honored.
- The "After Hours Security" policy has more information — about locked doors, etc., especially for nights.

Codes: Dial 3911 (days) or 55 (at night)

Days 0700 to 2300, Nights 2300 to 0700.
(If you use 55, it will be your voice on the overhead announcement system; please then repeat code and its location three times so people hear it clearly.)
Call 9 (to get outside line) and then 911 when appropriate.

Code Blue	Cardiac/Medical Emergency
Code Red	Fire
Code Yellow	Bomb Threat
Code Purple	Child Abduction
Code White	Pediatric Medical Emergency
Code White NRP	Newborn Medical emergency (0-28 days)
Dr. Strong	Manpower needed
Code Gray	Combative Person
Code Silver	Person with weapon and/or active shooter and/or hostage situation
Code Orange	Hazardous material spill/release
Code Pink	Infant abduction
Triage Internal	Internal Disaster
Triage External	External Disaster
Code Shelter-in-Place	Sealing of building to outside air
Code Security	Lock Down
Rapid Response Team	Patient needing emergency assistance [response to a patient before condition deteriorates]
Code Trauma	Trauma patient with unstable VS or airway, severe head injury, certain high risk anatomic injuries, etc.

Most items above per "Safety & Emergency Codes" policy (Code Trauma per "Trauma Activation Guidelines").

Staff Appearance / Identification

Per the "Dress Code/Name Badges" policy, staff need to dress professionally and appropriately for their unit. All staff must be identified by an MRCH ID badge with a photo. MRCH badges also contain an ID barcode and employee number. To see HR personnel policies: On the Intranet under "Policies," choose the *Human Resources Manual* and click on "Search."

Parking

Paved parking areas close to hospital entrances are for patients and their visitors. Staff park in graveled and certain concrete areas away from hospital entrances. While on duty, *night shift* staff also may park in any unrestricted space in the West lot. Please see the "Employee Parking" policy if you need more specifics.

Staff Rights

If staff believe they have difficulty caring for a certain patient or undertaking a procedure for personal reasons, or feel threatened by anyone, they need to notify the lead/manager/supervisor. More is discussed in policies such as "Staff Rights in Treatment or Care of Patients" and "Disruptive Behavior Guidelines-Assessment, Intervention and Documentation Procedures."

Harassment Policy

"MRCH is committed to providing a work environment free of unlawful discrimination or harassment" ("Harassment, Sexual Harassment, Discrimination, and Non-Retaliation" policy).

- According to the U.S. EEOC, "[h]arassment is unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability or genetic information. . . . [T]he conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive."
- Retaliation for opposing harassment or discrimination is also strictly prohibited.
- Employees who believe they have experienced harassment or discrimination must report this to their manager, supervisor, or HR immediately.

Workplace Violence Prevention / Disruptive Behavior

Disruptive behavior includes improper behavior that interferes with a safe work environment or patient care; it may be physical or verbal threats/abuse. Please read the "Work Place Violence Education/Disruptive Behavior Guidelines" policy.

- If disruptive behavior occurs: **Notify your lead/manager**. Maintain professionalism and **use de-escalation techniques** (e.g., active listening, empathy, quiet pause, setting limits, non-threatening body language). **Leave/walk away** if the patient becomes verbally abusive or threatening. (Have **clear access** to area's **EXIT**.) **Do NOT deny a patient's basic needs** or use corporal punishment or fear-eliciting techniques. Do NOT use restraints except for patient or others' safety and follow the MRCH restraint policies. Thoroughly **document**, and please complete an Occurrence Report.
- IF THE INDIVIDUAL'S BEHAVIOR POSES RISK OF VIOLENCE OR THREATENS INTEGRITY OF THE ENVIRONMENT OF CARE, IMPLEMENT A DR. STRONG CODE (or Code Gray if the person escalates to becoming combative and Code Silver for someone threatening with a weapon).

Body Mechanics / Ergonomics

- Safe lifting: Stretch before lifting and try to have a strong core. Lift slowly and carefully; don't jerk. Keep your back straight. Lift with bent knees. Keep item close to body (in your "power zone" from mid-chest to mid-thigh). Do NOT twist: Bending and Twisting at the same time as lifting = Injury. Push, don't pull. If an item is too bulky, heavy, or awkward, get HELP.
- Safe work station: Maintain a comfortable working posture with joints naturally aligned; stretch and walk. Let employee/occupational health know if you have ergonomic difficulties with your work station.
- The "Safe Patient Handling & Movement" policy provides additional guidance.

EMTALA

EMTALA (Emergency Medical Treatment and Active Labor Act) is a federal law that mandates medical screening and stabilization requirements before a patient can be transferred. The purpose is to require proper screening and care of people regardless of their ability to pay. Penalties for EMTALA violations are significant. Any potential violations should be reported to the supervisor immediately. (MRCH has several EMTALA-related policies, including "EMTALA Compliance," "EMTALA Transfer," and "Interfacility Patient Transfer.")

Discharge of the Homeless Patient

Per California law and the Social Services "Discharge Planning for Homeless Patients" policy, "[p]atients without permanent, stable housing will be provided with adequate resources and referred to an appropriate community agency to assist them with housing or shelter needs." This information must be furnished in a culturally competent manner.

- Assistance is also provided for appropriate transportation needs and health-care follow up.
- Adequate documentation should occur.

.

Medicare Discharges

The federal CMS (Centers for Medicare & Medicaid Services) requires all hospitals to deliver the "Important Message from Medicare" (IM) to inpatient Medicare beneficiaries.

- The IM informs inpatients of rights regarding services, decisions about their care, quality of care, and discharge appeals.
- The IM details steps Medicare patients can take if they feel they are being discharged too soon, including discussing concerns with their providers and appealing. (Appeals must occur in a timely manner, before leaving MRCH.)

Additional Phone Numbers That May Be Useful

Also on the MRCH Intranet, under "Contacts," are a Department Phone Directory and other useful numbers.

Revised August 2019

Essentials for Nurses (in addition to "Essentials" for all staff)

Policies and Procedures Related to Patient Care Activities

The nurse is advised to become familiar with the current policies posted on the MRCH Intranet and to select patient care actions guided by these policies.

- As noted above, the MRCH **Intranet** has a link on the left side of the page entitled "Policies." This link provides a search engine for a hospital-wide search of topics related to patient care and safety activities.
- Manuals most specific to nurses may be *Nursing Administrative and Clinical Manual*, *Org Wide Manual*, *Pharmacy manuals*, and various department manuals (e.g., for ICU, ER, Birth Center, and Surgical Services). Each department has a link under "Policies" on the Intranet that provides department-specific policies and procedures.

Core Measures

To ensure quality patient care, nurses will align patient care with current Core Measures identified by Centers for Medicare and Medicaid Services (CMS) and best-practice standards.

- Sepsis identification, monitoring, and treatment is one of the Core Measures being observed at MRCH. "Sepsis" and "Physician Orders per Protocol" are two of the policies that address sepsis (including identification and treatment).

Methods of Assigning Patient Care / Delegation

- MRCH assigns patient care based on ratios designated by California Code Title 22 ("Nursing Service Staff"), as well as by calculations of acuity measured by a patient classification system. Acuity is reassessed each shift ("Acuity Assignment" policy).
- Patient care activities delegated to LVNs, CNAs, techs, volunteers, or unlicensed assistive personnel must be within their Scope of Practice with consideration of MRCH job descriptions/policies and California practice codes.

EMR / Chart Documentation

Each new nurse is trained in the use of the current MRCH EMR system. Order transcription and verification, nursing care documentation of assessments, care activities, and discharge planning and education are included in this training.

- Personal identification of staff (signatures) are based on the bar code on the back of the badge given to each employee. Entering the EMR system under the badge ID number serves to recognize the nurse as the one providing documentation.
- The nurse providing care must TIME, DATE, and electronically SIGN all entries placed in the medical record.
- Protecting EMR records by logging out of the computer when not directly documenting is essential as a protection of the patient's HIPAA rights.

Falls

- Every patient is assessed for risk of falls upon admission, at the start of every shift, and with changes in patient care/condition (including medication changes).
- Patients scoring higher than 15 on the Fall Risk Screen are considered at High Risk for Falls, and several steps are taken, including yellow armband and sign, toileting every one-two hours, and alarms 24/7.
- Please see "Fall Prevention" policies for further information and steps to prevent falls.

Skin Care

"All patients are assessed for the presence of wounds upon admission, every shift and as needed" (more frequently for critically ill patients). For more details, please see the "Wound Management" policy, as well as other skin care policies or guidelines. Also, MRCH has an inpatient wound care nurse, who should be called for pressure injuries, etc., and MRCH has a wound care center in Shaw.

POC Blood Glucose Monitoring

Glucometer use is a hospital competency that is completed upon hire and then, per federal CLIA regulations, at least annually. Contact Staff Development or the lab about completing this competency.

Restraints

- Restraints are used solely to **protect** the patient, staff, or others. They are administered after other methods have been attempted. Only trained staff can apply restraints.
- All documentation on the Restraint Documentation electronic form must be complete, and the form provides helpful guidance. E.g., patient safety monitoring occurs every 15 minutes; patient safety and continued need assessment is documented every two hours.
- "Restraint of Patients" and other related policies provide further information.
- Other: Never tie restraints to a movable object. Pad bony prominences PRN. Maintain good body alignment and watch CMS. Ensure restraints are not too tight, and if tying, use a knot that can be released easily.

Blood Administration

- When a patient requires a transfusion, a type & cross match is done (except for certain emergencies). The lab tech places a red blood ID band on the patient's wrist; *this band only can be repositioned with lab personnel present*. Consent for a transfusion is obtained. NS is hung/primed and IV insertion site assessed preferably before getting blood unit from lab.

Administration of Medications

(There are several medication policies -- in Nursing, Pharmacy, Org Wide, and various department manuals. These include, but are not limited to, "Medication Administration & Monitoring," "Medication Orders," and "Pediatric Medication Management.")

- **Safety systems** shall be used, including observing the rights of medication administration, and utilizing two patient identifiers (name and DOB).
- Watch for **confirmation bias**: Reading what you expect to see on the label rather than reading the actual medication.
- If you have questions, do not hesitate to **contact Pharmacy**. And **if a medication's appearance, dose, etc., do not look right, question it**.
- Medications are administered per **orders** (please also check for provider comments accompanying orders). Self-administration of medication by patients is limited to the use of Patient Controlled Analgesia (PCA).
- Certain meds, such as heparin and insulin, must be checked and co-signed by **two licensed personnel**.
- When a **first-time** medication dose is administered, the nurse administering the medication stays with the patient for the first few minutes and remains close-by for the first 30 minutes.
- Per the "Pain Management" policy, **pain** is assessed at least once per shift, with VS, and PRN, using an age-appropriate pain scale. Reassessment to determine the effectiveness of a pain medication intervention is done when the medication should have taken effect (15-20 minutes for IV/IM; one hour for PO).
- **Errors** in administration of medications are reported to the pharmacy and QAPI by completion of Medication Error and Occurrence Reports. Report to the patient will be at the discretion of the physician and/or manager of the nursing unit. **Adverse drug reactions** are reported *immediately* to the patient's physician and pharmacy. An Adverse Drug Reaction form and Occurrence Report are completed, and reactions documented.
- **Patient education** about meds and possible side effects must be included in care.
- ***Lexicomp*** is available on computers and in the pharmacy, for detailed drug information.

Blood Administration, continued

- Documentation of blood administration is done electronically on the EMAR Blood Administration Form; please follow it thoroughly. When the nurse picks up the unit of blood from the lab, the lab tech opens the Blood Administration Form; the initial part (page 2) is completed in the lab.
- The Blood Administration Form is opened again at bedside by the RN, with two licensed personnel verifying right patient and right unit.
- PRBC and FFP are blood products kept in the MRCH lab. Other products can be delivered in about 20 minutes by the Northern California Community Blood Bank.
- A blood unit must be infused within four hours and can only be held on the care unit for 20 minutes before beginning infusion. (If it must be held longer, the unit should be returned to lab.)
- Patient assessment, including VS and lung sounds, is done frequently and at intervals indicated on the Blood Administration Form. The RN stays with the patient for the first minutes of administration. Observe for s/s of fever, chills, flushing, urticaria (hives), difficulty breathing, anxiety, change in VS, etc. If present, stop transfusion and notify provider and lab immediately; keep all infusion items.
- It is key to listen to lung sounds because, when present, pulmonary-related transfusion reactions (which cause pulmonary edema) are a leading transfusion-reaction cause of mortality.
- When a transfusion is complete, including post-transfusion vitals, a second RN verifies completion of the Blood Administration Form.
- Please be aware of the blood transfusion policies, including "Blood and Blood Products: Ordering, Obtaining, Transfusion."

Organ and Tissue Donation

- MRCH is required by law to notify our organ procurement organization, Donor Network West (DNW), of all potential organ/tissue donations. The hospital should *call DNW early*: e.g., when clinical cues, such as loss of neurological reflexes, are present -- ideally within one hour that it is anticipated the patient will meet the criteria for imminent death.
- If donation may be appropriate, DNW will discuss the option of donation with the family.
- To maintain cellular viability, administer intravenous fluids, medications, and vasoactive agents as prescribed; and provide other patient/family support.
- Related policies include "Organ Donation," "Anatomical Donations for Transplantation," and "Organ Donor Care."

Revised August 2019

For all employees, from *Initial Orientation Essentials* page 5:

Emergency and Disaster Response

The highest priority in emergencies and disasters is the safety and welfare of patients, staff, and the public in the hospital. Emergency actions may be necessary during earthquakes or law enforcement actions, or other emergencies to protect individuals or groups, and include the following:

- Earthquake: Duck under sturdy piece of furniture; Cover head with hands; Hold on. (Protect yourself from falling objects.)
- Active shooter: Run away fast; Hide in secure area; Fight aggressively.* *Think about these options in your work area* before you are in this situation.

- Procedures are posted at different locations throughout the facility, and can be found in different plans on the hospital Intranet in the *Environment of Care Manua*l under *Emergency Preparedness*.
- MRCH manages its response to emergencies and disasters using the Hospital Incident Command System (HICS). The first, most qualified person on scene serves as the incident commander and will assign tasks according to the needs of the incident. Employees assigned under HICS may be required to serve outside their normal duties. If necessary, the Minckler Room or the mailroom will be activated as the Command Center.
- In the event of an emergency involving large numbers of actual or potential casualties, employees are expected to report to the hospital for duty as soon as possible after ascertaining the safety of their immediate families, unless it is not possible or they are directed not to do so. All employees are to respond *with their ID badges* to the labor pool (sometimes called the people power pool), located in the cafeteria.
- MRCH uses the Everbridge mass notification system for emergency notifications and to provide direction for employees. Messages may include polling questions to assist the incident managers in emergency response.
- Emergency supplies are staged at various locations throughout the hospital, including personal protective equipment for infectious hazards, hazardous materials decontamination, mass casualty incident supplies, and alternate care site supplies. Check with your supervisor for emergencies supplies located in your department. In part, emergency supplies are located in the Emergency Department break room and in a pod-type storage unit near the garden.
- All employees are responsible for knowing their duties in a disaster as outlined in the "Emergency Response Plan" and "External Disaster Plan," and should coordinate preparedness activities with their supervisor. Plans detailing specific emergency procedures are located on the MRCH Intranet in the *Environment of Care Manual*. Additional training is available on-line through Staff Development and during drills and exercises. For further information, contact the Emergency Preparedness Coordinator at x 4953.

* Per Department of Homeland Security, "Planning and Response to an Active Shooter": If it is safe to do so, the first course of action that should be taken is to **run**. When possible, individuals should exit the building through the safest route and proceed to a designated assembly location(s) or an alternate vetted site. If running is not a safe option, staff should be trained to **hide** in as safe a place as possible where the walls might be thicker and have fewer windows. Lock the doors and/or barricade them with heavy furniture, if possible; turn off lights; silence all electronic devices. If neither running nor hiding is a safe option, when confronted by the shooter individuals in immediate danger should consider trying to disrupt or incapacitate the shooter by **using aggressive force** and items in their environment, such as fire extinguishers, chairs, etc. More DHS information: https://www.dhs.gov/cisa/private-citizen .

Revised May and August 2019