Orientation
Nursing Students

St. Joseph Hospital
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Welcome to St. Joseph Hospital. The first health care facility established by the Sisters of St. Joseph of Orange in 1920, St. Joseph Hospital is a full-service acute care facility with two campuses. We specialize in cancer treatment, heart care, emergency care, childbirth, and women's services.

The hospital moved to its current location in 1950. The General Hospital was purchased in 2000 and became our 2nd campus. The hospital has 125 beds and approximately 1,033 staff.
History and Heritage

The history of the Sisters of St. Joseph of Orange spans more than 350 years.

The sisters trace their roots back to 17th Century France and the unique vision of a Jesuit priest, Jean-Pierre Medaille. He sought to organize an order of religious women who, rather than remaining safely cloistered in a convent, would go out into the community, find out the needs, minister to those needs, and find lay people to help them.

The congregation managed to survive the French revolution and eventually expanded, not only throughout France, but throughout the world.
In 1912, a small contingent of the **Sisters of St. Joseph** led by Mother Bernard Gosselin came to Eureka at the invitation of the local bishop to establish a school.

A few years later, the great influenza epidemic caused the sisters to temporarily abandon their education efforts to care for the sick in their homes. They realized the community needed a hospital and in 1920, the sisters opened 28-bed St. Joseph Hospital. Their new health care ministry was born.
History and Heritage

St. Joseph Hospital Eureka was the flagship of what is now the **St. Joseph Health System** – an integrated healthcare delivery system providing a broad range of medical services. The system is organized into three regions: Northern California, Southern California, and West Texas/Eastern New Mexico and consists of 14 acute care hospitals as well as home health agencies, outpatient services and more.

The Health System office and Sister’s Motherhouse are located in Orange, California.
The mission, vision and values of St. Joseph Health System work in concert to shape our decision and guide our actions. They form the heart of our health care ministry.

**Our Mission** – Why We Exist

*To extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.*

**Our Vision** – What We are Striving to Become

*We bring people together to provide compassionate care, promote health improvement and create healthy communities.*
Mission, Vision, Values and Goals

Our Values: How We Work and Treat Each Other

Dignity: We respect each person as an inherently valuable member of the human community and as a unique expression of life.

Service: We bring people together who recognize that every interaction is a unique opportunity to serve one another, the community and society.

Excellence: We foster personal and professional development, accountability, innovation, teamwork, and commitment to quality.

Justice: We advocate for systems and structures that are attuned to the needs of the vulnerable and disadvantaged and that promote a sense of community among all persons.
Mission, Vision, Values and Goals

Our Goals: What We are Striving to Become

Perfect Care –
All Patients will Receive Perfect Care

Sacred Encounters –
Every encounter will be experienced as a Sacred Encounter

Healthiest Communities –
100% of the Communities We serve will be in the Top Decile for Healthiest Communities
Emergency Codes

TO CALL ANY CODE:
Use any hospital extension and Dial 7111 (SJE) or dial 811 (GH)
Emergency Codes

As a hospital, we must be prepared to handle all sorts of emergencies. Codes have been established for some of these situations as a means of alerting staff and triggering a response. Codes are announced on the overhead paging systems.

**TO CALL ANY CODE:**
- Dial 7111 at St. Joseph Hospital
- Identify type of code and location
- Repeat the message.

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE RED</td>
<td>Fire</td>
</tr>
<tr>
<td>CODE BLUE</td>
<td>Adult medical emergency</td>
</tr>
<tr>
<td>CODE WHITE</td>
<td>Pediatric medical emergency</td>
</tr>
<tr>
<td>CODE PINK</td>
<td>Infant abduction</td>
</tr>
<tr>
<td>CODE PURPLE</td>
<td>Child abduction</td>
</tr>
<tr>
<td>CODE YELLOW</td>
<td>Notification of a bomb on campus</td>
</tr>
<tr>
<td>CODE GRAY</td>
<td>Combative person</td>
</tr>
<tr>
<td>CODE SILVER</td>
<td>Hostage or weapon</td>
</tr>
<tr>
<td>CODE ORANGE</td>
<td>Hazmat spill or release</td>
</tr>
<tr>
<td>CODE TRIAGE</td>
<td>Internal or external disaster</td>
</tr>
</tbody>
</table>
Emergency Codes – **YOUR ROLE**

- Students can call any code (except Code Triage) as a first responder to an emergent situation but may not participate in the code past the initial response.
Fire and Life Safety – **FIRE PREVENTION**

Goals of Fire Safety:
- Prevent fires from starting
- Stop the spread of fire

Your Role in Fire Safety:
- Handle flammables and combustibles safely
- Never store trash or supplies in hall
- Never block fire doors, exits, fire extinguishers or hoses
- Keep portable equipment on the same side of the hallway
- Enforce our smoke-free campus policy
Life Safety (Fire Safety) – **CODE RED**

**Immediate Response**

**Remove**
- All persons in danger
- Employees work together to remove anyone in danger

**Activate Alarm**
- Page by calling 7111 (SJE) or 811 (GH)
- Pull the alarm

**Confine**
- Fire by closing doors
- Closing doors and windows prevents the spread of smoke and flames

**Extinguish**
- The fire if manageable
- Only if you have trained in the proper use of a fire extinguisher
- Never turn your back on the fire
- If possible, two employees should work together

Call When:
- Fire
Life Safety (Fire Safety) – **CODE RED**

**Called When:**
- Fire

**Facility Wide Response**
- Chimes and strobes activate to let everyone know there is a fire. The overhead paging code is **CODE RED**.
- One **staff** (not students) person from every department brings an extinguisher to the fire.
- Use stairs and not the elevators.
- Touch Test doors for heat before opening – **DO NOT OPEN** hot doors.
- Smoky? Remember, air is cleaner 18” above floor.
Life Safety (Fire Safety) – CODE RED

Called When:
Fire

Department / Student Response

- Know the location of smoke/fire doors, fire alarms, extinguishers, and evacuation routes on your unit
- Close the doors and windows
- Clear hallways in work area-move equipment to one side

Fire Drills test your ability to respond correctly and are evaluated so that process improvements can be made.
Life Safety (Fire Safety) – **CODE RED**

**HOW TO OPERATE FIRE EXTINGUISHER**

Extinguishers are wall-mounted or in boxes in the hospital hallways.

**CLASS ABC EXTINGUISHER**

- Designed for electrical fires, flammable gases, wood, paper, textile fires
- Contains dry chemicals which smother the fire
- Recharge by bringing to the Engineering Dept.

1. **Pull** the pin
2. **Aim** at base of fire
3. **Squeeze** handle
4. **Sweep** from side-to-side

Trained hospital **staff** are authorized to shut off oxygen valves in the event of a fire or other emergency when directed by Engineering, House Supervisor, Respiratory Therapy or Fire Department.
Security Management
Security

We have Security / Engineering staff that provides security 7 days a week, 24 hours a day for our facility. We use interior/exterior close circuit monitoring of strategic areas and 2 way communication. Even with these measures, Security cannot be everywhere at all times. You are actually the extra “eyes and ears” of our Security / Engineering staff.

The key to providing effective security for our facility is prevention, and prevention begins with you.

Your Role in Security

- Always wear your ID badge
- Keep personal belongings out of sight
- Ask for a security escort when leaving after hours - dial 7101, enter 065 at the beep.
- Main doors are locked between 9p – 5a. Use ED entrance during those times.
- Be alert and observant of people that normally should not be in an area.
- Report all suspicious activity to the Clinical Supervisor on your unit.
The hospital has 4 emergency security codes (shown at right) that you need to be aware of. Each of these will be discussed in greater detail on the next few slides.

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SILVER</td>
<td>Hostage or weapon</td>
</tr>
<tr>
<td>GRAY</td>
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<tr>
<td>YELLOW</td>
<td>Notification of a bomb on campus</td>
</tr>
<tr>
<td>PINK</td>
<td>Infant abduction</td>
</tr>
<tr>
<td>PURPLE</td>
<td>Child abduction</td>
</tr>
</tbody>
</table>
Security: **CODE SILVER**

**Called When:**
Hostage or Weapon Situation

**When YOU hear “Code Silver” . . .**

**Staff / Student Response:**
- **DO NOT** go to announced location
- Restrict traffic into affected area
- This is an extremely dangerous and sensitive situation that should only be handled by local police agencies.

**Staff / Students who see person with weapon:**
- Seek cover / protection; warn others
- Report “Code Silver” to Operator including location, number of suspects/hostages, number and type of weapons
Security: **CODE GRAY**

**Call When:**
- Assistance needed with a combative person / situation.

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**When YOU hear “Code Gray” . . .**

**Staff Response:**
- Go to announced location and provide cautious support
- Do not escalate the situation

**Student Response:**
- Stay clear of announced location
- Reassure other patients
- Follow directions of your Clinical Instructor or Clinical Supervisor
Security: **CODE YELLOW**

**Call When:**
- Bomb Threat or Suspicious Package

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**When YOU hear “Code Yellow” . . .**

**Staff / Student Response -IMPORTANT:**
- *Do not* use radios or transmitters to avoid radio frequency activation of a bomb
- Turn off pagers/cell phones

**If you receive a bomb threat:**
- Record exact date and time
- Keep caller on the line and have staff person notify Admin Supervisor (pager 45 or ext. 5900)
- Write down answers to these questions:
  - What does bomb look like?
  - When will it explode?
  - Where is it?
  - Why was it planted?

**If you discover a suspicious package:**
- *Do not touch it or disturb it in any way.*
- Give the exact location of the object.
- Notify the Clinical Supervisor
Security: **CODE PINK / CODE PURPLE**

**Call When:** must also call 9-911

- **Code Pink:** discover/observe abduction of infant less than 27 days
- **Code Purple:** discover/observe abduction of child 28 days or older.

**When YOU hear “Code Pink or Code Purple” . . .**

**Staff Response:**
- Go to nearest unmanned exits, stairwell, or parking lot
- Politely ask for ID of people exiting hospital
- Do NOT go to area of abduction.

**Student Response:**
- **DO NOT** give out any information about a possible abduction.
- **DO** note any suspicious activities, persons or vehicles and report to Clinical Supervisor.
- **DO NOT** participate in facility wide response.
Emergency Preparedness
Emergency Management - CODE TRIAGE

Each of these Emergency Situations could result in activation of the Emergency Operations Plan, CODE TRIAGE.
Emergency Management - CODE TRIAGE

Called When:
A disaster or other catastrophic emergency has occurred which poses a significant threat to the ability of the hospital to provide care, treatment, and services.

This code activates the hospital’s Emergency Operations Plan (EOP). The EOP is a hospital-wide response plan for emergencies in 6 critical areas:

- Communications
- Resources and Assets
- Safety and Security
- Staff Responsibilities
- Utilities Management
- Patient Clinical and Support Activities

When Your Hear “Code Triage” . . .

Staff Response:
• Follow the EOP

Student Response:
• Follow the directions of your Clinical Instructor or the Clinical Supervisor for the unit.
The nature, scope and duration of an emergency may require the partial or complete evacuation of the facility.

The Incident Commander determines the need for evacuation along with the Safety Officer and the Administrator on Duty.

**Your Role in Evacuation**

- Your Clinical Instructor will determine whether or not nursing students will participate in patient evacuation.
- If students are instructed to evacuate, follow the directions of the Incident Commander - Hospital Command Center for evacuation.
- If students are staying to assist as determined by their Clinical Instructor, follow the directions of the Clinical Supervisor for that unit.
Emergency Management – CODE BLUE / WHITE

Call When:

**Code Blue:** adult medical emergency

**Code White:** pediatric (infant/child) medical emergency

When YOU hear “Code White or Code Blue” . . .

Staff Response:

- **Code Team** goes to announced location (ED MD & RN, ICU RN, RT, Admin Sup, Compressor, recorder)
- Unit / department staff bring crash cart

If YOU discover the patient:

- Identify signs/symptoms of cardiac / respiratory distress.
- Call the code and
- Begin first responder CPR until staff arrive to relieve you.
- Note: after the first response, students may only observe a Code Blue / White if first approved by their instructor.
Utilities Management
Utilities Management

UTILITY FAILURE

• In the event of a utility failure, follow the directions of the clinical supervisor on your unit.

• Emergency power outlets have a RED cover or outlet connections. These receive power from the emergency generator and are used for critical equipment only.

• The Safety manual contains failure plans for all of the major utilities in the buildings.
Utilities Management

EMERGENCY SHUT OFF VALVES

• Shut off valves for medical gases are located in hallways and labeled with the rooms affected.

• Only trained hospital staff can close a valve when instructed to do so by the Administrative Supervisor, Engineering, Cardiopulmonary or Fire Dept.

• Patients needing oxygen will need portable oxygen tanks provided for them.

CYLINDER GAS SAFETY

• Make sure the gas in the cylinder is the gas you want to administer.

• Use only the specific regulator for the gas you want to administer.

• Store cylinders upright and in a secure holder at all times.
Medical Equipment Management
Medical Equipment- Preventative Maintenance

Electrical safety is a critical component of SJE Fire Safety.

• Biomedical Equipment

  New equipment is inventoried and assessed for safety by Biomedical Engineering prior to use. Thereafter, it is checked at least annually and tagged with date of last inspection. It is ok to use if within 12 months of date.

• Other Equipment

  Other equipment must be double insulated and UL approved. Items which will not be used in a patient room still need to be checked by Engineering before use. All approved equipment will be tagged with an “OK to Use” sticker.

PATIENT-OWNED EQUIPMENT

• Convenience Items

  Many convenience items (hair dryers, radios, etc) do not meet hospital standards for use in patient areas and are not permitted. Exceptions must be approved by the Safety Officer. Battery operated equipment is allowed.

• Medical Equipment

  – Physician must write an order authorizing the use of any patient-owned medical equipment that needs to be used in the hospital (e.g. BIPAP).

  – RCP or Engineer must inspect such medical equipment for electrical safety.
Medical Equipment:

Take the Following Action for Broken Equipment:

• REMOVE broken equipment from service

• Label it **DO NOT USE** and identify the specific problem

• Notify the Clinical Supervisor who will create a Work Order for Engineering or Biomedical Engineering. Be prepared to provide the following information:
  ✓ Location of equipment
  ✓ Your name (in case of questions)
  ✓ Description (exactly what failed)
A federal law called the **Safe Medical Devices Act (SMDA)** requires hospitals to report any medical device that may have been involved in an occurrence that caused serious injury, serious illness, or death of a patient or user.

**What is a “Device”:** Under this law, the definition of a medical device includes electrical equipment, devices, blood products, supplies - just about everything used on a patient except drugs. For example, the IV bag and lines are a medical device, but the drugs in the solution are not.

**Action To Take**

- Administer / obtain immediate medical care to the individual.
- Remove equipment from service and do not alter or change control settings.
- Notify the Clinical Supervisor immediately.
Hazardous Materials and Waste Stream Management
Hazardous Materials (HazMat)

One of the common hazards you are exposed to in the health care environment is the presence of hazardous materials (chemicals). These chemicals are used in medical procedures, cleaning procedures, laboratory procedures etc.

Over the past years, we have been able to eliminate or drastically reduce the use of the more dangerous chemicals. There are still plenty of chemicals in use in our environment so we cannot let our guard down.
Hazardous Materials—Your Right to Know

The Occupational Safety and Hazard Act requires that we provide you with information regarding the hazardous materials you work with. This information is available from 2 sources:

- **Warning Labels on Containers**: indicate chemical name, health hazards, required personal protective equipment

- **Material Safety Data Sheets (MSDS)**: MSDS is written information supplied by the manufacturer or distributor of the product. The MSDS lists chemical composition, protective equipment, types of exposure and effects, spill clean up and more.

**YOUR ROLE in HazMat**

- Carefully read and follow warning labels and MSDS
- Ask staff if you are unclear about safety measures

The Occupational Safety and Hazard Act requires that we provide you with information regarding the hazardous materials you work with. This information is available from 2 sources:
HazMat: Material Safety Data Sheets

To access the MSDS information, call the toll free number shown at right and have the listed information available.

Emergency requests are responded to within 15 minutes.
Urgent requests are responded to within 30 minutes.

1-800-451-8346
- Product name and number
- Manufacturer Name
- UPC code if applicable
- Your fax number

MSDS
HazMat Spill – **CODE ORANGE**

**Call When**
There is a large spill or leak of Hazardous Material that requires special clean up procedures

**If You Witness a Spill:**
- **REMOVE** all persons in danger
- **NOTIFY** hospital staff immediately
- Keep others away from spill area
- **DO NOT** clean up the spill

**If You are Exposed:**
- Notify your clinical instructor and hospital staff.
- Follow emergency first aide measures as directed.
HazMat – **Radiation Safety**

Radiation sources are present in many areas of the hospital as shown below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Radiation Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology</td>
<td>X-Ray Machines</td>
</tr>
<tr>
<td>Surgery</td>
<td>Portable X-ray</td>
</tr>
<tr>
<td>ED</td>
<td>Portable X-ray</td>
</tr>
<tr>
<td>Cath Lab</td>
<td>X-Ray Machines</td>
</tr>
<tr>
<td>Nuclear Med</td>
<td>Radioactive Materials</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>Linear Accelerator</td>
</tr>
<tr>
<td></td>
<td>Radioactive Materials</td>
</tr>
<tr>
<td>Nursing Units</td>
<td>Portable X-ray</td>
</tr>
</tbody>
</table>

**Your Role in Ways to Reduce Radiation Exposure**

1 - **TIME**
Spend as little time as possible around Radiation sources

2 - **DISTANCE**
Stay as far away as possible from Radiation Sources

3 - **SHIELDING**
Put something between you and Radiation Sources
Portable x-rays are routinely taken on the nursing units. Please observe these precautions:

- When you hear the x-ray tech announce – “X-Ray” – get clear of the room.
- Only the patient and essential personnel remain in the room.
- Personnel remaining in the room must:
  - Wear a lead apron
  - Not be pregnant
  - Stay out of the path of the x-ray beam.
Magnet Safety – **MRI**

Our diagnostic imaging services include Magnet Resonance Imagery (MRI). The magnet in the MRI room is always on so the following measures must be observed at all times for patient and staff safety:

- No metal items are allowed in the magnet area.
- Patients must be screened for implanted metal devices prior to this procedure.
- Do NOT enter with equipment unless you have been screened by MRI staff.
Waste Stream Management

Special attention must be given to disposal of wastes as shown below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Disposal Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biohazardous waste</td>
<td>Red bags</td>
</tr>
<tr>
<td>Soiled linen</td>
<td>Yellow bags</td>
</tr>
<tr>
<td>Pathology waste</td>
<td>Labeled Red containers</td>
</tr>
<tr>
<td>Chemotherapy Waste</td>
<td>Labeled containers</td>
</tr>
<tr>
<td>Sharps and broken glass</td>
<td>Red sharps containers</td>
</tr>
<tr>
<td>Pharmaceutical waste</td>
<td>Blue and white containers</td>
</tr>
</tbody>
</table>

**PHARMACEUTICAL WASTE** - Any unused medication must be discarded in the pharmaceutical waste including:

- Narcotics that are being witnessed/wasted
- Fentanyl patches (must be witnessed/wasted)
- Some medications that are considered to be hazardous materials may be labeled to be returned to the Pharmacy
- Electrolytes/TPN may be discarded in sink

**VACUUM SYSTEMS** – Suction canisters must be evacuated using the Saf-T-Pump located in Dirty Utility room.

Closed vacuum systems: for systems that cannot be evacuated, sprinkle 1-2 packages of isolyzer into the bottom of the red bag in case the units should rupture and spill.
Infection Control
Hospital Acquired Infection (HAI)

HAI: How to break the Chain of Infection

1. Perform hand hygiene.
2. Clean equipment between patient use.
3. Wear recommended Personal Protective Equipment as listed on isolation signs. Inconsistent use confuses visitors and ancillary staff (such as volunteers)
4. Use gurney for transporting isolation patients to surgery or diagnostic imaging.
5. Identify type of isolation in hand-off report (National Patient Safety Goals).
**CDC Recommendations**

**What to Use:**
Alcohol-based hand rubs – 20 seconds (sing Happy Birthday)
Soap and Water

**When to Perform:**
- At the start of the shift
- After touching body fluids
- Immediately after removing gloves
- Between patients
- Before and after having patient contact
- After having direct contact with objects likely to be contaminated (bedside rails, blood pressure cuffs, Television remote, bedside table, toilet)
- Before eating, drinking, smoking, after using the rest room, after coughing or sneezing
HAI Prevention – **Hand Hygiene**

**Soap and Water** Required when:
1. Handling food
2. Using the restroom
3. Hands are visibly soiled
4. Your patient has *Clostridium difficile*

*Click here to view the Infection Control policy “Hand Hygiene and Artificial Nails”*
HAI Prevention - **Hand Hygiene**

1. Wet hands with warm running water
2. Apply soap
3. Rub hands for 20 seconds (If necessary, use a nail brush to clean nails. However, the brush must be kept clean and sanitary.)
4. Rinse hands thoroughly
5. Dry hands with a paper towel (the paper towel can then be used to turn off the tap)
6. Turn off the tap with the paper towel
HAI Prevention – **Clean Environment**

“Superbugs” live on surfaces…also known as Multidrug Resistant Organisms (MDROs)

**MRSA Survival** (Methacillin Resistant Staph Aureus)
- Formica surfaces = 14 days
- Cotton blanket material = 6-9 weeks
- *S. aureus* (MRSA) can remain virulent and capable of causing an infection for 10 days after exposure to dry surfaces

**VRE Survival** (Vancomycin Resistant Enterococcus)
- Bedrails = 24 hours
- Telephones = 60 minutes
- Gloved and ungloved hands > 60 minutes

**Clostridium difficile Survival** (Not a MDRO but “Other Organism of Concern”)
- C. diff spores can live and infect up to 5 months on environmental surfaces
- special requirements for hand hygiene and environmental cleaning (see next page)
HAI Prevention: **Clean Equipment**

All equipment should be wiped down with a germicidal wipe (Super Sani Cloths):

- Between patient use
- When equipment leaves the patient room (e.g. wheelchair, walkers, gurneys, etc)
Clostridium Difficile – Cleaning Recommendations

This sign is posted for patients with Clostridium difficile so that all Healthcare workers and visitors are aware of hand hygiene and environmental cleaning recommendations.

**Hand Washing** (Healthcare Workers and Visitors)

Soap & water required

for this patient’s condition

(alcohol hand sanitizers not effective)

**Cleaning of Equipment and Patient Rooms**

Healthcare Workers - **use our**

bleach based product

Hospital Disinfectant with Bleach (Caltech®)
HAI Prevention: **Use PPE**

Use Personal Protective Equipment (PPE)

- **Standard Precautions:** use PPE with anticipated exposure
- **Contact Precautions:** gloves, gowns upon entry to patient room
- **Droplet Precautions:** gloves, gowns, and mask upon entry to patient room
- **Airborne Precautions:** PPE: N95 mask - must be fit tested
HAI Prevention: Use of PPE

For more info:
CDC http://www.cdc.gov/ncidod/sars/ic.htm

Figure. Donning and Removing Personal Protective Equipment (PPE)

**DONNING PPE**
Type of PPE used will vary based on the level of precautions required, e.g., Standard and Contact, Droplet or Airborne Isolation Precautions

**GOWN**
- Fully cover torso from neck to knees, arms to end of wrist, and wrap around the back
- Fasten in back at neck and waist

**MASK OR RESPIRATOR**
- Secure ties or elastic band at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

**GOGGLES/FACE SHIELD**
- Put over face and eyes and adjust to fit

**GLOVES**
- Extend to cover wrist of isolation gown
HAI Prevention: Use of PPE

Perform hand hygiene immediately after removing all PPE!

**REMOVING PPE**

Remove PPE at doorway before leaving patient room or in anteroom; remove respirator outside of room

**GLOVES**
- Outside of gloves are contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining gloved hand at wrist

**GOGGLES/FACE SHIELD**
- Outside of goggles or face shield are contaminated!
- To remove, handle by “clean” head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

**GOWN**
- Gown front and sleeves are contaminated!
- Unfasten neck, the waist ties
- Remove gown using a peeling motion; pull gown from each shoulder toward the same hand
- Gown will turn inside out
- Hold removed gown away from body, roll into a bundle and discard into waste or linen receptacle

**MASK OR RESPIRATOR**
- Front of mask/respirator is contaminated – **DO NOT TOUCH!**
- Grasp bottom then top ties/elastics and remove
- Discard in waste container
HAI Prevention – Isolation Meal Tray Handling

All Isolation Trays except C. Diff

- Tray is color-coded with red-checkered placemat; usual utensils and dishware.
- After use, return tray directly to meal cart.
- If it cannot be placed directly in meal cart, place in regular trash bag and seal before leaving patient room. Then store it in the kitchenette for Nutrition Services staff to pick up later.

C. Diff Isolation Trays:

- Trays, dishware and utensils are disposable.
- Discard used tray etc. in a red bag and store in patient’s room. DO NOT place in meal cart.
MRSA Screening

1. **Patient screening for MRSA** is required by SB 1058 at admission and prior to discharge:
   - All inpatients admitted to ICU
   - All inpatients from a Skilled Nursing Facility
   - All inpatients scheduled for elective surgery that have a history of MRSA
   - All inpatients discharged from an acute care hospital within 30 days of current admission
   - All inpatients that receive dialysis

   “Relax – MRSA will get you before the Asian Flu”
Process for swabbing nares for MRSA screen

1. Use the recommended swab to collect the nasal specimen.
   The swab can be moistened with two drops (about 50 µL) of sterile physiological serum (saline) or used dry.

2. Carefully insert the swab into the patient’s nostril (the swab tip must be inserted up to 2.5 cm (1 inch) from the edge of the nares). Roll the swab 5 times.

3. Insert the same swab into the second nostril and repeat sampling as in the preceding step.

4. Return swab to its container and send to the laboratory immediately.

Slide provided by BD with permission
Isolation Guidelines (partial)

<table>
<thead>
<tr>
<th>DISEASE OR CONDITION</th>
<th>Type of Precaution</th>
<th>Private Room req’d</th>
<th>Negative Pressure Room req’d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abscess (soft tissue)</td>
<td>Contact</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>AIDS/HIV</td>
<td>Standard</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>C. difficile (use soap and water for hand hygiene)</em></td>
<td>Contact</td>
<td>X</td>
<td></td>
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<tr>
<td>Cellulitis</td>
<td>Contact</td>
<td>X</td>
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<tr>
<td>Chickenpox (Varicella)</td>
<td>Airborne and Contact</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>Standard</td>
<td></td>
<td></td>
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<tr>
<td>Cytomegalovirus infection, neonatal or immunosuppressed</td>
<td>Standard</td>
<td></td>
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</tbody>
</table>


Infection Control Office: *phone* ext: 5807 *pgr*: 618-9507 *fax*: 269-3713

*Infection Control Practitioner pgr*: 269-9735 (after hours, urgent or weekend issues)

*Infectious Disease Consultant*: Uzi Selcer, M.D., 443-9371
Quality Management
Quality: PERFECT CARE

Perfect care is defined as safe, timely, efficient, effective, evidence-based, patient centered, and spiritual.

Perfect care also describes the expected outcome of zero failures.
- Zero Delays
- Zero Preventable Deaths
- Zero Sentinel Events
- Zero Failure to Provide Evidence-based Care
- Zero Failure to Address the Spiritual Needs of Patient/Family

How Do We Get There?
- Performance Improvement Methods
- Engagement of physicians, staff and patients and students
- Use of Technology
Quality: Stepping Up to Perfect Care

The Quality Management Department directs our efforts to achieving perfect care and monitors our patient outcomes.

It has 3 main areas of focus related to achieving this goal:

- **Regulatory Readiness**
- **Performance Improvement**
- **Customer Satisfaction**
Quality: **Regulatory Readiness**

Who Regulates Us

[Diagram showing various regulatory agencies and their relationships with each other, including Congress, Medicare Integrity Program Contractors, PRRB, OIG, Federal Circuit Courts, Departmental Appeals, Regional Offices, Intermediaries, Carriers, PROs, DME Regional Contractors, Regional Home Health Intermediaries, DEA, FAA, OPOs, SEC, IRS, EPA, FTC, FCC, HHS/HRSA, HHS/NIOSH, FDA, DOT, OSHA, DOJ, Treasury, FBI, DOL, NRC, JCAHO.]

State Level:
- Survey and Certification
- Courts
- Attorneys General
- Medicaid
- Health Boards
- Medicare Boards
- Local Governments
- Licensure

YOUR HOSPITAL
Quality: **Regulatory Readiness**

The “Ripple Effect” – In Search of Perfect Care

Hospital Acquired Infections, Medical errors etc.

↓

Adverse patient outcomes, increased costs, media interest

↓

Increase Regulatory, Payer and Consumer Scrutiny

↓

Increased Outside Oversight:

- **Federal Government**: requires core measure reporting: Acute Myocardial Infarct (AMI), Heart Failure (HF), Pneumonia (PNE), wrong site/side surgery

- **State**: required adverse event reporting e.g. hospital acquired infections

- **Consumer**: public reporting initiatives such as Leapfrog, IHI
Plan for Improving Organizational Performance

On an annual basis, performance improvement activities/priorities for the organization are selected.

These priorities, shown at right, are consistent with our mission, values and current strategic goals.

Performance Improvement Priorities for Fiscal Year 2010

- Nosocomial Pressure Ulcers
  - Sepsis Mgmt
  - Anticoagulant Mgmt
  - Medication Reconciliation
- Core Measures: (PNE/HF/AMI)
- Universal Protocol
- Ventilator Associated Pneumonia
- Nosocomial Catheter Associated UTI
- Catheter Related Bloodstream Infections
- Surgical Care Improvement Program
- Mgmt of Multi Drug Resistant Organisms
- Values Streams
- AOA Accreditation
Quality: **Performance Improvement**

The method we use to improve processes affecting care and services is called **PDCA:**

**PLAN:**
- Establish goals and objectives
- Develop policies and procedures to guide employees

**DO:**
Train employees to accomplish objectives
- Follow policies and procedures

**Check**
- Monitor outcomes against desired goals and objectives

**ACT:**
- Take appropriate action responsive to findings of evaluation activities.
Quality: **Customer Satisfaction**

St. Joseph Hospital strives to be the provider of choice so the feedback of our patient’s is very important. Surveys are mailed to inpatients and outpatients in a variety of settings. These surveys help identify performance improvement opportunities and provide a means of monitoring effectiveness of measures taken.
POLICIES

Hospital policies are located on Carenet – our hospital intranet.

For quick access to select policies, look for the Mini-Manual on the desktop.
Patient Safety Initiatives

The following slides describe specific patient safety measures we have in place.
Patient Safety Initiatives – **Improve Communication Accuracy**

- **Use 2 Patient Identifiers**
  
  **Identifiers Used:** Patient name and date of birth; for OPs without armband use patient’s stated name and date of birth.

  **When to Check:** prior to administering blood/blood components, medications, ordering/delivering meals; prior to procedures, treatments, transport; collecting blood/specimens for clinical testing.

  **Patient:** Involve patient and family, as needed, in patient identification and matching process. If patient involvement not possible or reliability in question, caregiver must be designated for identity verification.

- **Eliminate transfusion errors**

  **Identifiers Used:** Patient name and date of birth used to match blood/blood component.

  **When to Check:** prior to initiating blood/blood component.

  **Who:** RN, IV certified LVN and/or MD; 1 must be qualified and will administer the blood/blood components
Patient Safety Initiatives – **Improve Communication Effectiveness**

- **Verbal or Telephone Orders**
  - When receiving verbal/telephone orders or critical test results:
    - Write down and “read-back” the complete order or test result.
    - Document orders as **VORB or TORB**.

- **Do Not Use Abbreviation List**
  - Only acceptable abbreviations are:
    - “U” or “u” Spell out the word “units”
    - “IU” Write out the words “International units”
    - “QD” or QOD Write “daily” or “every other day”
    - “MS”, “MS04”, “MgSO4” Write Morphine Sulfate or Magnesium Sulfate
    - BIW Write “twice a week”
    - DPT Write Demerol-Phenergan-Thorazine
    - Dram Write “Teaspoonful”
    - Minum Write “drop”
    - Use of “Trailing” zero’s (i.e. 0.5mg) Omit trailing zero’s (i.e. 5 mg)
    - Omission of leading zero’s (i.e. .5mg) Use leading zero’s (i.e. 0.5mg)

*Applies to all orders and medication-related documentation including orders to be implemented from external organizations.*
Patient Safety Initiatives – **Improve Communication**

**Handoff Communication**

**When:** nursing change of shift; transfer to different internal level of care including ED admissions; MD to MD transfer of care; anesthesia report to PACU; sending patient from inpatient unit to diagnostic and/or interventional unit. **Your role: verbal handoff report to the primary RN before leaving.**

**What:** current information regarding patient’s condition, treatments, medications, services and any recent and/or anticipated changes

**Reporting Format:** SJH uses SBAR format to organize information for verbal or written patient shift to shift reports:

**SBAR Technique:**

- **Situation**
- **Background**
- **Assessment**
- **Response**

**Methods:**

**Voice Care:** telephone taped report for giving/receiving handoff

**Ticket to Ride:** patient information form provided to transport staff when patient temporarily leaves unit for diagnostic and/or interventional area

**Other:** limit interruptions, provide opportunity to ask/respond to questions
Patient Safety Initiatives – **Improve Communication**

**Critical Test Results**
- timely reporting and receipt by caregiver

**Document:** time of receipt and/or reporting of test/imaging result.

**Critical Lab Values**
- timely reporting to caregiver

**What Is Critical:** values defined by the Lab as “critical”

**Action To Take:** Students to notify the primary RN immediately. MD must be called within **60 minutes** of notification. When calling, identify value and request read-back. Exception: expected values

**Document:** name of practitioner notified, date/time/ signature; read-back obtained (RBO) and whether or not there are any new orders.
Patient Safety Initiatives – **Improve Med Safety**

- **Look-Alike/ Sound-Alike Drugs (LASA)**
  - List of look alike, sound alike meds identified; reviewed annually; action taken to prevent errors.
  - List is posted in med room, Pyxis, night locker and **Pharmacy website**. Example: Oxycontin is **NOT** the same as Oxycodone.

- **Label Medications On And Off The Sterile Field**
  - Applies to all settings; bedside procedures as well as OR procedures
  - Label medication / solution when transferring from original packaging to another container on sterile field. **DO NOT PRE-LABEL CONTAINERS.**
  - Label medication/solution even if only 1 medication is being used. Label one at a time.
  - Labeling kits available on the unit.
  - 2 qualified person verification required if person preparing meds is not the person administering.
Use Of Anti-coagulation Therapy

- Applies when the clinical expectation is that the patient’s lab values for coagulation will remain outside normal values.
- Use of pre-printed orders to standardized therapy.
- For patients starting on Warfarin and low molecular weight heparin (LMWH), a baseline INR is obtained and on-going INR’s are used to monitor and adjust therapy.
- Nutritional Services are notified for all patients receiving Warfarin.
- An Alaris pump must be used when administering continuous IV Heparin infusion.
- Education to patients and families should include follow-up monitoring, compliance issues, dietary restrictions and potential for adverse reactions and interactions.
Patient Safety Initiatives – **Reconcile Meds**

- **Reconcile Meds**

  **Purpose:** avoid medication omissions, duplications, dosing errors, drug–drug interactions or drug-disease interactions.

  **Process:**
  1. **Obtain** home med list;
  2. **Reconcile** (compare home meds to meds the organization plans to provide) meds on admission/entry into service, at transfer (change in level of care) and at discharge;
  3. **Provide** med list to patient and primary care physician at discharge.

  **Document:** med list obtained upon entry/admission and with each change in level of care; hand off communication with change in level of care; patient instruction related to med list at discharge.

  **Outpatient setting:** if meds are used minimally or for a short duration and there are no changes being made to patient’s current meds, then obtain list of meds and any known allergies. No requirement to reconcile list or provide patient a med list at end of visit.
Patient Safety Initiatives

Reduce Falls

- **Fall Reduction Program**
  - Assess inpatients for fall risk using Morse Scale
    - Change door frame signage to reflect risk
    - If risk score 26 or greater - implement Fall Prevention Program.
    - **Apply yellow armband if at risk**
  - Outpatients - No specific assessment/reassessment required, however, appropriate action taken for patient’s presenting with obvious risk factors.

Involve Patients in Safety

- **Reporting Safety Concerns**
  - Inform/encourage patients / families to report safety concerns. Examples of how we inform patients and get feedback include:
    - **Provide Patient Teaching**: room orientation, medication teaching
    - **Feedback Tools**: Patient Satisfaction Surveys, Community Internet Site
Patient Safety Initiatives – **ID At-Risk Patients**

- **Assess Suicide Risk**

  **Purpose:** Identify patients at risk for suicide and ensure safety needs are met.

  **Who to Assess:** patient’s seeking care, treatment or service for primary diagnosis / complaint of emotional/behavioral disorder **OR** requiring acute care and intervention due to impact of the disorder.

  **When:** On admission/entry into service; reassess daily.

  **How:** Use Suicide Risk Assessment Tool.

  **Care:** Open Problem # 3 and implement plan based on assessed lethality level.
Patient Safety Initiatives –

Goal – Assistance When a Patient’s Condition Appears to be Worsening

• Rapid Response Team

Team Purpose: Provide expert assessment, early intervention and stabilization of patients to prevent clinical deterioration or cardiopulmonary arrest outside of the ED or ICU.

When to Call: worsening patient condition - acute change in HR, SBP, SPO2, mental status, UO; s/s of stroke, new/recurring chest pain etc.; staff concern about patient

Who Can Call: any staff member

How to Call: Dial 7101 and enter #50. State “Rapid Response Team to _______” and identify location.
Patient Safety Initiatives – **Universal Protocol**

Goal - Prevent Wrong Site, Wrong Procedure, Wrong Person Surgery

- **Pre-Procedure Verification**

  **Purpose:** verify relevant documents and studies are available prior to the start of a procedure.

  **When is Verification Required:** applies to all surgical and non surgical invasive procedures that are not considered minimal risk procedures; procedures are not begun and/or patients are not admitted to the OR/procedure room until the pre-procedure verification is completed.

  **What is Verified:**
  - Signed consent which matches physician order
  - Updated history and physical; pre-anesthesia assessment
  - EKG, Labs and x-rays as appropriate
  - Surgical Site marked by surgeon / procedure list
  - Any required blood products, implants devices and/or special equipment

  **Documentation:** Completion of pre-procedure checklist prior to moving patient to surgery/procedure room.
Patient Safety Initiatives – **Universal Protocol**

**Marking the Surgical Site**

**When is Site Marking Required:** for all procedures involving incision or percutaneous puncture or insertion; marking takes into consideration laterality, the surface (flexor, extensor), the level (spine), or specific digit or lesion.

**Who Marks:** the surgeon/person performing the procedure; involves patient, if possible.

**How Marked:** “yes” written in close proximity to surgical site

**When:** prior to moving the patient to surgery/procedure room

**Procedural Pause or Time Out**

**When /Where is a Time Out Required:** all surgical and non-surgical invasive procedures that are not considered minimal risk regardless of setting, e.g. OR, bedside, diagnostic area

**Elements Verified:** correct patient, procedure, site/side, accurate consent, correct patient position, relevant images and results, safety precautions based on patient history or medication use and, as applicable, implants, blood/blood products and special equipment

**Who Can Initiate:** any team member

**Document:** in the medical record; use the yellow Procedure Note and/or in department specific computerized documentation system.
Patient Safety Initiatives – **Condition H**

**What Is It:**
- Condition Help (H) enables patients and families to access a rapid medical opinion in a time when no one can/will give them the answers they are looking for.
- **To access, patient and families call 7113** from any hospital telephone. The operator will ask for caller identification, room number, patient name and patient concern.

**When Is It Called:**
- If a noticeable medical change in the patient occurs and the health care is not recognizing the concern.
- If there is a breakdown in how care is being given and/or confusion over what needs to be done for the patient.

**Who Responds:**
- The responding team is made up an ICU RN, Admin Supervisor and Respiratory Therapist.

**Your Student Role**
Be alert to patient/family expressed concerns about care and notify the primary RN immediately.
Pediatric Weight-based Medications

- **Population:**
  - Pediatric patients (13 years old and under)

- **Applies to:**
  - ALL pediatric medication orders

- **Nursing:** When Pharmacy is not available, two licensed staff (within their scope of practice) check the order for:
  - Appropriateness
  - Independent dose calculations checks
  - Double-checking of final product prior to administration is required at all times.
Other Patient Safety Policies
Color Coded Wrist Bands - NEW

SJH uses color-coded wristbands to identify and communicate patient-specific risk factors or special needs

- No handwriting on the wrist bands except the Allergy band – write NKA if no allergies.
- Patients may NOT decline wristbands; exception: patients may decline to wear the DNR.
- Applied to same limb; exception: limb restriction applied to affected limb.
- Document application / removal in nurses notes.

<table>
<thead>
<tr>
<th>Color</th>
<th>Description</th>
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<tbody>
<tr>
<td>Yellow</td>
<td>Fall Risk</td>
</tr>
<tr>
<td>Pink</td>
<td>Limb Restriction</td>
</tr>
<tr>
<td>Blue</td>
<td>Isolation</td>
</tr>
<tr>
<td>Red</td>
<td>Allergy</td>
</tr>
<tr>
<td>Purple</td>
<td>Do Not Resuscitate</td>
</tr>
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</table>
MEDICAL RESTRAINT
Assess Before Use

• Clinical Indications for Use
  – Patient is attempting to **pull out tubes, drains, or other lines** medically necessary for treatment and is unable to comply with safety instructions
  – Patient is attempting to ambulate, is at risk for falling, and is non-compliant with safety instructions

• Consider / Attempt Alternatives:
  – Hiding tubes/lines, reorientation, family intervention, companionship, mobility, distraction e.g. folding wash cloths; use of alarm devices

• Consider Causal Factors:
  – Identify medical problems that could be causing behavioral changes e.g. increased temp, hypoxia, low blood sugar, electrolyte imbalance, drug-drug interactions
MEDICAL RESTRAINT

Obtain MD Order

- **Obtain Initial Order Immediately** (without any time delay) after initiating restraint.
  - Order justification and patient behavior must match
  - Restraint device ordered and restraint device used must match
  - Notify attending physician within 24 hours if the attending did not order the restraint

- **Obtain Renewal Orders Every Calendar Day**
  - NO PRN orders
  - **NO TRIAL RELEASE**: Remove restraint if behavior no longer justifies use. New order required if behavior returns regardless of time left on order.
MEDICAL RESTRAINT

Plan of Care Goal - Injury Prevention

**Your Role**

- **Observe the patient every 60 minutes**

- **Monitor/Assess Every 2 Hours For:**
  - Restraints intact; appropriately applied, removed or reapplied
  - Signs of injury associated with the restraint device
  - CSM check and ROM of restrained extremity
  - Need for hygiene, toileting, nourishment and fluids
  - Physical, neurological and psychological status and comfort
  - Continued clinical justification for restraint use

- **Notify the primary RN if patient no longer has need of restraint**
RESTRAINT SAFETY

• **General:**
  - Consider relative contraindications to restraints for example: joint injury, dialysis fistula/graft, axillary node dissection
  - Remove all potentially harmful items (including jewelry)
  - Side rails up; Gap pads should be used on split side rails
  - **Patient’s head is free to rotate** when in the supine position

• **When Applying Jacket/Vest Restraint:**
  - Must fit at the waist and enable one flat hand to easily go under waist band.

• **When Applying Wrist restraints**
  - Allow one finger width between skin and device to ensure adequate circulation

• **When Securing Restraint Ties**
  - Use **quick release slip knots**
  - Secure to bed frame – not mattress or siderail
Abuse, Assault, Neglect Reporting

Who has Duty to Report?
- All physicians and health care providers

What Must be Reported:
- Abuse of Patients Received from Licensed Health Facilities
- Abuse of Elders and Dependant Adults
- Child Abuse
- Sexual Assault
- Adult Patient Abuse or Assault (includes spousal and domestic abuse)
Abuse, Assault, Neglect Reporting

Identifying Possible Victims

Consider the possibility when THE PATIENT:

• **History is incompatible with injuries.**
• **Has unusual injuries and/or unexplained bruises, lacerations, fractures or multiple injuries in various stages of healing.**
• **Presents with malnutrition or dehydration (not illness related), failure to thrive and/or poor physical hygiene.**
• **Has repeated ER visits, hospitalizations or a history of prior physical abuse.**
• **Delayed in seeking medical care.**

Consider the possibility when THE PARENT / SPOUSE / CAREPROVIDER:

• **Refuses to leave the patient’s presence despite the patient’s wishes.**
• **Offers conflicting, unconvincing or no explanation for patient’s injury.**
• **Delayed in getting medical care for the patient.**

**Action to Take**

Notify the primary RN immediately of your suspicions.
Test Time:

• Print out the Safety Quiz.
• Answer the questions.
• Turn in the form to your clinical instructor for grading.