West Florida
HOSPITAL

Orientation Handbook

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NURSING ADMINISTRATION

Angela Ellis

Chief Nursing Officer

Ext: 4175

Mission, Values and Guiding Principles, III – 01

SCOPE

This policy applies to the Medical Staff, Administration and employees of West Florida Healthcare.

PURPOSE.

To establish standards of performance excellence by defining the mission, values and guiding principles of West Florida Healthcare.

POLICY

Quality at West Florida Healthcare means providing services that meet or exceed the needs or expectations of patients and their families, the physicians, payers, our fellow employees and the communities that we serve. Achieving quality is a process of regular measurement, systematic feedback, continuous improvement and innovation. Everyone in the Hospital has a responsibility to do their job in as high a quality manner as possible and to continuously seek to improve the way we provide services to our customers.

MISSION AND VALUES STATEMENT

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve.
In pursuit of our mission, we believe the following value statements are essential and timeless.

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

PHILOSOPHY

We believe the following principles to be true and timeless.

- Our number one focus will always be on patient care.
- We are committed to caring for people with compassion and kindness.
- We are committed to consistently providing high quality care and service to our patients.
- We will work closely with and enthusiastically support the communities that we serve.
- Our success is dependent upon attracting, developing and retaining our greatest asset -- our people.
- We will foster an environment that:
    - Treats all people with dignity and respect
    - Encourages open and honest communication
    - Emphasizes and rewards teamwork
    - Builds loyalty and trust
- We believe in holding people accountable to our values and principles through fair and accurate metrics.
- We believe our business is best managed and run at the local level, giving responsibility and authority to those closest to the delivery of patient care.
- We will continue to evolve and grow our business in order to successfully fulfill our mission while unswervingly adhering to our values and principles.
- We will constantly look for ways to innovate and improve the quality of our care and service.
- We will maintain a strong, viable financial position that will continue to deserve the respect and give confidence to our shareholders.

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AIDET

A	**ACKNOWLEDGE:**	Greet the patient by name. Make eye contact, smile, and acknowledge family or friends in the room.
I	**INTRODUCE:**	Introduce yourself with your name, skill set, professional certification, and experience.
D	**DURATION:**	Give an accurate time expectation for tests, physician arrival, and identify next steps. When this is not possible, give a time in which you will update the patient on progress.
E	**EXPLANATION:**	Explain step-by-step what to expect next, answer questions, and let the patient know how to contact you, such as a nurse call button.
T	**THANK YOU:**	Thank the patient and/or family. You might express gratitude to them for choosing your hospital or for their communication and cooperation. Thank family members for being there to support the patient.

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West Florida Hospital

C.A.R.E.S. Service Behaviors

It all begins with "I will…"

What will you do today in your work? Will you solve a problem? Will you give your undivided attention to someone needing your help?

A job description tells us what to do, while our Service Behaviors guide us on how we do our job – how we show we CARE. They give us clear direction on how to approach our jobs as we interact with patients, visitors and co-workers.

At West Florida Hospital, our patients are top priority – that means we each share a responsibility to serve the patient or to serve those who do. That's what makes us West Florida Hospital and that's what allows us to fulfill our mission to provide the highest quality care to our patients.

We ask for a commitment from you and every other employee to help us build this culture of collaboration and respect by applying WFH's CARES Service Behaviors. You will be held accountable for living out these standards and you are expected to gently remind co-workers when you witness an action or decision that does not meet WFH's service behaviors. Not only managers, but all employees share this responsibility to inspire and guide each other.

C. A. R. E. S.

Communication

I will:

- Use AIDET as a framework to communicate with patients and their families.
- Speak respectfully and positively of co-workers, departments and leadership.
- Remember that my tone of voice and body language can say as much as my words.
- Not engage in hostile, condemning or demeaning communications.
- Acknowledge and respond to e-mail, voice mail and other forms of communication in a professional and timely manner.
- Communicate any concerns, suggestions and ideas to my supervisor in an open and honest manner.

Accountability

I will:

- Adhere to WFH's policies, procedures and Code of Conduct.
- Strive to exceed attendance expectations in order to provide consistency in quality of service.
- Be fiscally responsible by not wasting time or resources.
- Wear my WFH identification badge at all times and introduce myself to patients or those who may not know me.
- Take pride in my overall appearance and comply with the Dress Code.
- Take responsibility for making sure that my actions, behaviors and decisions reflect positively on WFH.
- Support a culture that finds solutions, rather than one that makes excuses or blames others.
- Hold myself and co-workers accountable for providing professional and reliable service in a consistent manner.
- Uphold patient, employee and institutional confidentiality.
- Attend and participate in staff meetings and other meetings as required; and be punctual for meetings and appointments.
- Promptly acknowledge errors and/or issues and take necessary actions to correct them.
- Accept responsibility for the work that I do at WFH.
- Demonstrate pride in being associated with WFH.

Respect

I will:

 Respect the knowledge, dignity, and perspective of the entire healthcare team.
 Follow the 10/5 rule; acknowledge the person 10 feet away by making eye contact, smiling and saying “hello” at 5 feet away.
 Address individuals by their name and avoid derogatory or offensive terms and nicknames.
 Embrace diversity throughout the workplace with patients and their families by making a genuine effort to understand their needs.
 Avoid sexual, harassing, intimidating or threatening behaviors that make others uncomfortable.
 Knock or announce myself before entering a room when feasible.
 Assist guests in finding their way by walking them to their destination.
 Practice telephone etiquette by answering the telephone within three rings, identifying myself and department and asking “How may I help you?”
 Keep all interactions positive and discuss internal issues only with those who need to know.
 Refrain from criticizing WFH in the workplace and in the presence of our customers.
 Practice elevator etiquette by allowing visitors to enter/exit first and will not discuss patient information.
 Show respect for all employees regardless of their position in the organization.
 Not use any electronic communication device (e.g., cell phone, iPad, internet) for personal business while working.

Excellence

I will:

 Actively work to understand our customer’s needs and deliver service that exceeds their expectations.
 Respond to our customers in a timely manner.
 Be part of the solution when a workplace problem arises.
 Always help one another to assist a customer.
 Exceed our customer’s expectations of care and comfort.
 Manage up, speaking well of each other, co-workers and medical staff.

Safety

I will:

 Maintain a safe environment for our patients, their families and our employees by understanding all safety codes and knowing how to respond to them and understanding and following the National Patient Safety goals.
 Be responsible for creating a safe, secure and accident-free environment by taking pride in the workplace and keeping the work area tidy by cleaning up litter, debris and spills promptly.
 Address any safety hazards I notice and will report them immediately if I am unable to correct.
 Notify the appropriate party when I observe burned out lights or damaged furniture, linen, or equipment.
 Follow our hand hygiene policy.
 Use personal protective equipment, proper lifting techniques/devices and practice standard precautions.
 Follow the five R’s when administering medication: Right Patient, Right Medication, Right Dosage, Right Route, Right Time

As you represent West Florida Hospital, we rely on you to make West Florida Hospital the finest health care organization in the community. We rely on you to say “YES, I WILL…”.

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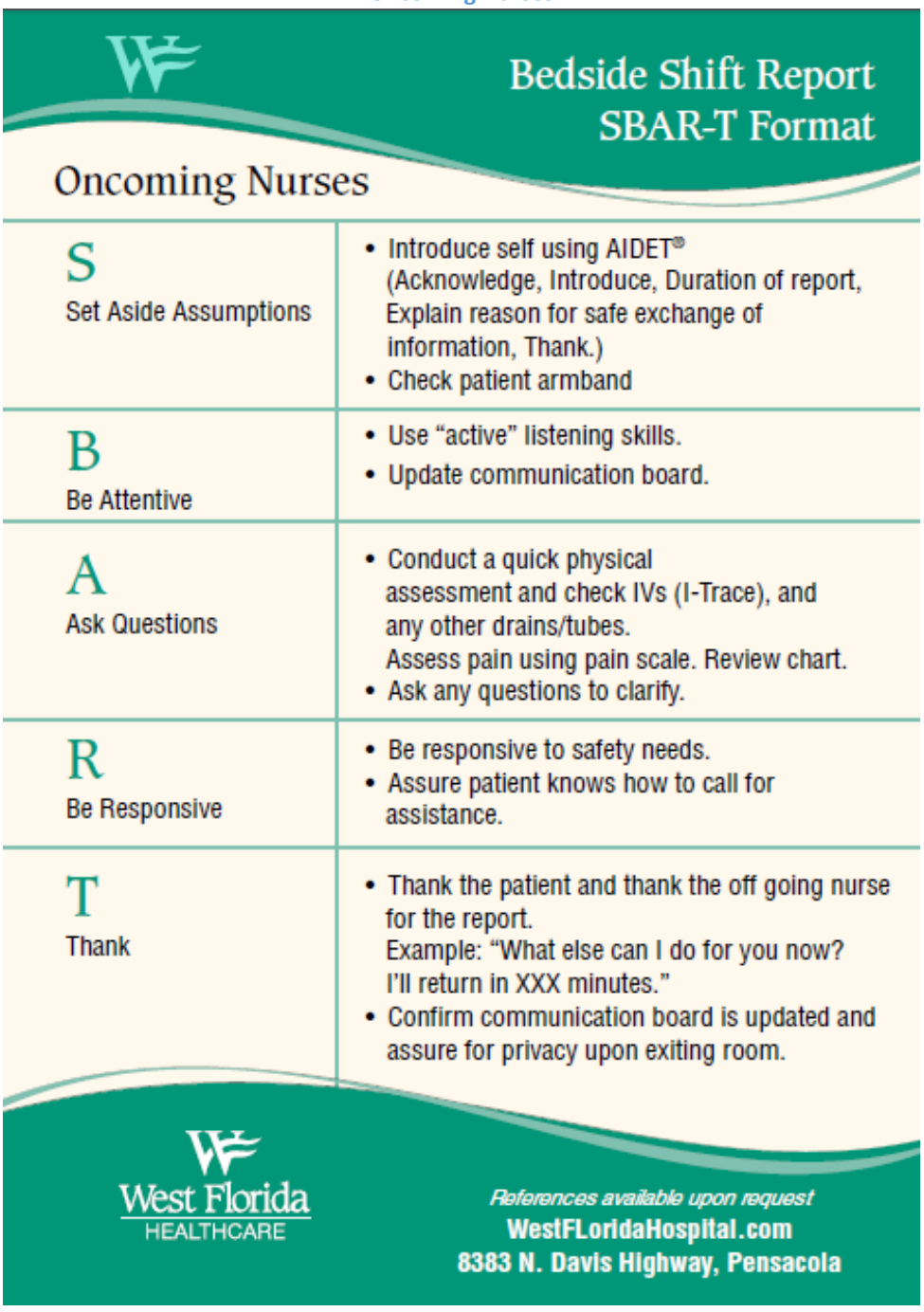
Bedside Shift Report: SBAR-T

Oncoming Nurses



Bedside Shift Report
SBAR-T Format

Oncoming Nurses

S Set Aside Assumptions	• Introduce self using AIDET® (Acknowledge, Introduce, Duration of report, Explain reason for safe exchange of information, Thank.) • Check patient armband
B Be Attentive	• Use "active" listening skills. • Update communication board.
A Ask Questions	• Conduct a quick physical assessment and check IVs (I-Trace), and any other drains/tubes. Assess pain using pain scale. Review chart. • Ask any questions to clarify.
R Be Responsive	• Be responsive to safety needs. • Assure patient knows how to call for assistance.
T Thank	• Thank the patient and thank the off going nurse for the report. Example: "What else can I do for you now? I'll return in XXX minutes." • Confirm communication board is updated and assure for privacy upon exiting room.

West Florida HEALTHCARE

References available upon request
WestFLoridaHospital.com
8383 N. Davis Highway, Pensacola

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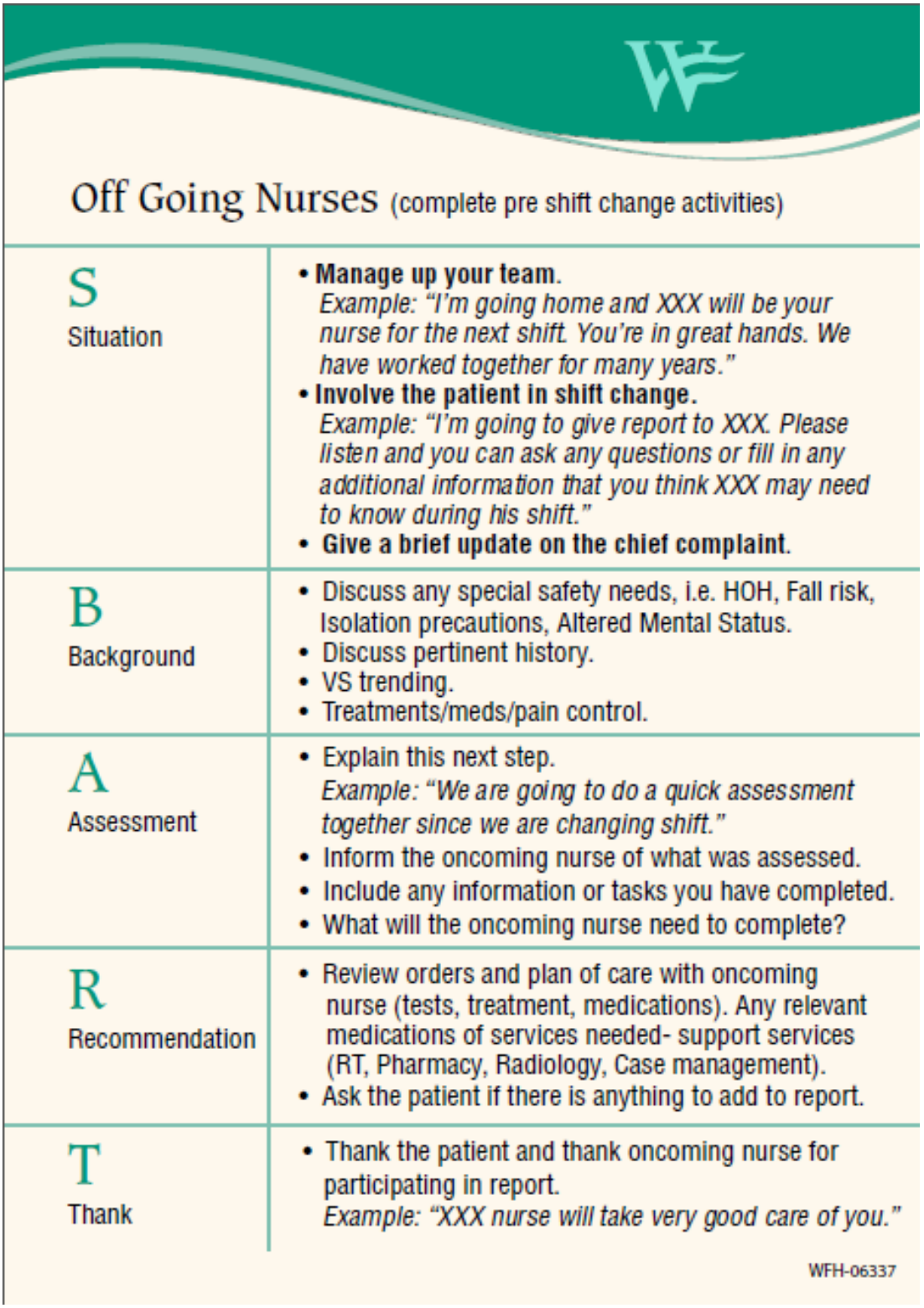
Off Going Nurses



Off Going Nurses (complete pre shift change activities)

S Situation	• **Manage up your team.** *Example: "I'm going home and XXX will be your nurse for the next shift. You're in great hands. We have worked together for many years."* • **Involve the patient in shift change.** *Example: "I'm going to give report to XXX. Please listen and you can ask any questions or fill in any additional information that you think XXX may need to know during his shift."* • **Give a brief update on the chief complaint.**
B Background	• Discuss any special safety needs, i.e. HOH, Fall risk, Isolation precautions, Altered Mental Status. • Discuss pertinent history. • VS trending. • Treatments/meds/pain control.
A Assessment	• Explain this next step. *Example: "We are going to do a quick assessment together since we are changing shift."* • Inform the oncoming nurse of what was assessed. • Include any information or tasks you have completed. • What will the oncoming nurse need to complete?
R Recommendation	• Review orders and plan of care with oncoming nurse (tests, treatment, medications). Any relevant medications of services needed- support services (RT, Pharmacy, Radiology, Case management). • Ask the patient if there is anything to add to report.
T Thank	• Thank the patient and thank oncoming nurse for participating in report. *Example: "XXX nurse will take very good care of you."*

WFH-06337

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Current Status: *Active* **PolicyStat ID:** *3517490*

Effective:	*10/15/2012*
Approved:	*4/17/2017*
Next Review:	*4/17/2018*
Owner:	*Jessica O'Neal: COO*
Policy Area:	*Marketing*
References:	*Plan*
Applicability:	*West Florida Hospital*

Cultural Competence and Diversity Plan

Scope

This Plan applies to all facilities and all locations for all inpatient and outpatient care.

Purpose

To establish a systematic approach to providing culturally competent, patient-centered care that recognizes, respects, and addresses the unique needs, thoughts, communications, behaviors, customs, beliefs and values that arise from an individual's culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status, and language.

Guiding Principles

1. The values, beliefs, and behaviors of people from other cultures are equally valid and valuable.
2. The values, beliefs, and behaviors of people from other cultures influence how they communicate, receive, and respond to healthcare.
3. Awareness of the values, beliefs, and behaviors of people from other cultures is essential for providing contextually appropriate, respectful, individualized, patient-centered care.
4. Organizational commitment to delivering culturally competent, patient-centered care will be evident in policy, care delivery, professional development, and quality improvement.
5. Delivering culturally competent, patient-centered care requires constant assessment of the diversity of the patient population and organizational ability to meet population specific needs.

Goals: Cultural Competence and Diversity Planning

1. Provides individualized care within each patient's unique cultural context
2. Promotes interactive communication between patients and providers

3. Aligns program policies and procedures with culturally competent principles and practices
4. Enhances understanding of different communication needs and styles of diverse patient populations
5. Improves staff performance related to cultural competence
6. Adapts patient-centered care to the diversity and cultural contexts of the patient population
7. Reduces bias and improves interpersonal communication within the organization.
8. Creates a safe inclusive environment that fosters respect for and acknowledgment of different needs.

Policy

1. Policies and procedures are regularly reviewed and revised to reflect the awareness and importance of Cultural Competency.
2. Annual staff performance reviews include self-assessment and leadership evaluation of culturally competent care.
3. Cultural Competence training is provided initially, annually, and in response to identified needs related to cultural competence.
4. Annual Education Needs Survey includes queries related to Cultural Competence and provides opportunity for supervisors and staff to identify ways to improve Cultural Competence in their day to day work and activities.
5. Commonly used forms and patient education are available in Spanish for patients with limited English proficiency who primarily speak Spanish.
6. Resources are available and utilized for patients with limited English proficiency, hearing impairment, and visual impairment.
7. Patient-centered plans formally document and address cultural variables related to Culture, Age, Sexual Orientation, Spiritual beliefs, Socioeconomic status, Gender and Language.

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2018 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

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.

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

Improve staff communication

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

Use medicines safely

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.

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

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

Use alarms safely

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

Prevent infection

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.

Use proven guidelines to prevent infections that are difficult to treat.

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

Use proven guidelines to prevent infection after surgery.

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

Identify patient safety risks

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

Prevent mistakes in surgery

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

Mark the correct place on the patient's body where the surgery is to be done.

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

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WFH Patient Bill of Rights

West Florida Healthcare is a committed advocate for its patients, their families, and their healthcare representatives. While we recognize that each patient is an individual with unique healthcare needs, we believe that all patients have basic rights in the receipt of their health care.

West Florida Healthcare affirms the following patient rights.

1. The right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, age, gender, physical handicap, or ability to pay.

2. The right to the hospital's reasonable response to his/her request and needs for treatment or services, including emergency conditions, within the hospital's capacity, its stated mission, and applicable law and regulations.

3. The right to receive a written statement of his or her rights, to be well informed, ask questions, and be involved in the decision making process related to the development and implementation of his or her plan of care.

4. The right to make informed decisions with your doctor and to understand the benefits and risks of each treatment, what you can reasonably expect from the treatment and any long-term effects it might have on your quality of life, as well as what you can expect when you leave the hospital. You may accept or refuse treatment based on these decisions.

5. The right to appropriate assessment and management of pain, and to be involved in care planning and pain management.

6. The right to be informed about services not available or not covered. You also have the right to know the identity of doctors, nurses and others involved in your care and to know when they are students, residents or other trainees.

7. The right to the confidentiality of his/her clinical record and financial information and to access information contained in his/her clinical records within a reasonable time frame.

8. The right to personal privacy and security and an environment that contributes to the patient's care and sense of wellbeing, free of all forms of harassment and abuse or neglect.

9. The right to pre-designate a representative to make healthcare decisions on his/her behalf in the event he/she becomes incapable of making them and to formulate advance directives, including the withholding and withdrawing of life-sustaining treatment and to have hospital staff and practitioners who provide care comply with those directives.

10. The right to have a family member or representative of his/her choice and his or her own physician is notified promptly of his/her admission to the hospital and the right to exclude any and all family members from participating in his or her healthcare decisions.

11. The right to religious, pastoral, or spiritual services and to care sensitive to a patient's end-of-life needs.

12. The right to be given individualized care that is considerate and respectful of the patient's personal values and beliefs, appropriate to his/her age and developmental needs and sensitive to different treatment practices.

13. The right to request and participate in ethical issues and questions that arise in the course of his/her care and treatment, including issues of conflict resolutions, withholding resuscitative services, foregoing or withdrawal of life-sustaining treatment, and participation in investigational studies or clinical trials.

14. The right to be advised, through the informed consent process, if the hospital proposes to engage and/or perform experimentation or other research/educational projects affecting his/her care or treatment and right to refuse to participate. The patient has the right to be advised of a full description of expected benefits, risks and potential discomforts, alternative services and a full explanation of procedures to be followed. They have the right to refuse to participate and must be informed that refusal will not compromise their access to care.

15. The right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation.

16. The right to access protective services including guardianship, conservator ship, and advocacy services, and be informed of available patient support services, including self-help groups.

17. The right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care and the financial consequences of using uncovered services or out-of-network providers.

18. The right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and the right to receive a copy of a reasonably clear and understandable, itemized bill, and, upon request, to have charges explained.

19. The right to means of communication, as appropriate to the condition of the patient, including speech impaired, and in a language they can understand at no cost to the patient.

20. The right to express his/her concerns, questions, suggestions, or grievance regarding care and services and participate in the grievance process as outlined in the Patient Handbook under Patient/Family Concerns.

21. The right to be informed about anticipated outcomes of care, as well as unanticipated outcomes and the right to be told if anything unexpected and significant happens during your hospital stay.

West Florida Healthcare affirms the following patient responsibilities:

1. The responsibility for providing to the best of his/her knowledge accurate and complete information about present complaints, past illnesses, hospitalizations, medications, dietary supplements, allergies, advanced directives, spiritual wishes and other matters which may be relevant to his/her health or care including any network or admission requirements under your health plan.

2. The responsibility for understanding and acknowledging his/her plan of care and what is expected of him/her and to tell your caregivers if you need more information about those treatment choices.

3. The responsibility for informing your caregivers if you have concerns about your care or have pain. The patient also has the responsibility to follow medication, diet and therapy plans to the best of his/her ability.

If you have questions, grievances, suggestions, ethical issues or concerns, please direct them to the department director or unit nurse manager.

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Therapeutic Boundaries

A therapeutic boundary is the distance a professional places between the patient and himself. Due to the need for the hospital staff to remain objective and maintain a therapeutic distance it is the general expectation that the staff member will not establish a personal relationship with a current or former patient. This includes accepting gifts, financial transactions or romantic relationships. This could lead to negative consequences for the facility, staff and patient.

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PAIN MANAGEMENT

Pain management is an important aspect of the recovery process for any patient admitted to West Florida Hospital. Our organization is dedicated to keeping patients as comfortable and pain free as possible during their stay, and considers every employee to be a patient's advocate regarding pain management and pain control.

Employees can help contribute to meeting goals of pain management by:

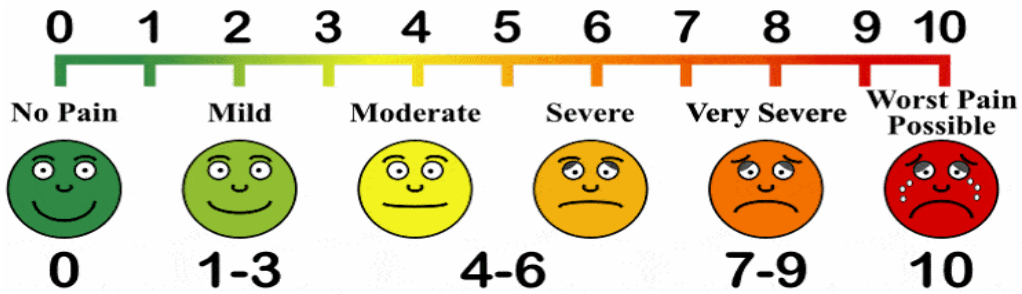
- Informing patients of their rights to:
  - Receive information and education about pain and pain relief measures.
  - Receive answers to their questions regarding pain and pain relief measures.
  - Discuss their medical plan and personal goals for pain management.
  - Be treated with respect and concern at all times, and be believed when reporting pain.
  - Have their cultural beliefs included in their pain management plan.
  - Receive prompt response from the staff when reporting pain.
  - Receive adequate pain management with best possible pain relief treatments.

  Bringing any reports of pain from the patient to the nursing staff's attention.
- Assessing the patient's pain level prior to conducting activities such as transferring or moving the patient.
- Observing the patient for verbal and non-verbal evidences of discomfort.
- Allowing the patient to voice their concerns and offering to help them as needed.

Simple actions to help prevent and reduce pain:

-Dim the lights.
-Reposition, offer pillows, blankets or comfort.
-Speak softly and calmly, and avoid unnecessary noise, re-assure.
-Comforting and reassuring verbally.
-Offer to help with hygiene and cleaning as needed.
-Propose distractions such as soft music, TV, or movies.
-Keep the room temperature at a comfortable level.
-Allow the patient to rest, and respect their resting time.
-Educate the patient on who you are and why you are there.

At West Florida Hospital, every employee is part of the "Pain Relief" Team. Report any concerns or observations to the nursing staff to help patients and their family experience a comfortable and pleasant hospital stay. Working together as a team, we can succeed in controlling and managing our patients' pain.



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HUMAN RESOURCES

Maggie Smith,

Vice President,

Human Resources

Ext: 4096

Professional Dress Standards Policy

DEPARTMENT: Human Resources	**POLICY NAME:** Professional Dress Standards
PAGES: 2	**REPLACES POLICY DATED:**
DATE RETIRED:	
APPROVAL DATE: February 2, 2017	**REFERENCE NUMBER:** WFD.HR.002

SCOPE:

All employees including contract staff.

If any provision of this policy conflicts with a collective bargaining agreement, the collective bargaining agreement will prevail for represented employees.

PURPOSE:

The purpose of the dress code is three fold: 1) To display a professional appearance that instills confidence and respect among patients, visitors and colleagues 2) To maintain standards of infection control and safety 3) To promote customer service by providing patients and their families with easier identification of employees.

POLICY:

All leaders are responsible for ensuring all employees are in compliance with the professional dress standards. Employees not in compliance may be sent home without pay to change, and are subject to disciplinary action up to and including termination.

1. Name Badge – All employees must wear their facility ID badge at all times while on duty within the hospital or hospital premises. The badge must be located above the waist to support a clearly visible view of the employee's name, position and photo on both sides.
2. Tattoos – Tattoos are strongly discouraged but if present must be covered or minimized as much as possible.
3. Jewelry – Jewelry will be kept to a minimum and limited to a watch, one ring on each hand. Earrings should be studs or small hoops less than one inch in diameter. Earrings are limited to two small earrings per ear; no gauges or bars permitted. Any existing gauges need to be filled with a flesh colored gauge plug. Oversized or excessive jewelry or other accessories are not permitted. Employees may not have any facial jewelry such as nose, cheek, chin, lip, tongue or eyebrow rings.
4. Pins – Only Healthcare related pins are allowed on the badge or uniform. Pins advertising organizations, products, etc. are not allowed to be worn at any time.
5. Makeup – Makeup may be used in moderation and applied with discretion to create a well-groomed appearance.
6. Hats – only hats that are part of a uniform may be worn.
7. Hair must be clean, neat, and of a natural looking color. Facial hair must be neat and trimmed. Hair will be styled so as to not enter the work field during patient care.
8. Nails – Natural nails must be kept clean and groomed. Nails should be short enough to perform patient care safely. Nail polish is acceptable if professional and in good repair (no neon or multi-colored nails).
9. Artificial nails may not be worn by employees providing direct patient care, in food services, environmental services, or sterile processing. Artificial nails are defined as anything applied to natural nails other than polish. This includes but is not limited to artificial nails, tips, wraps, appliques, acrylics, shellac and other items applied to the nail surface. Gel polish is acceptable.
10. Shoes need to be clean and in good repair. Employees exposed to blood or body fluids may not wear open toes or shoes with openings.
11. Fragrances/perfumes should be worn conservatively as not to bother others.
12. Holiday and special event exceptions must be approved by senior leadership.
13. Staff may wear long sleeve shirts or t-shirts under their scrub tops only if they are solid white, black or the same color as their scrub tops.
14. Employees may wear a scrub jacket that matches the color of their uniform. Professional healthcare providers in business attire should wear a white lab coat in clinical areas. Nurses wishing to wear a jacket should also wear a white lab coat. No sweat shirts, or hoodies are allowed.

Application of the hospital logo on the uniform is highly recommended but not required.

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Smoking & Use of Tobacco Products

In light of our effort to provide a safe, clean and healthy environment for our patients, employees, visitors and customers, smoking and the use of tobacco products is not permitted inside any of our buildings, owned or leased vehicles nor on any of our grounds, parking lots/structures or ramps. Electronic cigarettes are also prohibited at all company-owned or leased buildings, grounds, parking lots, ramps, and owned/leased vehicles.

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Attendance and Tardiness - HR.ER.001

DEPARTMENT: **Human Resources**	**POLICY DESCRIPTION:** Attendance and Tardiness
PAGE: 1 of 2	**REPLACES POLICY DATED:** HR.OP.001
EFFECTIVE DATE: April 1, 2015	**REFERENCE NUMBER:** HR.ER.001
DIVISION/LOB/ENTERPRISE: Enterprise-Wide	

SCOPE:

Applies to all employees except employee groups listed as 'At Will' in the Limitations on Employment policy HR.ER.019 and employees under an employment agreement

PURPOSE:

To provide clear guidance for employee attendance and tardiness

DEFINITIONS:

1. **Absence:** An absence is an unscheduled absence from work on one (1) or more consecutively scheduled workdays or shifts that is not a result of protected leave.
2. **No-Call/No-Show:** A no-call/no-show is failure to report to work or notify a manager or designee of an absence.
3. **Grace Period:** There is a seven (7) minute grace period before being tracked as tardy; reference Timekeeping – Non-Exempt. This excludes tardiness protected by federal or state regulations such as Family Medical Leave Act (FMLA) and Americans with Disabilities Act, amended (ADAAA); reference Leave of Absence policy **HR.TR.004**.
4. **Tardiness:** Tardiness (or a "tardy") occurs when an employee fails to report for duty at the time outlined in his/her schedule and/or fails to return to duty promptly at any point during his/her normal schedule (e.g., promptly returning from a meal or break period). This excludes tardiness protected by federal or state regulations such as Family Medical Leave Act (FMLA) and Americans with Disabilities Act, amended (ADAAA); reference Leave of Absence policy **HR.TR.004**.
5. **Punctual:** Punctual means strictly following a schedule or observing an appointed time. Following a schedule includes refraining from clocking in early. Non-exempt employees should clock in no earlier than it takes to reach their workstation.
6. **Patterns of Behavior:** Patterns of behavior are considered a trend of absences before or after a regularly scheduled day off; routine Monday/Friday absences; absences in conjunction with holidays; absences shortly after an occurrence has dropped off record; regularly leaving work prior to the end of the schedule or shift; repeated failure to be punctual; or regularly "missing" punches; reference Break and Meal Period policy **HR.ER.004**.

RESPONSIBILITIES:

1. Employee:

a. An employee should personally notify his/her manager or designee two (2) hours prior to the start of the schedule or shift if he/she will be absent or tardy.

2. Manager:
   a. Managers are responsible for tracking attendance through the applicable systems of record.

REQUIREMENTS:

1. Occurrences:
   a. Occurrences are tracked using a twelve- (12) month backward rolling calendar and are calculated using the following criteria:
      - A tardy is equal to (1/2) occurrence
      - An absence with notification at least two (2) hours prior to the start of a schedule or shift is equal to one (1) occurrence
      - Missing more than two (2) hours of a schedule or shift due to tardiness or leaving early is equal to one (1) occurrence
      - An absence without notifying a manager within a two (2) hour window of scheduled start time is equal to two (2) occurrences
      - A no-call/no show is equal to four (4) occurrences
2. Step process for occurrences:
   a. The recommended disciplinary steps associated with occurrences (or patterns of behavior) accumulated in a twelve- (12) month backward rolling calendar are as follows (see Discipline, Counseling and Corrective Action policy **HR.ER.008**:
      - A verbal warning is issued at the equivalent of four (4) occurrences
      - A written warning is issued at the equivalent of five (5) occurrences
      - A final written warning is issued at the equivalent of six (6) occurrences
      - Employment is terminated at the equivalent of seven (7) occurrences or upon two (2) no-call/no-shows in a twelve- (12) month backward rolling calendar.
3. If an employee has exhibited a pattern of behavior previously defined, the manager has discretion to move forward with disciplinary action as deemed appropriate. The manager is also responsible to communicate any action and expectation to the employee.

ORGANIZATION RIGHTS:

1. The business entity reserves the right to:
   a. Initiate the step process for disciplining patterns of behavior
   b. Authorize or refuse to authorize an employee's request to be absent
   c. Investigate absences
   d. Determine whether an absence is necessary or justifiable
   e. Deny pay for an absence in violation of this policy
2. A manager or designee may request a physician's note after eight (8) days of absence; reference Time Away From Work.

DISCLOSURE:

If there is any conflict between the information in this policy and a Collective Bargaining Agreement (CBA), the CBA prevails for covered employees.

REFERENCED POLICIES:

1. Leave of Absence, HR.TR.004
2. Discipline, Counseling, and Corrective Action, HR.ER.008
3. Timekeeping – Non-Exempt, HR.ER.020
4. Break and Meal Period, HR.ER.004
5. Limitations on Employment, HR.ER.019
6. Communicable Disease Preparation (or Texas Vaccine Preventable Disease), HR.ER.006

WORK INSTRUCTIONS:

1. Monitoring for patterns of behavior
2. Receiving call out notification

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Parking

Parking is provided for employees and is restricted to certain employee-only designated areas. Employees are not allowed to park in areas designated for patients, physicians and visitors.

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QUALITY MEASURES

Debbie Wroten,

Facility Privacy Officer,

Vice President of Quality

EXT: 6559

HIPAA and HITECH Summary

This summary serves as a review of important Health Insurance Portability and Accountability Act (HIPAA) and HITECH (Health Information Technology for Economic and Clinical Health Act) requirements. Many of these requirements are included in our Code of Conduct, Privacy and Information Security and Ethics and Compliance policies and procedures. All patient information is confidential.

The objectives of the HIPAA and HITECH training are:

- To heighten your awareness of and compliance with HIPAA and HITECH regulations and WFH policies.
- To reinforce the role you play in creating and maintaining organizational integrity, ethics, and compliance.
- To renew your working understanding of HIPAA and HITECH compliance.

Reporting Concerns

There will be no retribution for asking questions, raising concerns about the Code of Conduct or for reporting possible improper conduct that are done in good faith. Any colleague who deliberately makes a false accusation with the purpose of harming or retaliating against another colleague will be subject to punishment.

We encourage the resolution of issues at the local level whenever possible. To obtain guidance on an ethics or compliance issue or to report a potential violation, you may choose from several options.

- Consult your supervisor
- Consult your Facility ECO or another member of management at your facility
- Call the Ethics Line at 1-800-455-1996

The Ethics line is an easy and anonymous way to report possible violations or obtain guidance on an ethics or compliance issue. You are encouraged to use the Line anytime, especially when it is inappropriate or uncomfortable to use one of the other methods. In order to properly investigate reports, it is important to provide enough information about your concern.

Information Security

IDs and Passwords

Patient Financial Information, Clinical Information, and User Passwords are all examples of confidential information. A User ID without a password is not confidential and is frequently included in directories and other tools widely available. The person granting access to a system or application typically assigns a

User ID to the end user, and the User ID is sometimes used for identification, tracking and other maintenance procedures within IT&S.

If you have access to information systems, please keep in mind that your password acts as an individual key to our network and to critical patient care and business applications, and it must be kept confidential.

It is part of your job to learn about and practice the many ways that you can help protect the confidentiality, integrity and availability of electronic information assets.

Confidential Information

A patient's diagnosis, the Company's marketing strategy, and computer network configurations are all considered confidential information. The Confidentiality and Security Agreement states that individuals with access to confidential information will not disclose or discuss any confidential information even after termination of their relationship with HCA.

No HCA colleague, affiliated physician, or other healthcare partner has a right to any patient information other than that **necessary to perform his or her job.**

Although you may use confidential information to perform your function, it must not be shared with others unless the individuals have the need to know this information and have agreed to maintain the confidentiality of the information. Patient and confidential information may not be removed from the facility.

Patient or Confidential information should not be sent through our Intranet or the Internet unless Information Systems has put in place appropriate security safeguards. The hospital utilizes encryption software for approved transmissions of protected health information.

Privacy

HIPAA and HITECH regulations set forth a number of requirements regarding ensuring the privacy of protected health information (PHI). Patients are more likely to give honest, accurate information to health care providers, if they believe the information will be kept private.

HIPAA requires healthcare entities to appoint a facility privacy official (FPO). The FPO in our facility oversees the Privacy Program and works to ensure the facility's compliance with the requirements of the HIPAA Standards for the Privacy of Individually Identifiable Health Information and HITECH. The FPO is also responsible for receiving complaints about matters of patient privacy, educating the workforce regarding HIPAA and HITECH, and maintaining policies regarding HIPAA and HITECH compliance.

HIPAA regulations encourage reasonable safeguards be put in place to protect the patient's information from inappropriate uses or disclosures. At WFH, we do not keep records at the patient's bedside.

The HIPAA regulations contain a number of restrictions on the transmission of PHI; however, they do not prevent faxing or mailing health information as long as certain precautions are taken. Reasonable precautions include verifying fax numbers, validating pre-set numbers, and using a cover sheet on all transmissions. The regulations mandate that health information may not be sold by a facility.

Our WFH Notice of Privacy Practices is provided to all patients, posted on our facility's Internet site and the consent form language refers to the notice.

Patients have the right to request access to any health information that has been used to make decisions about their healthcare at our facility. They can also request access to billing information with approval from the FPO or designee. A patient may fill out a request for a copy of their record. Accessing the Meditech System is not an approved method of providing access to PHI.

A patient may request access to the complete designated record set. This record set includes any information that is maintained, collected, used or disseminated by our facility to make decisions about individuals. A copy of the legal medical record and a copy should be provided upon approved request. A patient may be denied access under certain circumstances (e.g. when a person may cause harm to him or herself or others, or when protected by peer review). Our FPO has more information on the right to access.

In order for the HIM department to track releases of patient information, patients (including employees) should be directed to the Health Information Management Release of Information Department for access to any health information.

A patient may request to amend his/her medical record for as long as the record is maintained by the facility. The request for amendment should be made in writing to the facility. Our FPO and the HIM department have more information on the right to amend. While patients have a right to amend their record that does not mean that health information can be deleted from the record. The patient may submit an addendum correcting or offering commentary on the record, but no information may be deleted from the record.

Policies prohibit employees from accessing their own records in Meditech. Employees do not have a "need to know" for the performance of their job. Employees may, however, fill out the appropriate authorization for release of information in HIM and can obtain a copy of their records.

Everyone is responsible for protecting patients' individually identifiable health information. Any piece of paper that has individually identifiable health information on it must be disposed of in appropriate receptacles. The paper must be handled and destroyed securely. The elements that make information individually identifiable include: name, zip or other geographic codes, birth date, admission date, discharge date, date of death, e-mail address, Social Security Number, medical record/account number, health plan id, license number, vehicle identification number and any other unique number or image.

West Florida Healthcare allows for the use of PHI, including photography, video-taping and digital imaging, for marketing/media purposes in a manner consistent with patient privacy rights and the facility guidelines.

Important Points of PHI and Marketing Policies:

1. A valid HIPAA-compliant authorization signed by the patient or the patient's personal representative (as defined by state law) is required and must be obtained for any uses or disclosures of PHI for purposes of marketing under the HIPAA Privacy Standards.
2. Facilities may communicate to patients via newsletters, mailing or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives in which the facility is participating.
3. A valid HIPAA-compliant authorization will be obtained prior to any patient photography, videotaping or imaging associated with marketing, media or publicity activities.
4. Anyone who engages in recording or filming (not already bound by the hospital's confidentiality policy) signs a confidentiality statement to protect the patient's identity and confidential information.
5. The patient authorization is only good for the type of photographs/recordings indicated and the timeframe listed in the authorization. Otherwise, a new authorization form must be obtained. When the photography/audio recording is for publicity purposes, the facility must obtain "Authorization for Use and Disclosure of PHI for Marketing and/or Promotional Purposes" (Form 850364) and a separate "Consent for Use and Disclosure of Image, Voice and/or Written Testimonials" (Form 850265). These forms are available in Forms on Demand.
6. Authorizations must be kept on file for a period of six (6) years.

Any member of the workforce with a legitimate need to know to perform their job responsibilities may access a patient's health information. However, the amount of information accessed should be limited to the minimum amount necessary to perform their job responsibilities. Use appropriate and reasonable safeguards when discussing patient information.

Patients who request confidentiality will have a small “c” in front of their name in the directory. No information is to be given out. Patients are given a 4 digit passcode to give to relatives who may call for information.

The hospital directory or listing of patients used by the PBX operator, information desk or volunteers should contain only patient name, room/location and condition in general terms. Patient diagnosis or procedures should not be released. Patients have the right to opt out of the facility directory Information may not be released on patients that have opted out of the facility directory.

Personal Use of Social Media

HCA and its affiliates respect the right of employees to participate in blogs and use social networking sites during non-working hours and does not discourage self-publishing or self-expression. Employees are expected to follow these guidelines and policies to provide a clear distinction between you as an individual and you as an employee.

- Personal Responsibility. You are personally responsible for your commentary on social media. You can be held personally liable for commentary that is considered defamatory, obscene, proprietary or libelous by any offended party, not just HCA.
- Non-threatening. Employees should not use blogs or social networking sites to harass, threaten, discriminate or defame employees or anyone associated with or doing business with HCA or its affiliates.
- Disclaimer. When you identify yourself as an employee of HCA or an affiliate, some readers may view you as a spokesperson for HCA and/or that affiliate. Because of this possibility, you must state that the views expressed by you through social media are your own and not those of the Company, nor of any organization affiliated or doing business with HCA and/or an affiliate.
- Privileged or Confidential Information. Employees cannot post on personal blogs or other sites the trademark or logo of HCA, its affiliates, or any business with a connection to HCA or its affiliates. Employees cannot post Company-privileged or confidential information, including copyrighted information, Company-issued documents, or patient protected health information.
- Workplace photographs. Employees must follow the Company’s policy regarding photos taken in the workplace.
- Advertising. Except as authorized or requested by HCA or an affiliate, employees may not post on personal blogs and social networking sites any advertisements or photographs of Company products, nor sell Company products and services.
- Patient Information. Do not use your personal social media account to discuss or communicate patient information with one of your patients, even if the patient initiated the contact or communication. Always use Company-approved communication methods when communicating with patients about their health or treatment.

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West Florida HEALTHCARE

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Owner:	*Denise Moland: ACNO*
Policy Area:	*Nursing Services*
References:	
Applicability:	*West Florida Hospital*

Patient Identification, I-49

SCOPE:

This policy applies to all components of West Florida Healthcare.

PURPOSE:

All patients will be properly identified through the Continuum of Care.

POLICY:

1. All patients will be identified on admission by application of appropriate armband. (See Admin. Policy VII-21, Identification of Patients/Employee/Visitor/Vendor)
2. Patient Identification for outpatients will be accomplished through the Admitting/Registration process. All outpatients requiring an H&P or undergoing Sedation Analgesia will receive patient identification armbands.

PROCEDURE:

1. On admission to the nursing unit, the admitting nurse will assure proper identification of patient to include:
    a. Patient is in assigned bed and room.
    b. Correct and legible armband is in place.
    c. Patient's records are correctly labeled.
2. Prior to any intervention/procedure, the identity of the patient will be verified by:
    a. Read name and medical record number on armband.
    b. Ask patient to state first and last name.
    c. If patient unable to state name, verify with family when possible.
3. Whenever the patient care area or caregiver changes, the above steps will be followed to assure proper identification.
4. When a patient is transported to another area of the hospital for a procedure, identify the patient by the person transporting to include:
    a. Enter patient name on unit locator board.
    b. Pick up transport slip and patient record.
    c. Verify patient name and medical record number by armband.
    d. Compare armband with patient name on chart.
    e. Ask patient to state first and last name.

f. If patient is unable to state name, verify patient identity by family member or patient caregiver on the unit.

5. The receiving area nurse will identify patient name by:
   a. Verify name and medical record number on armband.
   b. Ask patient to state first and last name.
6. Upon return to the patient care unit, patient identification will include:
   a. The nurse caring for patient will be notified by transporter when patient arrives on floor.
   b. Locator board will be updated by transporter.
   c. Nurse on unit will re-assess the patient to include verification of patient identity.

All revision dates: 1/6/2010, 1/30/2003, 9/12/2000

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West Florida HEALTHCARE

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Owner:	*Valerie Boylan: Nursing Director, 4N/4S*
Policy Area:	*Nursing Services*
References:	
Applicability:	*West Florida Hospital*

Patient at High Risk for Falls, 34

SCOPE:

This procedure applies to all inpatients and outpatients of all ages in all patient care settings at West Florida Hospital.

PURPOSE:

To identify those patients who may be at high-risk for falls and identify those at risk for injury.

STANDARD OF CARE:

*Expected Outcomes of this procedure:

A. Patient safety maintained and fall potential minimized;
B. Appropriate measures were instituted to meet patient needs.
C. Interventions are customized for each patient.
D. Communication between patient, family and caregivers is ongoing.

* Variations from Expected Outcomes will be documented in patient care notes per hospital policy.

STANDARD OF PRACTICE (POLICY):

The following are examples of patients who MAY be at high risk for falls.

One who:

A. Has a history of falls
B. Is incoherent or confused;
C. Is on medication known to affect mobility or safety awareness;
D. Is physically debilitated (i.e., weakness, unsteady on feet, impaired vision);
E. Exhibits signs of orthostatic hypotension or syncope;
F. Has a disturbance in equilibrium or vertigo;
G. Uses appliances for mobility (e.g., cane, walker, etc.);
H. Has decreased mobility or unsteady gait;

PROCEDURE:

1. RN will perform the "ABC;s" of falls assessment.

   A.=Assess if a patient is high risk;

   B.=Background: Investigate past falls;

   C.=Cultural and learning needs addressed.

   S.=Standardize and customize interventions.

2. Perform a risk injury assessment. The "ABC's" of risk injury:

   A – AGE – Patients over age 75 are at greatest risk for injury.

   B – BONES – Patients who have osteoporosis or impaired mobility are at greatest risk for fractures.

   C – COAGULATION – Patients who are on aspirin therapy or other anticoagulation are at greatest risk for cerebral bleeds; low platelet count.

   S – Surgery – Abdominal or lower extremity.

3. The following measures will be instituted by a nurse when a patient's assessment identifies them at high-risk for falls.
   A. Place a yellow high risk sticker on the patient's chart, "High Risk Patient for Falls".

      EXCEPTION: The Emergency Department is exempt from using chart stickers.

   B. For patients identified as high risk for falls**Place a yellow falling star magnet on each side of the patient's door frame.**

   C. EYE SIGN EXPEMPTIONS: critical care units and procedural units are exempt from posting High Risk for Falls EYE signs.

   D. Place a yellow arm band on the patient.

   E. Institute the ABC;s of Fall Prevention Strategies:
      a. Active Toileting – use scripting, example "I'm going to take you to the bathroom" not "do you have to go to the bathroom?"
      b. Bedside Assessment – Assess the patient environment for needs, utilizing the 4 "P's"; Pain, Position (comfort/bed in low position), Possessions, Personal needs.
      c. Communicate – Communicate risk during handoff between caregivers.

   F. Educate Patient and Family about fall risk and injury risk concerns. Use "teach back methodology" to assure understanding.

   G. **Hourly or more frequent rounding.**

4. The nurse will assess the patient's condition to determine if additional safety measures are needed. Additional safety measures could include:
   A. Bed Alarms

   B. Other assistive devices – bedside commode, walker.

   C. Constant patient attendance by family members or the application of restraint/seclusion devices. When restraint/seclusion devices are necessary, the nurse will follow the hospital's Administrative Policy on these devices. (Administrative Policy Manual I-14 **Restraint/Seclusion of Patients**).

   D. High Risk for Falls and High Risk for Injury will be communicated between caregivers during all phases of handoff.

5. The RN assigned to the patient will determine when a patient is to be taken off High-Risk precautions. The reasons for termination will be documented in the Patient Notes.

   Exception: High Risk for Falls intervention cannot be discontinued on patients who have a history of falls or have received high risk medications in the past 12 hours.

6. When protective devices are necessary and a patient (or surrogate/proxy of a patient who is unable to make this decision) refuses to have protective restraint devices:

A. Efforts will be made to persuade the patient or surrogate/proxy of the need to use protective restraint device, or in lieu of these, arrangements for constant patient attendance by the family. If the patient or surrogate/proxy refuses to cooperate, the Administrative Assistant/Nursing and/or the Risk Manager is to be contacted. The patient's physician will be contacted for further assistance and/or orders.

NOTE: ALL DISCUSSION MUST BE THOROUGHLY DOCUMENTED IN THE PATIENT RECORD.

B. If the patient or surrogate/proxy continues to refuse, a Protective Restraint Device Release Form #693 must be signed, placed in the chart, and the physician notified.

7. Documentation in Meditech system will include:
   A. The **admission and each** shift-to-shift assessment will be used to identify the patient as High-Risk for Falls and whether additional precautions are needed.
   B. At the time of each shift assessment a nurse will evaluate whether or not additional precautions of the High-Risk designation is needed.
   C. Notification of the physician and any orders received.
   D. Education/explanation and discussion with patient/family and their response will be documented on the Patient/Family Education Record in Meditech.
   E. Any exception to be documented in Meditech, patient care notes per hospital protocol.

See Also: **Restraint/Seclusion of Patients**, Administrative Policy Manual, Filing Number I-14.0.

8. Physical Rehabilitation Patients admitted to the Rehabilitation Institute are inherently all high risk for falls and will have the yellow arm band applied on admission. Those Rehab patients, who, after admission are identified as even greater risk for falls, will be identified by the "Yellow Eye Sign" on their door and have the "Rehab Patients at Risk for Falls Precautions" implemented. (See Rehab Policies and Procedures, Section II, #26.)

9. ## Post Fall Guidelines:

If a fall is witnessed, patient is found on the floor, or states they have fallen, the following guidelines should be followed:

   A. Assess patient for obvious injuries and latent injuries including but not limited to: Skin tears, lacerations, fractures, head injuries
   B. Notify physician of fall, patient assessment and obtain necessary orders;
   C. Notify House Supervisor and family. Document all notifications in Meditech;
   D. Complete QM Risk Module / Occurrence Screen;
   E. Assure High Risk for Falls guidelines have been implemented;
   F. Complete "Post Fall Assessment and Debriefing" (form #447018) in collaboration with unit based clinical leadership and/or House Supervisor.
   G. Initiate additional interventions after Post Fall Assessment.

10. All falls should be communicated to the Nursing Manager for review, analysis and staff debriefing utilizing Post Fall Assessment Form #447018 (Forms on Demand).

Nursing Alert: DOCUMENT DATE OF PATIENT FALL ON YELLOW ARMBAND.

This will help communicate recent fall occurrence to all caregivers and departments.

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West Florida HEALTHCARE

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Owner:	*Denise Moland: ACNO*
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References:	
Applicability:	*West Florida Hospital*

Patient Transportation, I-15

SCOPE:

This is a hospital-wide transport policy that addresses patient transportation and supplements department specific policies.

PURPOSE:

To ensure all patients are safely transported within the hospital or between facilities.

POLICIES:

A. **Personnel Training**

Individuals transporting patients (nurses, orderlies, volunteers, etc.) will have basic transportation orientation covering hospital policies and safety practices. New transporters will be required to satisfactorily complete the Transporter Skills **Competency Form**.

B. **Safety Measures**

Patients transported by stretcher will always be within sight of Hospital personnel, have side rails raised, and be transported feet-first.

C. **Emergency Situations**

Any patient in transport experiencing difficulty will be taken to the nearest nurse's station where emergency equipment and additional personnel are available to render assistance.

D. **Critical Care Transports**

Monitored patients transported to or from a Critical Care Unit must be monitored during transport unless otherwise ordered by the physician. A nurse will remain with the patient until the appropriate person assumes care of the patient.

E. **PACU**

A nurse will accompany the patient transferred from PACU to a patient-care area. The PACU nurse will report to a licensed nurse. (Exception: local anesthesia).

F. **Progressive Care/Remote Tele Patients**

Telemetry/Remote Tele patients that leave the unit for another department will continue to be monitored by telemetry (unless otherwise ordered by physician).

The telemonitor tech should be notified when a patient is being transported out of their department and upon return.

G. **Obstetrical Patients (OB)**

OB patients may be directed to the Labor and Delivery unit (LDRP) for outpatient services (non-stress test, amniocentesis, etc.) and may be transported by the LDRP nurse if patient census allows. Otherwise, Emergency Department personnel may transport. An orderly or volunteer may transport the patient if directed by the Administrative Assistant/Nursing. OB patients will be transported from the Emergency Department to LDRP by wheelchair if in labor, or suspected of being in labor, unless otherwise requested by the patient. Patients who report possible ruptured membranes and/or bleeding may not ambulate, but must be transported by wheelchair or stretcher.

H. **Endoscopy Lab Patients**

Outpatient Endoscopy patients report directly to the Endoscopy Lab from Admitting with transport/escort as needed. Inpatients may be transported by wheelchair or stretcher, based on condition. Endoscopy Lab personnel are responsible for transport arrangements.

I. **Pavilion Patients**

Pavilion patients will be transported with a Pavilion Nursing Staff escort. The Pavilion Nursing Staff escort will remain with the patient during procedure except in cases where the patient is unconscious.

J. **Discharge Patients**

Patients are not required to be discharged via wheelchair. The discharge nurse will determine the appropriate mode of transportation. ***See*** **Nursing Service Procedure "Patient Discharge Procedure", Section 1, #56.**

PROCEDURES:

A. **Patient Assessment and Hand-Off Communications**

Prior to transportation, the nurse in charge, or his/her designee, will evaluate the patient's condition to determine the transportation needs of the patient. Upon patient pick-up, the transporter will identify the patient's nurse's Spectra link telephone number, which will be placed on the patient's chart. This number will be shared with staff having contact with the patient while off the floor.

B. **Medical Records**

The medical record will accompany the patient when transported off-unit for studies/ treatment. (Exception: **Emergency Department** and Rehabilitation Institute patients transported for therapies within the Rehab facility.)

C. **Equipment**

Patients with the following equipment must be transported with the equipment intact: Patients in continuous traction (stability of the weights and constant traction must be assured), the patient is transported in the traction bed; Patients with intravenous medications controlled by infusion pumps are subject to the Intravenous Therapy Procedures of Nursing Services, Category 1 medications must not be removed from the pump for transport (see Nursing Service Procedure "IV Priority List" for exceptions); and any patient being transported (anywhere) will be provided with same level of oxygen support as they are receiving in their room. If this level of oxygen cannot be provided, the attending physician must be notified prior to the transport*)*.

D. **Locator Record**

The locator record will be completed by the **person transporting** the patient and/or chart to or from the patient care unit or by the **person receiving a call** from the patient's current location advising them of a change in location. The transporting department is responsible for notifying the unit of the change in location. (Exception: The Emergency Department, the Rehabilitation Institute**,** and internal movement within Diagnostic Imaging Services. If patients are transported **beyond** the Rehab facility, the locator record is used.) The transporter is responsible for completing the locator log **when taking the patient off the unit, and upon return**. The transporter will note on the log who is notified.

E. **Isolation**

Patients in isolation should not be transported unless it is essential. If transport is necessary, the patient care unit will notify the receiving department of the nature of the isolation prior to the transport. Patients should be instructed as to how they can assist in maintaining their isolation and protect themselves or others from transmission of infection.

NOTE: Equipment used in transporting patients in isolation must be cleaned with a hospital-approved detergent/disinfectant (phenolic base) or 1:10 bleach solution, if visibly soiled.

Patients will be placed on the transport vehicle upon a clean sheet and covered or wrapped with another clean sheet. Additional barriers (impervious drapes, gowns, etc.) should be used as appropriate. Transport personnel should remove their own protective equipment upon leaving the destination location.

Patients shall wear a disposable mask during transport if on **"Airborne" or "Droplet".**

F. **Respiratory Therapy**

The Respiratory Therapy Department will maintain oxygen therapy for a mechanically ventilated patient during transport. (***Exception*****:** Patients leaving the Operating Room).
They will be available to assist, upon request, transports of any intubated or trached patients. They will provide and set up a bedside transport oxygen cylinder and regulator for units that do not have their own. They will also accompany any patient during transport as deemed necessary by the nurse and assist in transporting patients requiring respiratory support from the heliport to their destination.

Any patient who is on a Bi-Level Pressure device (Bipap) needing to be transported within the facility must have a written order indicating what method of transport is to be used. The physician should prescribe that the patient be placed on an appropriate oxygen device or be bagged via Bipap mask so that adequate oxygenation is maintained during transport.

Respiratory Therapy will not be responsible to the following areas for transport (except as previously noted):

1. Emergency Department
2. Outpatient Surgery
3. PACU
4. ICU
5. Diagnostic Imaging
6. EKG
7. Nuclear Cardiology
8. Cath Lab
9. Physical Therapy
10. Neurodiagnostics
11. Radiation Therapy
12. Nuclear Medicine
13. Endoscopy
14. Ultrasound
15. CCU
16. CT Scan

REFERENCES:

Transportation Safety, Safety Manual.

Safety, Nursing Services Policy Manual.

All revision dates:	4/20/2011, 4/21/2010, 3/11/2009, 10/22/2008, 10/11/2007, 5/24/2006, 10/31/2002, 9/12/2000, 6/12/2000, 1/14/1998, 11/14/1994, 7/15/1994

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West Florida HEALTHCARE

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References:	*Policy*
Applicability:	*West Florida Hospital*

Patient Restraint/Seclusion, CSG.CSG.001

SCOPE

This policy/procedure applies to healthcare professionals operating within HCA facilities that have responsibility for ordering, assessing, care planning, restraining, or monitoring the restrained patient. This policy is applicable to all age groups of patients, including neonates.

PURPOSE:

1. To protect the dignity and safety of inpatients, outpatients, staff and visitors through safe restraint processes.[1]
2. To identify patients at risk for restraint or seclusion and provide alternatives to restraint use.
3. To provide guidelines for use of least restrictive interventions to avoid restraint or seclusion use.
4. To define the procedure to be followed when all alternatives have been exhausted and proven ineffective, and restraints are necessary to maintain patient safety.
5. To define staff training requirements related to safe restraint or seclusion processes. Refer to Appendix A for training requirements.

POLICY:

HCA is dedicated to fostering a culture that supports a patient's right to be free from restraint or seclusion. Restraint or seclusion use will be limited to clinically justified situations, and the least restrictive restraint will be used with the goal of reducing, and ultimately eliminating, the use of restraints or seclusion. The facility Chief Nursing Officer (CNO), Ambulatory Surgery Center (ASC) Administrator and ASC Nurse Manager provides leadership and organizational accountability for monitoring the safety, appropriateness and necessity of restraint or seclusion use.

PROCEDURE:

1. **Assessment for Risk for Restraint**

a. The Registered Nurse (RN) performs an assessment for risk for restraint or seclusion when a patient exhibits behavior that may place the patient at risk for restraint or seclusion. This risk assessment includes:[2]

1. Does the patient have a medical device?
2. Does the patient understand the need to not remove the device?
3. Is the patient required to be immobile?

4. Does the patient understand the need to remain immobile?
5. Is the patient exhibiting aggressive, combative or destructive behavior?
6. Does this behavior place the patient/staff/others in immediate danger?

a. The assessment for the risk for restraint or seclusion also includes:

1. Patients who arrive in restraint.
2. Patients in restraint who have recovered from the effects of anesthesia and are awaiting transfer to a bed.

Note: Patients in the NICU and nursery are excluded from the assessment for risk for restraint.

1. **Alternatives to Restraint or Seclusion**
   Patients that are determined to be at risk for restraint or seclusion will have alternatives initiated promptly. Appendix B contains a listing of alternatives to restraint or seclusion.
2. **Determination That Alternatives to Restraint or Seclusion Have Failed**
   The RN determines that alternatives to restraint or seclusion have failed and that the patient will be safer in restraints than continuing without restraint.
3. **Second Tier of Review[2]**
   A member of nursing administration/management (e.g., nursing supervisor/manager, charge nurse, manager/director, CNO, etc.) will review the need for restraint or seclusion with the RN who has determined that the patient requires restraint or seclusion. The second tier of review will occur with the initial application of restraint or seclusion. Renewals of restraint or seclusion orders do not require a second tier of review. The review includes:

a. Alternatives attempted
b. Reason for restraint or seclusion
c. Least restrictive type of restraint
d. Staff's knowledge of the cause of patient behavior (physiological, psychological, environmental, medication)
e. Appropriate restraint for vulnerable patient populations
f. Staffing available for monitoring
g. Affirmation of partnering to meet the patient needs with safety and compassion

Note: In an emergency application of the restraint or seclusion, the above review will be done immediately after the application of restraint.

1. **Order for Restraint or Seclusion**

a. An order for restraint or seclusion must be obtained from an LIP/physician who is responsible for the care of the patient prior to the application of restraint or seclusion. The order must specify clinical justification for the restraint or seclusion, the date and time ordered, the duration of use, the type of restraint to be used and behavior-based criteria for release.
   1. An order for restraint or seclusion may not be written as a standing order, protocol or as a PRN or "as needed" order.[3]
   2. If a patient was recently released from restraint or seclusion and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order is required.[3]

b. If a telephone order is required, the RN must enter the order in CPOE while the physician is on the phone and read-back the order to verify accuracy.[4] The order must specify clinical justification for the restraint, the date and time ordered, the duration of use, the type of restraint and behavior-based criteria for release.

c. The treating physician is to be notified as soon as possible if another physician (e.g., on-call physician) orders the restraint.

d. When a LIP/physician is not available to issue a restraint or seclusion order, an RN with demonstrated competence may initiate restraint or seclusion use based upon face-to-face assessment of the patient. In these emergency situations, the order must be obtained during the emergency application or immediately (within minutes) after the restraint or seclusion is initiated.

5A. Order for Restraint with Non-Violent or Non-Self-Destructive Behavior

a. Duration of order for restraint must not exceed 24 hours for the initial order and must specify clinical justification for the restraint, the date and time ordered, the duration of use, the type of restraint and behavior-based criteria for release.

1. Twenty-four (24) hours is the maximum duration. The physician may order a shorter period of time.
2. Staff assess, monitor, and re-evaluate the patient regularly and release the patient from restraint when criteria for release are met.

a. To continue restraint use beyond the initial order duration, the LIP/physician must see the patient, perform a clinical assessment and determine if continuation of restraint is necessary.

b. If reassessment indicates an ongoing need for restraint, a new order must be written each calendar day by the LIP/physician.

5B. Order for Restraint with Violent or Self-Destructive Behavior[5, 6, 12]

a. Physician orders for restraint or seclusion must be time limited and must specify clinical justification for the restraint or seclusion, the date and time ordered, duration of restraint or seclusion use, the type of restraint, and behavior-based criteria for release. Orders for restraint or seclusion must not exceed:

1. Four (4) hours for adults, aged 18 years and older
2. Two (2) hours for children and adolescents aged nine (9) to 17 years, or
3. One (1) hour for children under nine (9) years

i. The time frames specified are maximums. The physician may order a shorter period of time.

ii. Staff assess, monitor, and re-evaluate the patient regularly and release the patient from restraint or seclusion when criteria for release are met.

a. To continue restraint or seclusion beyond the initial order duration, the RN determines that the patient is not ready for release and calls the ordering physician to obtain a renewal order. Renewal orders for restraint/seclusion may not exceed:

1. Four (4) hours for adults, aged 18 years or older
2. Two (2) hours for children and adolescents aged nine (9) to 17 years, or
3. One (1) hour for children under nine (9) years

a. Orders may be renewed according to time limits above for a maximum of 24 consecutive hours. Every 24 hours, unless state law is more restrictive, a physician or other authorized LIP primarily responsible for the patient's care sees and evaluates the patient before writing a new order for restraint or seclusion.

Application of Restraints

a. **Restraints are applied by staff with demonstrated competence in restraint application.**
b. **The patient is informed of the purpose of the restraint or seclusion and the criteria for removal.**
c. **The patient's family is informed of restraint or seclusion use, the purpose of the restraint or seclusion and the criteria for removal.**
d. **The restraint type for violent or self-destructive behavior shall be non-locking synthetic, quick release (Velcro or buckle), and with the product ability to be cleaned with antimicrobial cleaning product between uses. No synthetic leather, locking or hard restraint such as handcuffs will be permitted for use in the application of restraints for violent or self-destructive behaviors. Additional non-approved restraint devices include spit sock hoods, vest restraints and full body net restraint devices.**

7. Monitoring the Patient in Restraints or Seclusion

a. Patients are assessed by an RN immediately after restraints or seclusion are initiated to assure safe application/initiation of the restraint or seclusion.
b. An RN will assess the patient at least every two (2) hours. The assessment will include where appropriate:

1. Signs of injury associated with restraint, including circulation of affected extremities
2. Respiratory and cardiac status
3. Psychological status, including level of distress or agitation, mental status and cognitive functioning
4. Needs for range of motion, exercise of limbs and systematic release of restrained limbs are being met
5. Hydration/nutritional needs are being met
6. Hygiene, toileting/elimination needs are being met
7. The patient's rights, dignity, and safety are maintained
8. Patient's understanding of reasons for restraint and criteria for release from restraint
9. Consideration of less restrictive alternatives to restraint

a. More frequent monitoring and notification of the ordering physician or LIP occurs when:

1. Patient's medical and emotional needs and health status change
2. The type and design of the device or intervention poses increased risk
3. The level of patient agitation/distress at being placed in restraint as evidenced by an escalation of behavior
4. Evidence of injury related to use of restraint

a. A trained staff member monitors each patient in restraint or seclusion at least three (3) times an hour for safety, and to confirm that the patient's rights and dignity are maintained. This check will be documented in either electronic record or on paper. If a paper checklist is used as a summary, recording time and observation from each of the three (3) times an hour check, may be recorded at the end of the shift and the checklist scanned into the EHR/HPF patient record.

b. For patients under continuous audio, video or in-person observation (e.g., ICU), care is rendered in real time, but documentation that safety, rights, and dignity were maintained for the defined period of time may be entered at end of the shift.
c. Monitoring is based on the individual needs of the patient. Variables of the patient's condition, cognitive status, and risks associated with the chosen intervention may require more frequent evaluations.

Any change in physical or psychological response will be reported to the RN. The RN will determine if medical intervention is required or if criteria for release have been met.

8. Simultaneous Use of Restraint and Seclusion

A patient in restraint and seclusion simultaneously requires a higher level of monitoring:[7]

a. Continuous, uninterrupted monitoring, face-to-face by a specifically assigned staff member with demonstrated competence in close proximity to the patient for at least the first hour.
b. After the first hour, continuous uninterrupted monitoring, by a specifically assigned staff member with demonstrated competence using both video and audio equipment, with monitoring done in close proximity to the patient so as to allow emergency intervention if a problem arises. The use of video and audio equipment does not eliminate the need for frequent monitoring and assessment of the patient.

9. Face-to-face assessment by a Physician or LIP:

a. A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence, must be done within one (1) hour of restraint or seclusion initiation or administration of medication to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. At the time of the face-to-face assessment, the LIP/physician/RN/PA will:[8]

1. Work with staff and patient to identify ways to help the patient regain control
2. Evaluate the patient's immediate situation
3. Evaluate the patient's reaction to the intervention
4. Evaluate the patient's medical and behavioral condition
5. Evaluate the need to continue or terminate the restraint or seclusion
6. Revise the plan of care, treatment and services as needed

Note: A telephone call or telemedicine methodology does not constitute face-to-face assessment.

a. When the one (1)-hour face-to-face is performed by a RN or physician assistant with demonstrated competence, the following must occur:

1. The RN or physician assistant with demonstrated competence must consult the attending physician or LIP who is responsible for the care of the patient as soon as possible after the completion of the one (1)-hour face-to-face evaluation. ("As soon as possible" is to be as soon as the attending physician is able to be reached by phone or in-person.) A consultation that is not conducted prior to renewal of the order would not be consistent with the requirement "as soon as possible."[9]
2. The consultation should include, at a minimum, a discussion of the findings of the one (1)-hour face-to-face evaluation, the need for other treatments, and the need to continue or discontinue the use of restraint or seclusion.

3. If a patient who is restrained or secluded for aggressiveness or violence quickly recovers and is released before the physician arrives to perform the face-to-face assessment, the physician must still see the patient face-to-face to perform the assessment within 24 hours after the initiation of restraint or seclusion.

1. **Care of the Patient/Plan of Care:10**

a. **The plan of care will clearly reflect a loop of assessment, intervention, and evaluation for restraint, seclusion and medications.**
b. **Patients and/or families should be involved in care planning to the extent possible and made aware of changes to the plan of care.**

1. **Discontinuation of Restraint or Seclusion:**

a. **The patient in restraint or seclusion is evaluated frequently and the intervention is ended at the earliest possible time. The time-limited order does not require that the application be continued for the entire period.**
b. **When an RN determines that the patient meets the criteria for release in the restraint order, restraints or seclusion are discontinued by staff with demonstrated competence.**
c. **Once restraints or seclusion are discontinued, a new order for restraint or seclusion is required to reapply or reinitiate.**
d. **A temporary release that occurs during patient care, e.g. toileting, feeding or range or motion, is not considered a discontinuation of restraint or seclusion.**

1. **Documentation Requirements:**

The medical record contains documentation of:

a. Assessment for risk for restraint or seclusion
b. Restraint or seclusion alternatives employed
c. Determination of effectiveness/ineffectiveness of restraint or seclusion alternatives
d. Second tier review of need for restraint or seclusion
e. Order for restraint or seclusion and any renewal orders for restraint or seclusion
f. Restraint or seclusion application/initiation
g. Family notification of restraint or seclusion use
h. Patient and family education regarding restraint or seclusion use
i. Assessment of the patient in restraint or seclusion
j. Monitoring of the patient in restraint or seclusion
k. Medical and behavioral evaluation for restraint or seclusion management of violent or self-destructive behavior
l. Modifications of the plan of care
m. Physician notification of changes in patient condition
n. Restraint or seclusion removal/termination
o. Documentation requirements related to deaths of patients who were in or expired within 24 hours of being in restraint are located in Appendix C. Documentation requirements are also located in Appendix C for patients who expired within one (1) week of being in restraint and it is reasonable to assume that the restraint contributed to the death.

Performance Improvement:

a. Data on the use of restraint and seclusion is collected to monitor appropriate use and to identify process improvement opportunities.
b. Data elements include:

1. Number of patients restrained or secluded
2. Number of restraint or seclusion hours
3. Type of restraints
4. Number of restraint or seclusion episodes
5. Number of patient injuries/deaths while restrained or secluded

a. Data is trended, patterns of use, safety, and effectiveness are evaluated. Progress toward preventing, reducing and eliminating the use of restraints or seclusion is assessed.
b. Results of analysis are shared with facility leadership and appropriate committees, the Medical Executive Committee and the Board of Trustees/Governing Body.
c. If any inappropriate use of restraints or seclusion is identified, a root cause analysis will be performed, measures identified and implemented to remedy the issue(s).
d. Hospital CMS Reporting Requirements: The hospital must report the following information to CMS Regional Office by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of a patient's death: 1.) Each death that occurs while a patient is in seclusion or restraint (with the exception of soft, non-rigid, cloth-like material restraints used on the patient's wrist[s], specific requirements apply to this group. See Appendix C); 2.) Each death that occurs within 24 hours after the patient has been removed from seclusion or restraint (with the exception of soft, non-rigid, cloth-like material restraints used on the patient's wrist[s], specific requirements apply to this group. See Appendix C); 3.) Each death known to the hospital that occurs within one (1) week (occurring on day two [2] through seven [7]) after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint. For deaths occurring outside the hospital there may be a delay in this process based on when hospital became aware. Hospitals must use Form CMS-10455 to report those deaths associated with restraint and/or seclusion that are required by 42 CFR §482.13(g) to be reported directly to their Centers for Medicare & Medicaid Services (CMS) Regional Office (RO). This requirement also applies to rehabilitation or psychiatric distinct part units (DPUs) in Critical Access Hospitals (CAHs).[11]Specific requirements for reporting and/or logging are located in Appendix C.

REFERENCES:

1. TJC PC.03.05.01
2. HCA Best Practice
3. TJC PC.03.05.05; CMS §482.13(e)(6)
4. TJC PC.02.01.03
5. TJC PC.03.05.05; CMS §482.13(e)(8)
6. TJC PC.03.05.05; CMS §482.13.(e)(8)(i)
7. TJC PC.03.05.13; CMS §482.13(e)(15)
8. TJC PC.03.05.11; CMS §482.13(e)(12)(i-ii)
9. CMS §482.13(e)(14)

10. CMS §482.13(e)(4)(i) Interpretive Guidelines
11. CMS Ref" S&C: 14-27-Hospital-CAH/DPU May 9, 2014
12. APNA Standards of Practice: Seclusion and Restraint Revised April 2014

APPENDIX A: TRAINING REQUIREMENTS

A. **Direct Care Staff**

Staff will demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment and providing care for a patient in restraint or seclusion. Training will be provided to all staff designated as having direct patient care responsibilities (the facility to list), including contract or agency personnel. In addition, if hospital/ASC security guards or other non-healthcare staff (the facility to list) assist direct care staff, when requested in the application of restraint or seclusion, the security guards, or other non-healthcare staff (as defined by the facility) are also expected to be trained and able to demonstrate competency in the safe application of restraint and seclusion. Training will occur:

1. Before performing restraint application, implementation of seclusion, monitoring, assessment and providing care for a patient in restraint or seclusion,
2. As part of orientation, and
3. On a periodic basis to ensure staff possess requisite knowledge and skills to safely care for restrained or secluded patients.
4. The results of skills and knowledge assessment, new equipment, or QAPI data may indicate a need for targeted training or more frequent or revised training.

A. **Staff who conduct the one hour face-to-face evaluation**

The purpose of the one (1)-hour face-to-face evaluation is to complete a comprehensive review of the patient's condition and determine if other factors such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior.

Training for the RN or PA who conduct the one (1)-hour face-to-face will include:

1. Application of restraints.
2. Implementation of seclusion.
3. Monitoring, assessment and providing care for a patient in restraint or seclusion, including:
    a. The patient's immediate situation
    b. The patient's reaction to the intervention
    c. The patient's medical and behavioral condition
    d. The need to continue or terminate the restraint and seclusion

A. **Physicians and other LIPs authorized to order restraint**

Physicians and other LIPs authorized to order restraint will have a working knowledge of this policy on the use of restraint and seclusion.

B. **Individuals Providing Training**

Individuals providing training will be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors for the populations served. In addition these individuals will demonstrate a high knowledge regarding all the requirements as set forth in this policy and procedure. There will be documentation to ensure that the individuals providing education and training have the appropriate qualifications required.

Training Content

A. **Restraint and Seclusion**
   All staff, including contract or agency personnel designated as having direct patient care responsibilities, will receive training in identifying patient and staff behaviors, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion. Education and training will be based on the specific needs of the patient populations served. For example, staff who routinely provide care for patients who exhibit violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others (such as an emergency department or on a psychiatric unit) may receive more in-depth training than staff routinely providing medical/surgical care.

B. **Nonphysical Interventional Skills**
   Staff will be trained on the use of nonphysical interventional skills. These alternative techniques include redirecting the patient, engaging the patient in constructive discussion or activity or otherwise assisting the patient to maintain self-control and to avert escalation. Training will address application of nonphysical interventions based on the assessment of the individual patient's responses.

C. **Least Restrictive Interventions**
   Staff will be trained on choosing the least restrictive intervention based on the individualized assessment of the patient's medical or behavioral status or condition. Safe patient care requires looking at the patient as an individual and assessing the patient's condition, needs, strengths, weaknesses, and preferences and tailoring interventions to individual patient's needs after weighing factors such as the patient's condition, behaviors, history, and environmental factors.

D. **Safe Application**
   Staff will be trained on the safe application of all types of restraint and seclusion used in this facility including training to recognize and respond to signs of physical and psychological distress (e.g., positional asphyxia).

E. **Necessity of Restraint**
   Staff will be trained and able to demonstrate competency in identification of specific behavioral changes that may indicate that restraint or seclusion is no longer necessary and can be safely discontinued.

F. **Monitoring**
   Staff will be trained and demonstrate competency in monitoring the physical and psychological well-being of a patient who is restrained or secluded. This training will include but will not be limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements identified by the facility associated with the one-hour face-to-face evaluation.

G. **First Aid**

Staff will be trained and able to demonstrate competency in first aid techniques for patients in restraint or seclusion who are in distress or injured. The patient populations will be assessed to identify potential scenarios and develop training to address those scenarios. For example, for patients who are found hanging in a vest restraint, a restrained patient choking on food, a secluded and suicidal patient found hanging, a secluded suicidal patient who has cut himself, etc. Staff will be trained and certified in the use of cardiopulmonary resuscitation and periodically recertified.

APPENDIX B: ALTERNATIVES TO RESTRAINT OR SECLUSION

A. **Psychosocial Alternatives**
   Diversion

Family interaction
Orientation
Pastoral visit
Reassurance
Reading
Relaxation techniques
Interpreter services
Personal possessions available
Quiet area
One-on-one discussion
Decreased stimulation
Change in environment
Re-establishing communication
Setting limits

B. **Environmental Alternatives**

Commode at bedside
Decreased noise
Music/TV
Night light
Room close to nursing station
Call light within reach
Bed alarm in use
Specialty low bed
Sensory aids available (glasses, hearing aid)
Decreased stimulation
Providing a quiet area
Physical activity Orientation

C. **Physiological Alternatives**

Toileting

Fluids/nutrition/snack

Positional devices

Pain intervention

Assisted ambulation

Re-positioning

Rest/sleep

Providing assistance

Additional warmth

Decreased temperature

Check lab values

Pharmacy consult

APPENDIX C: HOSPITAL CMS REPORTING REQUIREMENTS

A. Hospitals (meaning all types of hospitals, including Psychiatric Hospitals, Rehabilitation Hospitals, Long Term Care Hospitals, and not just Short Term Acute Care Hospitals) and Critical Access Hospitals with rehabilitation and/or psychiatric Distinct Part Unit (DPUs) must now use Form CMS-10455, "Report of a Hospital Death Associated with Restraint or Seclusion," to report deaths associated with restraint and/or seclusion that are required by 42 CFR §482.13(g) to be reported directly to the CMS Regional Office. The hospital must report the following information to CMS Regional Office by telephone, facsimile, or electronically, as determined by CMS Regional Office, no later than the close of business on the next business day following knowledge of the patient's death:

1. Each death that occurs while a patient is in restraint (with the exception of soft, non-rigid, cloth-like material restraints used on the patient's wrist(s), see reporting requirements for this group below) or seclusion.
2. Each death that occurs within 24 hours after the patient has been removed from restraint (with the exception of soft, non-rigid, cloth-like material wrist(s) restraints used on the patient, see reporting requirements for this group below) or seclusion.
3. Each death known to the hospital that occurs within one (1) week (days two (2) through seven (7)) after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. ''Reasonable to assume'' in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation. In a case where only two-point soft wrist restraints were used and there was no seclusion, it may be presumed that the patient's death was not caused by the use of restraints.
4. The staff must document in the patient's medical record the date and time the death was reported to CMS.

The report to the CMS Regional Office must include basic identifying information related to the hospital, the patient's name, date of birth, date of death, name of the attending physician/practitioner, primary diagnosis(es), cause of death and types of restraint or seclusion used. (After review of the submitted information, the Regional Office will determine whether an on-site investigation is warranted.)

A. When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:

1. Any death that occurs while a patient is in such restraints.
2. Any death that occurs within 24 hours after a patient has been removed from such restraints.
3. The staff must document in the patient's medical record the date and time the death was:

a. Recorded in an internal log or other system for deaths of patients in soft, non-rigid, cloth-like material wrist(s) restraints described.

1. Entries into the internal log or other system must be documented as follows:

a. Each entry must be made not later than seven days after the date of death of the patient.

b. Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).
c. The information must be made available in either written or electronic form to CMS immediately upon request.

APPENDIX D: DEFINITIONS

The definitions of restraint use types are applicable in any setting in the facility and are not driven by diagnosis.

A. **Physical restraint:** Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body to include immobilization or reduction of the ability of a patient to move his or her arms, legs, body, or head freely is considered a physical restraint. An object may be a restraint by functional definition, which is when an object restricts the patient's movement or access to his or her body. Under this definition, many commonly used facility devices and practices could meet this definition of a restraint (e.g., tucking in sheets very tightly, use of side rails to prevent a patient from voluntarily getting out of bed, holding a patient to prevent movement, pinning of mitts on infants, arm restraints and other wrappings that prevent infants, children and/or adults from removing invasive lines or reopening surgical sites, etc.)
B. **Seclusion:** Seclusion may only be used for the management of violent or self-destructive behavior. Seclusion is not limited to confining an individual to an area but involuntarily confining him/her alone in a room or area where he/she is physically prevented from leaving. A situation where a patient is restricted to a room alone and staff is physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room/area is considered seclusion.

1. **Timeout:** The definition of seclusion does not apply to "timeout" which is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses.

A. **Drugs as restraints:** A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition is considered a restraint. When medications are used as restraints, it is important to note that the decision as to whether they constitute restraint is not specific to the treatment setting, but to the situation the restraint is being used to address. A medication that is not being used as a standard treatment or in a dosage for the patient's medical or psychiatric condition and that results in controlling the patient's behavior and/or in restricting his or her freedom would be a drug used as a restraint.

A "**standard treatment**" for a medication to be used to address a patient's medical or psychiatric condition would include the following:

1. The medication is used within the pharmaceutical parameters approved for it by the FDA and the manufacturer, for the indications it is manufactured and labeled to address, listed dosage parameters, etc.
2. The use of the medication follows national practice standards established or recognized by the appropriate medical community and/or professional medical association; and
3. Use of the medication to treat a specific patient's clinical condition is based on that patient's target symptoms, overall clinical situation and of the LIP's knowledge of that patient's expected and actual response to the medication.

An additional component of "standard treatment" for a medication is the expectation that the standard use of a psychotherapeutic medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around him/her than

would be possible without the use of the medication. Psychotherapeutic medications are to enable, not disable. If a psychotherapeutic medication reduces the patient's ability to effectively or appropriately interact with the world around him/her, then the psychotherapeutic medication is not being used as a "standard treatment" for the patient's condition.

A. **Physical Escort:** A physical escort would include a "light" grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint.

B. **Physical Holds:** The regulation permits the physical holding of a patient for the purpose of conducting routine physical examinations or tests. However, patients do have the right to refuse treatment. This includes the right to refuse physical examinations or tests. Holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint. This includes holds that some members of the medical community may term "therapeutic holds." Many deaths have occurred while employing these practices. Physically holding a patient during a forced psychotropic medication procedure is considered a restraint. If the patient is in a physical hold, a second staff person is assigned to observe the patient to ensure safety and the patient's airway is not compromised.

C. **Physical Holding for Forced Medications:** The application of force to physically hold a patient, in order to administer a medication against the patient's wishes, is considered restraint. The patient has a right to be free of restraint and also has a right to refuse medications, unless a court has ordered medication treatment. A court order for medication treatment only removes the patient's right to refuse the medication. Additionally, in accordance with State law, some patients may be medicated against their will in certain emergency circumstances. However, in both of these circumstances, health care staff is expected to use the least restrictive method of administering the medication to avoid or reduce the use of force, when possible. The use of force in order to medicate a patient, as with other restraint, must have a physician's order prior to the application of the restraint (use of force). If physical holding for forced medication is necessary with a violent patient, the one-hour face-to-face evaluation requirement would also apply. In certain circumstances, a patient may consent to an injection or procedure, but may not be able to hold still for an injection, or cooperate with a procedure. In such circumstances, and at the patient's request, staff may "hold" the patient in order to safely administer an injection (or obtain a blood sample, or insert an intravenous line, if applicable) or to conduct a procedure. This is **not** considered restraint.

D. **Weapons:** CMS regulations specifically state that the use of weapons (pepper spray, mace, nightsticks, Tazers, stun guns, etc.) used in the application of restraint is not considered to be safe appropriate health care intervention. The use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital/ASC staff as a means of subduing a patient in order to place that patient in restraint or seclusion. If a weapon is used by security or law enforcement personnel on a person in a hospital/ASC (patient, staff, or visitor) to protect people or hospital property from harm, the situation should be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement.

E. **Licensed Independent Practitioner (LIP):** An LIP (for the purpose of restraint ordering) is any practitioner permitted by state law and by facility policy with the authority to independently order restraints or seclusion for patients. This authority to order restraint/ seclusion and perform or delegate face-to-face assessment must be in the scope of the individual's license and consistent with individually granted clinical privileges at the facility.

F. **Restraints with Heightened Risk:** Vest restraints which tie crisscross have proven to contribute to patient injury and should not be used within HCA facilities. The FDA published a Public Health Notification on Vail Products in March 25, 2005, recommending that facilities stop using Vail beds. Alternative beds should be chosen from the HCA approved list. If another manufacturer is chosen, the facility must ensure that beds have been checked for possible entrapment zones prior to putting them into service. Entrapment zones include, but are not limited to, areas between the side rails and the mattress, between the mattress and the canopy in places where the rails do not extend, and areas between the end rails and the mattress.

G. **Restraint Episode:** A restraint episode is calculated from the date/time the restraint is applied to the date/time the restraint is discontinued. If there are multiple applications of restraint and only one discontinue date/time this would be calculated as one episode.

H. **Side rails considered restraint:** Using side rails to prevent a patient from voluntarily getting out of bed would be considered a restraint. The use of side rails is inherently risky, particularly if the patient is elderly or disoriented. Frail elderly patients may be at risk for entrapment between the mattress or bed frame and the side rail. Disoriented patients may view a raised side rail as a barrier to climb over, may slide between raised, segmented side rails, or may scoot to the end of the bed to get around a raised side rail and exit the bed. When attempting to leave the bed by any of these routes, the patient is at risk for entrapment, entanglement, or falling from a greater height posed by the raised side rail, with a possibility for sustaining greater injury or death than if the patient had fallen from the height of a lowered bed without raised side rails. In short, the patient may have an increased risk for a fall or other injury by attempting to exit the bed with the side rails raised. The risk presented by side rail use should be weighed against the risk presented by the patient's behavior as ascertained through individualized assessment. (See Exclusion to Restraint Section)

Exceptions to the Definition of Restraints:

1. **Exclusion to Restraint:**

   Side rails not considered restraint

   A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed. A therapeutic bed includes beds that constantly move to improve circulation or prevent skin breakdown.

   The use of side rails in these situations protects the patient from falling out of bed and, therefore, would not be considered restraint. When a patient is placed on **seizure precautions** and all side rails are raised, the use of side rails would not be considered restraint. The use of padded side rails in this situation should protect the patient from harm; including falling out of bed should the patient have a seizure.

   Placement in a crib with raised rails is an age-appropriate standard safety practice for every infant or toddler. Therefore, placement of an infant or toddler in the crib with raised rails would not be considered restraint.

   If the patient is on a **stretcher** (a narrow, elevated, and highly mobile cart used to transport patients and to evaluate or treat patients), there is an increased risk of falling from a stretcher without raised side rails due to its narrow width, and mobility. In addition, because stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rails on stretchers is not considered restraint but a prudent safety intervention. Likewise, the use of a seat belt when transporting a patient in a wheelchair is not considered restraint.

2. Generally, if a patient can easily remove a device, the device would not be considered a restraint. In this context, **"easily remove"** means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g., side rails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the patient's physical condition and ability to accomplish objective (e.g., transfer to a chair, get to the bathroom in time). **Interpretive Guidelines §482.13(e)(1)(i)(C)**

3. **Use of voluntary mechanical support devices:**

   Devices that are used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such mechanical support are not considered restraints. These may include, but are not limited to, orthopedic appliances and braces.

4. **Use of Handcuffs:**

   The use of handcuffs and other restrictive devices used by law enforcement who are not employed or contracted by the facility for custody, detention or other public safety reasons, and not for the provision of healthcare, is not governed by these standards. However, the use of such devices are considered law enforcement restraint devices and are not considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients.

5. **Voluntary mechanical positioning or securing device:**
   A medically necessary and voluntary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, surgical, dental, or diagnostic procedures is not considered a restraint (e.g., backboards, surgical positioning, IV boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients).
6. **Age or developmentally appropriate protective safety interventions:**
   Devices such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails and crib covers, that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler or preschool-aged child, are not considered restraints.
7. **Recovery from anesthesia:**
   Recovery from anesthesia that occurs when the patient is in the intensive care unit or recovery room is considered part of the surgical procedure and is not considered restraint. Recovery from anesthesia would be defined by the organization (i.e., Aldrete score).
   Note: However, if the intervention is maintained when the patient is transferred to another unit or recovers from the effects of anesthesia (whichever occurs first), a restraint order would be necessary and the requirements related to restraint use should be followed. In addition, if the patient presents to the surgical area either Inpatient, Outpatient, or Ambulatory Surgical Center, in restraints prior to surgery, the restraint standards would apply.
8. **Protective devices or equipment:**
   Equipment, such as helmets, are not considered restraints if they are easily removed by the patient**.**
9. **Behavior management**

Behavior management and treatment interventions should be therapeutic interventions that foster adaptive behaviors. They should not be used exclusively for behavior control. The use of mechanical restraint and seclusion as treatment interventions for behavior management is prohibited and should only be considered for patients who exhibit intractable behavior that is severely self-injurious or injurious to others and who have not responded to traditional interventions and who are unable to maintain self-safety. The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation.

All revision dates: 5/1/2017, 9/9/2015, 6/25/2013, 2/14/2012, 3/21/2011, 1/10/2011, 1/10/2010, 10/26/2009

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West Florida HEALTHCARE

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Owner:	*Karen White-Trevino: CNO*
Policy Area:	*Nursing*
References:	
Applicability:	*West Florida Hospital*

Management of Suicidal Patients, I-70

SCOPE:

This policy applies to all patients of West Florida Hospital Acute Care and the West Florida Rehabilitation Institute (WFRI).

PURPOSE:

To provide guidelines for the management of patients known or suspected to have suicidal thoughts or actions.

POLICY: -

1. A patient known or suspected of being suicidal, either by expression of suicidal thoughts, actual plan, or attempt, will be admitted to the Pavilion by the attending psychiatrist, unless the needs of the patient demand care and/or monitoring not available in the Pavilion. Please refer to the Pavilion Policy Manual for management of suicidal patients admitted to the Pavilion.
2. Should a patient's condition warrant admission to the acute care facility or WFRI, the following will take place.

a. Any patient, known or suspected to be suicidal, if not attended by a psychiatrist, will have an urgent psychiatric consult ordered by the attending or treating physician.
b. Suicide precautions will be ordered by the attending or treating physician. Behaviors leading to use of suicide precautions should be documented by the physician.
c. Hourly observations of patient behavior will be performed and documented in the medical record by nursing staff. If changes in the patient's mental condition or behavior are observed, the psychiatrist and/or attending physician will be contacted and interventions will be implemented as ordered.
d. If it is necessary to transport the patient to another area of the Hospital for any testing or procedures, a staff member must accompany and remain with the patient at all times.
e. Twenty-four hour sitters will be assigned to the patient unless he/she is under other continuous observation in a critical care unit.

PROCEDURE: -

1. Suicide precautions to be implemented include:

a. Patient will be assigned a room close to the Nurse's Station whenever possible.
b. Patients may not have in their possession or use for the duration of the time they are on suicide/self-harm precautions:

i. Razor
ii. Hairdryer
iii. Headset (any item with a cord)
iv. Plastic Knife
v. Hard plastic containers such as make-up
vi. Containers
vii. Mirrors
viii. Shoelaces
ix. Pantyhose/stockings
x. Belts
xi. Ties
xii. Metal cans
xiii. Glass of any kind
xiv. Any other items that staff assesses maybe used for self-harm or harm to others.

a. A twenty-four hour sitter will be assigned to the patient until an order to discontinue suicide precautions has been obtained from the physician. **Exception**: Patients under continuous observation in a critical care unit.
b. Search of patient's personal possessions for sharps and other potentially dangerous items, including medication.
c. Body search (male staff member to have search responsibility for male patients; female staff member to have search responsibility for female patients).
d. Removal of all sharps or dangerous objects from room such as razors, hangers, aerosol cans, nail files, scissors, medications.
e. Removal of belts.
f. All beverages to be served in Styrofoam cups rather than cans, bottles, glasses or ceramic cups.
g. Trays to be checked before serving and rechecked after serving for missing objects.
h. Windows to be checked upon admission to assure they are secured.
i. Patient's bathing and shaving are to be supervised.
j. Personnel assigned to care for the patient will not carry scissors, nail files, or other sharp objects in their pockets.
k. Meals to be served on disposable dishes.
l. Personnel assigned to care for the patient will accompany the patient for all procedures off the unit.

1. If patient becomes highly disruptive or agitated, restraints are to be used in accordance with the hospital policy.
2. A Code M may be initiated when additional manpower is required to deal with a patient's behavior. (See Administrative Policy I-23: Codes).
3. The Administrative Assistant/Nursing is to be notified of any known or suspected suicidal patient who has not been admitted to the Pavilion.

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West Florida HEALTHCARE

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Policy Area:	*Administrative Policies*
References:	*Policy*
Applicability:	*West Florida Hospital*

Care of Suspected Abuse/Neglect/ Sexual Abuse/Exploitation of Victims, I-17

SCOPE:

All patients with suspected abuse/neglect/sexual abuse/exploitation.

PURPOSE:

To provide a protocol so that legal, emotional and physical support can be provided to the victim and family in compliance with regulatory requirements related to the appropriate identification and reporting of suspected abuse

POLICY:

CF-MH-3021Every staff member of West Florida Hospital has an affirmative duty to report any actual or suspected case of child, disabled adult, elderly or spouse abuse or neglect to the Florida Abuse Hot Line.

1. Anyone participating in making a report of abuse or neglect to HRS shall be presumed to be acting in good faith, and in doing so shall be immune from any liability, civil or criminal charges.
2. No patient/resident or employee of a facility servicing the aged or disabled persons shall be subject to reprisal or discharge because of his/her actions of reporting abuse or neglect.
3. Florida Statutes require mandatory reporting of abuse, neglect or exploitation of a child, aged person or disabled adult.
4. Facility education of abuse/neglect/sexual abuse/exploitation:

a. All employees will receive education during the hospital orientation program.
b. All employees will receive education while completing their mandatory education requirements for each performance evaluation.
c. Domestic Violence education is required for all nurses and social workers every three years.

DEFINITIONS:

1. **Abused or Neglected Child** means a child whose physical or mental health or welfare is harmed, or threatened with harm, by act of omissions of the parent or other person responsible for the child's welfare or for purposes of reporting requirements, by any person.
2. **Child Abuse or Neglect** means harm or threatened harm to a child's physical or mental health or welfare by the acts or omissions of the parent, adult household member, or other person responsible for the child's welfare, or for purposes of reporting requirements by any person.

3. **Child** means any person under the age of eighteen (18).
4. **Abused Person** means any aged person or disabled adult who has been subjected to abuse or whose condition suggests that he/she has been abused.
5. **Abuse** means the non-accidental infliction of physical or psychological injury to an aged person or disabled adult by a relative, caregiver, or adult household member, or the failure of a caregiver to take reasonable measures to prevent the occurrence of physical or psychological injury to an aged or disabled adult.
6. **Aged Person** means a person sixty (60) years of age or older who is suffering from the infirmities of aging as manifested by organic brain damage, advanced age or other physical, mental or emotional dysfunctioning to the extent that the person is impaired in his ability to adequately provide for his own care or protection.
7. **Caregiver** means a person or persons responsible for the care of an aged person or disabled adult; Caregiver includes, but is not limited to, relatives, adult children, parents, neighbors, day care personnel, adult foster home sponsors, personnel of public or private institutions and facilities, nursing homes, adult congregate living facilities, and state institutions.
8. **Disabled Adult** means a person eighteen (18) years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations which restrict his ability to perform the normal activities of daily living.
9. **Exploitation** means, but is not limited to, the improper or illegal use or management of an aged person's or disabled adult's funds, assets, or property or the use of an aged person's or disabled adult's power of attorney or guardianship for another's or one's own profit or advantage.
10. **Neglect** means the failure or omission of the part of the caregiver or aged person or disabled adult to provide the care and services necessary to maintain the physical and mental health of an aged person or disabled adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would deem essential for the well-being of an aged or disabled adult.
11. **Medical Neglect** means the failure to provide adequate medical care and includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition.
12. **Withholding of Medically Indicated Treatment** means the failure to respond to an infant's life-threatening condition by providing treatment (including appropriate nutrition, hydration and medications) which, in the treating physician's reasonable medical judgment, will be most likely to be effective in improving or correcting all such conditions.
13. **Domestic Violence** means any assault, battery, sexual assault, sexual battery, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling; or has reasonable cause to believe he or she is about to become the victim of domestic violence.
14. **Spouse** means a person to whom another person is married or a person to whom another person has been married and from whom such person is now separated or divorced
15. **Family of Household Member** means spouses, former spouses, adults related by blood or marriage, persons who are presently residing together as if a family and persons who have a child in common regardless of whether they have been married or have resided together at any time.
16. **Sexual Abuse** means sexual harassment, coercion or sexual assault.

PROCEDURE:

1. Recognition of Abuse:

a. Common injuries associated with child abuse or neglect include but are not limited to:

i. Unexplained bruises
ii. Unusual burn
iii. Head injuries in very young infants/children
iv. Abdominal injuries **Most common cause of death from abuse**
v. Suspicious fractures
vi. Failure to thrive
vii. Injury inconsistent with history

a. Traits common to the abused child may include but not be limited to:

i. Cries a lot or too little
ii. Poor eye contact
iii. Wary of physical contact
iv. Quiet and/or withdrawn
v. Hesitant to discuss nature of injury
vi. No parent separation anxiety

a. Common injuries associated with Elder/adult/spouse abuse may include but not be limited to:

i. Unexplained bruises: on upper arm, back, torso, groin, breasts, genital area
ii. Unusual burns
iii. Head or facial injuries, black eye, bruised cheek bones, suspicious marks on throat
iv. Abdominal injuries, unexplained discoloration, unusual tenderness, suspicious fractures
v. Evidence of injuries in several states of healing, (bruises that are fresh mixed with older bruises that have turned blue-black or purple)
vi. Injuries inconsistent with history

a. Traits common to the abused Elder/adult/spouse may include but not be limited to:

i. Poor eye contact
ii. Wary of physical contact
iii. Unusually quiet, withdrawn or tearful
iv. Hesitant to discuss nature or circumstances of injury
v. Unusual nervousness, anxiety, or self-blaming, undeserving
vi. Reluctance of patient spouse/caregiver to allow patient to be interviewed alone

a. Common injuries associated with sexual abuse:

i. Torn, stained or bloody underwear
ii. Trouble walking or sitting
iii. Pain or itching in the genital area
iv. Bruises or bleeding in the genital area

v. A sexually transmitted disease

a. Common traits associated with sexual abuse

i. Have an unusual knowledge of sex or acts seductively
ii. Fear of a particular person

i. Seems withdrawn or depressed
ii. Gain or lose weight suddenly

i. Shy away from physical contact
ii. Run away from home

1. Reporting of Abuse/Neglect/Exploitation:

a. Florida Statutes require mandatory reporting of abuse, neglect or exploitation of a child, aged person or disabled adult. Any person including, but not limited to, any:

i. physician, osteopath, medical examiner, chiropractor, nurse, or hospital personnel engaged in the admission, examination, care or treatment of persons;
ii. health or mental health professional other than one listed in a) above;
iii. practitioner who relies solely on spiritual means of healing;
iv. school teacher or other school official or personnel;
v. nursing home staff, adult congregate living facility staff, adult/child day care center staff, social worker, or other professional adult/child care, foster care, residential or institutional staff;
vi. state, county, or municipal criminal justice employee or law enforcement officer;
vii. human rights advocacy committee or long-term care ombudsman council member; or,
viii. bank, savings and loan, or credit union officer, trustee or employee who knows or has reasonable cause to suspect, that a child/aged person or disabled adult is abused/neglected or exploited, shall report such knowledge or suspicion to the central abuse registry and tracking system on the Florida Abuse Hotline.

a. Any person participating in the making of an abuse/neglect or exploitation report or participating in a judicial proceeding resulting from a report is presumed to be acting in good faith and, unless lack of good faith is shown by clear and convincing evidence, is immune from liability, civil or criminal.
b. Reporters may reach the Florida Abuse Hotline by calling: 1-800-962-2873

or by faxing a report to the Florida Abuse Hotline at 1-800-914-0004.

Information that will be needed when making the report:

i. reporter's name/agency/address/phone number/fax number and date (the name of any person reporting abuse/neglect or exploitation will not be released to any person other than employees of the agency responsible for protective services, the Central Abuse Registry or the appropriate attorney, without the written consent of the person reporting)

ii. victim's name, date of birth/race/sex/address/phone number and for adult victims describe the disability and how the victim is impaired in the ability to care for or protect self
iii. other household member's name/date of birth/race/sex/relationship to victim
iv. significant other's name/relationship/address/home phone/work phone
v. description of incident: describe the injuries or threat of injuries/date of last incident/how long the maltreatment has occurred/describe concern for protection of victim
vi. Identify others who might be aware of the abuse/neglect or exploitation of the victim, to include: name/address/home phone/work phone.

a. Upon receiving a report of known or suspected abuse/neglect/sexual abuse or exploitation, the central abuse registry shall determine if the report requires an immediate onsite protective investigation or if a family service response can be commenced within 24 hours.
b. If the report is made of a known or suspected child abuse by a non-caretaker, the report is immediately electronically transferred to the appropriate county sheriff's office by the central abuse registry.
c. Any person with knowledge or suspicion of abuse/neglect/sexual abuse or exploitation, should report this to the physician, registered nurse, administrative supervisor, department head, and/or case manager.

i. Evaluation of suspicion will be conducted by The Nurse Manager or Administrative Assistant of Nursing. After conducting the evaluation, the individual whom identified the suspicion, in consultation with the Nurse Manager or Administrative Assistant of Nursing will immediately notify the Florida Abuse Hotline at 1-800-962-2873. The name and badge number of the operator at the abuse hotline will be documented.
ii. The Case Management Department, or after hours, the Administrative Supervisor will be notified of the report.
iii. The Risk Manager and Administrator on Call will be notified of all calls made to the Florida Abuse Hotline.
iv. The reporting physician will be notified of the findings of the Protective Services investigation.
v. If abuse is known and protective services is involved, the patient will not be discharged until the Protective Services gives consent; if the Protective Services request that the patient not be discharged, the Case Management Department will notify the physician, the risk manager, nursing unit, and business office. Documentation will be made in the Progress Notes. If abuse is suspected but not yet proven, Protective Services must provide documentation (via fax, if necessary) before the patient can be held from discharge.

a. The Protective Services investigator, while investigating a report, will have access to, inspect and copy all medical, social and/or financial records which are relevant to the allegations of children, aged or disabled adults for the purpose of investigation of cases. Competent adults are required to authorize the release of information to the Protective Service Investigator
b. Assessment of the patient's physical, as well as emotional appearance shall be documented in the patient's medical records. (Progress Notes or Nursing Assessment Needs) Pertinent statements made by the patient or accompanying individuals, shall also be documented.
c. In any case involving suspected child abuse, abandonment or neglect**,** at the request of the Department of Children and Family Services, the hospital shall designate a staff physician to act as a liaison between the hospital and the Department of Children and Family Services office that is investigating the suspected abuse, abandonment or neglect; and the child protection team as defined in Section 39.01, Florida Statutes, when the case is referred to such a team. In the general course of business this shall be the reporting physician or the Vice President Medical Affairs in the event the reporting is unable to serve in this role.
d. Additional documentation shall include:

i. Consents from the patient, parent, or legal guardian, or compliance with other applicable law;
ii. Collecting and safeguarding evidentiary material released by the patient;
iii. Legally required notification and release of information to authorities. Including accounting of disclosure requirements for HIPAA; and
iv. Referrals made to private or public community agencies for victims of abuse.

1. Community Resources:

Abuse Hot Line (Counselor)……..1-800-962-2873

(FAX)……..1-800-914-0004

(Voice Mail)……1-800-770-0953

Child Abuse Hot Line……1-800-422-4453

Runaway Hot Line (Florida)……..1-800-786-2929

Favor House Crisis Line……1-850-434-6600

Favor House Counseling Office……1-850-434-1177

Rape Crisis Center……1-850-433-7273

REFERENCES.

Florida Statutes 741.29, 741.30, 784.046, 943.1701

JCAHO Standard PE.8

Administrative Policy I-28 Assessment of Patients

Nursing Policy>Emergency Department > Management of Sexual Assault Victims

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West Florida HEALTHCARE

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Policy Area: *Quality*
References:
Applicability: *West Florida Hospital*

Stroke Alert, I-75

PURPOSE

To identify the roles and responsibilities of care providers in the care of the patient experiencing an acute stroke.

To insure rapid evaluation and treatment of patients with new onset acute stroke.

POLICY

1. Acute stroke is a medical emergency. Treatment interventions are time sensitive requiring emergent recognition, assessment and intervention. Patients exhibiting signs and symptoms of an acute stroke will be triaged and treated with the highest level of priority to ensure that there are no avoidable delays which could result in the patient being medically ineligible for certain treatments.
2. Inpatient care of patients with a diagnosis of acute stroke will be provided in the following designated stroke units: ICU, CCU, 2 North, 4 North, 4 South, 6 North or 6 South, depending primarily on the patient's acuity and nursing care needs.
3. The National Institute of Health (NIH) Stroke Scale will be the standard neurological assessment utilized for the acute stroke patient prior to thrombolytic administration. Neurological checks will be completed as per routine or as ordered by Physician. For unresponsive, comatose patients, the Glasgow Coma Scale with pupil checks will be utilized in place of the NIH Stroke Scale.
4. Orders for diagnostic services requested during a Stroke Alert will automatically be considered STAT priority orders. Stroke Alert diagnostics (lab, radiology, CT Scan, EKG, etc.) will be completed with results available to the Physician within the following criteria:
    a. For ED Stroke Alerts
        i. CT results available within 45 minutes of patient's arrival.
        ii. Other diagnostic results available within 45 minutes of test order time.
    b. For Inpatient Stroke Alerts:
        i. All diagnostic results available within 45 minutes of test order time (including CT results).
5. The Stroke Alert Team is a multidisciplinary group with team members varying according to patient's needs and location at the time of identification of acute stroke symptoms.

PROCEDURE

STROKE ALERT: EMERGENCY DEPARTMENT (ED)

1. The following personnel will comprise the Stroke Alert Team when Stroke Alert is activated by the ED:
    a. EMT/Paramedic (if patient presents to West Florida Hospital via ambulance)
    b. PBX Operator
    c. ED Triage Nurse
    d. ED Charge Nurse/ANM/Manager
    e. ED Primary Nurse
    f. ED Physician
    g. CT Scan Technician
    h. Radiologist
    i. ED Technician / ED Unit Secretary
    j. Teleneurologist or Neurologist (on call)
    k. Nursing Supervisor
    l. Stroke Program Coordinator
2. Roles and Responsibilities:
    a. EMS (if patient presents to West Florida Hospital via ambulance)
        i. Notifies ED via radio in advance of arrival that patient with signs and symptoms of acute stroke is being transported to ED.
        ii. Provides information to ED staff about patient's time of onset of symptoms, signs and symptoms noted any changes in patient's status noted from time of identification, medications and treatments provided.
    b. ED Triage Nurse
        i. Responsible for rapid initial evaluation and identification of possible signs and symptoms of acute stroke in patient presenting for treatment.
        ii. Elicits information to determine time of onset of stroke symptoms or time patient was last seen without stroke symptoms.
        iii. Immediately places patient into the appropriate ED exam room and notifies both ED Charge Nurse and ED Physician of findings.
    c. ED Charge Nurse/ANM/Manager
        i. Assigns ED Primary Nurse to patient and monitors patient's management to ensure that there are no avoidable delays during evaluation and treatment.
        ii. Keeps Nursing Supervisor informed of patient's status and progression of medical decision related to Thrombolytic administration.
    d. ED Primary Nurse
        i. Completes initial assessment (including ABCs, vitals, neuro-checks) and history of the patient presenting with acute stroke symptoms. Verifies or determines time of onset of stroke symptoms or time patient last seen without stroke symptoms.
        ii. Initiates ED Stroke Alert order set upon notification from ED Physician.
        iii. Accompanies patient to CT scan if condition warrants.
        iv. Responsible for ongoing monitoring and assessment of the acute stroke patient, as well as documentation of nursing interventions and completion of stroke orders.

v. Calls OneStep Transfer (ext. *44734) center to initiate Teleneurology consult. Provides set up of robot (RP-Lite) and assists Teleneurologist in patient evaluation via remote presence Telemedicine.
vi. Assists the ED Physician and/or Teleneurologist with the review of the Inclusion-Exclusion Criteria for Thrombolytic therapy.
vii. Ensures Informed Consent Form has been obtained prior to Thrombolytic therapy administration.
viii. Initiates IV Thrombolytic therapy order set and follow orders upon medical decision to administer t-PA to the acute ischemic stroke patient.
ix. Initiates documentation of vitals signs and neuro-checks on Post IV t-PA Neurological Assessment Flowsheet; communicates any changes to ED physician.

e. PBX Operator
i. Activates Stroke Alert paging system to notify Lab, CT Tech, Nursing Supervisor, and Stroke Program Coordinator.
ii. Indicates location of patient and estimated time of arrival (ETA) to responsible parties being paged.
iii. Records Stroke Alert demographics in PBX log.

f. ED Physician
i. Evaluates patient promptly upon arrival to ED and determines whether to activate Stroke Alert based on patient's eligibility to receive thrombolytic therapy, endovascular and surgical treatment.
ii. Initiates ED Stroke Alert order set and any additional orders needed in the care of the acute stroke patient.
iii. Consults Tele-neurologist or Neurologist on call as available for immediate evaluation and recommendations related to the acute stroke patient treatment.
iv. If indicated, completes Inclusion-Exclusion Criteria for Thrombolytic therapy.
v. If indicated, obtains informed consent for administration of t-PA and provides education to patient and family members regarding Thrombolytic therapy and stroke treatment options.
vi. Initiates IV Thrombolytic therapy order set.
vii. In cases involving Cerebrovascular Hemorrhage, the ED Physician will follow appropriate recommendations regarding transfer. The ED Physician will coordinate care and actively communicate with the House Supervisor to ensure rapid transfer of the patient to the receiving facility.

g. Teleneurologist or Neurologist on-Call
i. Responds promptly by phone or in person upon notification of ED Stroke Alert.
ii. Collaborates with ED Physician regarding CT/diagnostic results and treatment choices.
iii. Evaluates the acute stroke patient via video conference or in person to determine patient's eligibility for Thrombolytic therapy.
iv. Confirms Inclusion-Exclusion Criteria for Thrombolytic therapy.
v. Verifies informed consent for administration of t-PA is obtained, and provides education to patient and family members regarding Thrombolytic therapy and stroke treatment options.
vi. Provides additional recommendations and/or orders regarding the acute stroke patient care and treatment.

vii. Guides Stroke Alert team to ensure appropriate and timely treatment.

h. CT Scan Technician / Radiology Technician
   i. Upon initial notification of Stroke Alert, the CT Tech ensures that the CT scanner is available for immediate scan of the patient and notifies Radiologist of pending STAT study.
   ii. Immediately notifies Radiologist of scan completion for STAT reading, and initiates appropriate steps to forward CT study to Teleneurologist as needed. CT Scan Technician ensures that CT study is completed and reported to ED Physician.
   iii. Radiology Technician ensures that chest X-ray, if ordered, is completed and reported to ED Physician.

i. Radiologist
   i. Immediately reads CT scan and verbally reports to ED Physician/APP.
   ii. Reads chest X-ray, if ordered, and reports results to ED Physician/APP.
   iii. Written report of results will follow verbal Physician-to-Physician/APP report.

j. ED Technician/ ED Unit Secretary
   i. ED Technician or ED Unit Secretary notifies the PBX Operator ext. *44111 to initiate Stroke Alert notification and calls OneStep transfer center (ext. *44734) for Teleneurology consult.
   ii. ED Technician ensures that Stroke Alert laboratory specimens are sent immediately to the clinical laboratory and facilitates prompt delivery.
   iii. ED Technician obtains baseline EKG.
   iv. Functions of the ED Technician may be performed by ED Nursing staff if technician is not available.

k. Nursing Supervisor
   i. Upon notification of ED Stroke Alert, evaluates bed status of designated Stroke Units, and formulates a plan to ensure availability of bed and staffing to care for the acute stroke patient.
   ii. Communicates with ED Charge Nurse and ED Physician to coordinate appropriate care of the acute stroke patient.
   iii. Once admission unit has been determined, assists unit's Charge Nurse to determine appropriate bed placement and nursing assignment.
   iv. In cases involving Cerebrovascular Hemorrhage, the Nursing Supervisor will actively communicate with the ED Physician and regarding treatment options for the patient.

l. Stroke Program Coordinator
   i. Assists during Stroke Alerts and provides guidance and resources to staff, patient and family.
   ii. Coordinates care of the acute stroke patients.
   iii. Analyzes education needs and facilitates patient education process during hospitalization.
   iv. Communicates with physician services regarding patient management, progress and outcome achievement.

STROKE ALERT – INPATIENT (for inpatients presenting with new onset of signs and symptoms of acute stroke)

1. The following personnel will comprise the Stroke Alert Team for events occurring "In House"
   a. Primary Nurse
   b. Charge Nurse/ANM/Manager

c. PBX Operator
d. Attending Physician
e. Tele-neurologist or Neurologist on call
f. CT Scan Technician / Radiology Technician
g. Radiologist
h. Nursing Supervisor.
i. Stroke Coordinator

2. Roles and Responsibilities
   a. Primary Nurse
      i. Identifies new acute stroke signs and symptoms in patient. Assesses ABCs, vitals and neuro checks. Determines time of onset of stroke symptoms or time patient last seen without stroke symptoms.
      ii. Immediately notifies Charge Nurse and Attending Physician of change in patient's neurological status, and activates Rapid Response Team through the PBX operator ext. *44111.
      iii. If directed by physician, the Primary Nurse initiates Internal Stroke Alert orders.
      iv. Communicates brief report to Nursing Supervisor including the following information:
         1. Reason for admission with brief history.
         2. Neurological changes noted.
         3. Time of onset of symptoms and/or time patient last observed to be without neurological changes.
      v. Accompanies patient to CT scan if requested by House Supervisor.
      vi. Elicits further orders for evaluation / treatment from Attending Physician which may include consults with Neurologist/Tele-neurologist.
      vii. Calls OneStep Transfer (ext. *44734) center to initiate Teleneurology consult. Provides assistance with setting up robot (RP-Lite) in front of patient and assist Teleneurologist in patient evaluation via remote presence Telemedicine.
   b. Charge Nurse/ANM/Manager
      i. Evaluates patient with Primary Nurse.
      ii. Ensures that Attending Physician is STAT paged and updated on patient's status.
      iii. Elicits further orders from Attending Physician. Assures call to OneStep transfer center for Teleneurology consult. After Teleneurology consult is completed, ensures that consult is documented in Meditech or faxed copy of the consult is placed in patients' medical record.
   c. PBX Operator
      i. Activates Stroke Alert paging system to notify Lab, CT Tech, Nursing Supervisor, and Stroke Program Coordinator.
      ii. Indicates location of patient (room number) to responsible parties being paged.
      iii. Records Stroke Alert demographics in PBX log.
   d. Attending Physician
      i. Evaluates ongoing information provided about patient's status and determines whether to activate Internal Stroke Alert based on patient's eligibility to receive thrombolytic therapy.
      ii. Initiate Internal Stroke Alert orders and any additional orders needed in the care of the acute stroke patient.

iii. Consults Teleneurologist or Neurologist on call as available for immediate evaluation and recommendations related to the acute stroke patient treatment.
iv. If indicated, obtains informed consent for administration of IV Thrombolytic therapy if not already done by Teleneurologist or Neurologist on call.
v. Initiates IV Thrombolytic therapy order set.
vi. In cases involving Cerebrovascular Hemorrhage, the Attending Physician will consult Neurosurgical services and follow appropriate recommendations regarding potential transfer to an outside facility in patients deemed candidates for surgical intervention. The Attending Physician will coordinate care and actively communicate with the House Supervisor to ensure rapid transfer of the patient to the receiving facility.

e. Teleneurologist or Neurologist on Call
i. Responds promptly by phone or in person upon notification of Internal Stroke Alert.
ii. Collaborates with Attending Physician regarding CT/diagnostic results and treatment choices.
iii. Evaluates the acute stroke patient via video conference or in person to determine patient's eligibility for Thrombolytic therapy.
iv. Completes Inclusion-Exclusion Criteria for Thrombolytic therapy or documents appropriate contraindications and/or reasons for decision not to administer thrombolytic therapy.
v. Obtains informed consent for administration of IV Thrombolytic therapy, and provides education to patient and family members regarding Thrombolytic therapy and stroke treatment options.
vi. Provides additional recommendations and/or orders regarding the acute stroke patient's care and treatment.
vii. Guides Stroke Alert team to ensure appropriate and timely treatment.

f. CT Scan Technician/ Radiology Technician
i. Upon initial notification of Stroke Alert, the CT Tech ensures that the CT scanner is available for immediate scan of the patient and notifies Radiologist of pending STAT study.
ii. Immediately notifies Radiologist of scan completion for STAT reading and initiates appropriate steps to forward CT study to Tele-neurologist as needed.
iii. Radiology Tech ensures that chest X-ray, if ordered, is completed.

g. Radiologist
i. Immediately reads CT scan and verbally reports to Attending Physician/APP.
ii. Reads chest X-ray, if ordered, and reports to Attending Physician/APP.
iii. Written report of results will follow verbal Physician-to-Physician/APP report.

h. Nursing Supervisor
i. Responds to patient's bedside.
ii. Evaluates patient's neurological status with the Primary Nurse.
iii. Assists with the communication of findings regarding patient's neurological status to Attending Physician, and elicits further orders.
iv. Arranges patient's transport to CT if patient's condition warrants.
v. Evaluates bed status of designated stroke units, and formulates a plan to ensure availability of bed and staffing to care for the acute stroke patient.
vi. Once transfer unit has been determined, assists unit's Charge Nurse to determine appropriate bed placement and nursing assignment.

vii. Assures call to OneStep transfer center for Teleneurology consult. After Teleneurology consult is completed, ensures that consult is documented in Meditech or faxed copy of the consult is placed in patients' medical record.
viii. Ensures completion of baseline NIH stroke scale prior to thrombolytic administration.
ix. In cases involving Cerebrovascular Hemorrhage, the Nursing Supervisor will actively communicate with the Attending Physician regarding treatment options for the patient. If patient transfer is ordered, the Nursing Supervisor will facilitate and help coordinate rapid transfer of the patient to the receiving facility.

i. Stroke Coordinator
  i. Assists during Stroke Alerts provide guidance and resource to staff, patient and family.
  ii. Coordinates care of the acute stroke patients
  iii. Analyzes education needs and facilitates patient education process during hospitalization.
  iv. Communicates with physician services regarding patient management, progress and outcome achievement.

STROKE ALERT – OUTPATIENTS (for outpatients being seen in any department other than ED)

1. Outpatients identified as exhibiting new onset of signs and symptoms of acute stroke will be taken immediately to the Emergency Department.
2. Emergency Department will initiate evaluation, treatment and "Stroke Alert" procedure as appropriate.

MANAGEMENT OF STROKE PATIENT

1. Stroke order sets will be initiated upon Physician order.
2. The Stroke Program Coordinator will monitor stroke patient's and stroke program's outcomes as defined by West Florida Hospital's Stroke Plan.

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6/1/2016, 11/27/2013, 4/19/2011, 3/16/2010, 1/20/2009, 10/16/2007, 3/21/2006, 1/24/2004

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Owner:	*Denise Moland: ACNO*
Policy Area:	*Nursing Services*
References:	*Plan*
Applicability:	*West Florida Hospital*

Chest Pain Center Plan, I - 82

SCOPE:

The Chest Pain Center Plan activities are directed at patients, employees, medical staff members, contract services workers, volunteers, students and visitors.

West Florida Hospital is a 515 bed organization located in Pensacola, Florida. The primary service area includes a population of approximately 360,000 in Escambia and Santa Rosa counties, Florida with a secondary service area of Okaloosa and Walton counties, Florida and Baldwin and Escambia counties, Alabama. The facility employs approximately 1,200 personnel. The complexity of services provided include Behavioral Health, Cancer Group, Family Birthplace, Heart Center, Joint Replacement, Memory Disorders Clinic, Neuroscience, Orthopedics, Pavilion, Psychiatry/Psychology, Rehabilitation Institute, Senior Health Services, Sleep Disorders Center, Sports Medicine, Wellness Center and a full service Emergency Department. Outpatient services include Radiology and Laboratory.

Physician offices (on and off campus), nursing home admissions, and community admissions support the patient population. The community consists primarily of Americans plus other ethnic and foreign-born individuals. Hispanic and Vietnamese populations are increasing in number.

GOALS OF CHEST PAIN CENTER PROGRAM:

The goals of the Program are:

1. Improve the care for patients with symptoms of Acute Coronary Syndrome.
2. Provide timely access, diagnosis and treatment to individuals experiencing symptoms of acute coronary syndromes in the emergent setting.
3. Plan and organize the delivery of care in a systematic manner conducive to the process improvement and patient safety approach.
4. Demonstrate continuous improvement in the care of the ACS patient through process improvement.
5. Provide state of the art diagnostic capabilities.
6. Provide evidence-based protocols for the treatment of ACS patients.
7. Review charts of patients who did not meet defined goals for reperfusion.
8. Achieve superior outcomes in a compassionate environment throughout the continuum of care.

9. Promote increased community awareness, response and health promotion though educational efforts.
10. Maintain staff competency through ongoing education.
11. Foster an integrated relationship with EMS.

RESPONSIBILITY:

Responsibility for expedient identification and management of the patient with chest pain extends to all staff throughout the organization.

Responsibility for optimum care for patients who are treated in the hospital rests with the Governing Board. The specific responsibility for chest pain guidelines is delegated to the Medical Staff, which acknowledges its responsibility for the same in accordance with the Medical Staff Bylaws, as approved by the Governing Board.

Hospital Administration is responsible for provision of adequate support as needed to the Chest Pain Center Program to accomplish its goals and objectives.

A Medical Director is designated by Hospital Administration who provides medical supervision of the Chest Pain Center Program.

The Chest Pain Center Coordinator is responsible for the coordination of the Program.

West Florida Hospital and the Medical Staff have committed that Percutaneous Coronary Intervention is the reperfusion strategy of first choice in the management of a patient experiencing an acute ST Elevated MI.

SCOPE OF SERVICE:

1. Major departments/services participating in the Chest Pain Center:
    1. Medical Staff
    2. Nursing
    3. Education – Medical staff, hospital staff, patients, pre-hospital providers, and Community.
    4. Laboratory
    5. Diagnostic Imaging
    6. Cardiovascular lab
    7. Nuclear cardiology
    8. Quality Improvement
2. Primary sites where care of the ACS patient is delivered:
    1. ED
    2. CVL
    3. CCU
    4. 4S (progressive care)
    5. 2N (progressive care)
    6. ICU
    7. 4N (Remote)
    8. Nuclear Cardiology
    9. 5 South

CHEST PAIN CENTER COMMITTEE

Purpose:

The Chest Pain Center Committee's purpose is to identify ongoing opportunities for improvement with the West Florida Hospital Chest Pain Center Program. This program is comprehensive and based on the processes and activities, in both direct patient care and support services that are critical to the success of the program.

Responsibility:

1. Selection of Clinical Practice Guidelines (CPG), from current reputable sources such as medical specialty associations (American College of Cardiology, American College of Emergency Physicians), relevant professional societies (Society of Chest Pain Centers), public or private organizations (American Heart Association), government agencies or health care plans (Core Measures), to guide the management of patients with chest pain.
2. Review Clinical Practice Guidelines annually or when significant changes in the field occur to ensure their appropriateness.
3. Implementation of these CPG's within the hospital.
4. Ensure ongoing in-services and other education and training activities relevant to the Program's needs and CPG's to practitioners and other appropriate health care givers.
5. Recommend and approve appropriate policies and procedures that relate to patients with chest pain.
6. Ensure Performance Improvement is well designed and planned to allow for the collection of relevant data, and the analysis of current performance. Based on findings and input received from participants in the program recommended actions are implemented.
7. Data related to processes and/or outcomes of care are collected for the individual participant.
8. The Chest pain Center Medical Director and Chest Pain Center Coordinator will participate in strategic planning related to Chest Pain Center initiatives.
9. The Senior Management Chest Pain Center representatives have responsibility for the oversight of the CPC committee meetings.

Structure and Membership:

A. Membership of the Chest Pain Committee shall be multi-skilled and multi-disciplinary and shall include at a minimum:
    1. Medical Director of the Chest Pain Center Program.
    2. Chest Pain Center Coordinator
    3. Medical Staff representation from the departments of Emergency Medicine and Hospitalists.
    4. Senior Vice President for Medical Affairs
    5. Sr. Vice President of Patient Care Services
    6. Nursing Representation from the Emergency Department, Critical Care, Progressive Care, General Medical Care, and Cardiovascular Lab
    7. Quality Improvement Representative
    8. Ancillary Providers relevant to chest pain patients, such as Laboratory, Diagnostic Imaging, Nuclear Cardiology, and Cardiovascular Lab.

B. Other membership may be added on a permanent or ad hoc basis at the discretion of the Committee Chairperson to best meet the goals and responsibilities of the Committee.

Meetings and Reporting:

A. The Chest Pain Center Committee shall meet at least quarterly and shall report their recommendations and activities to the Senior Management Team meeting, Cardiology Operations Committee, Emergency Department Leadership Committee, Quality Coordinating Committee, Medical Executive Committee and the Board of Trustees via the attendance of the Committee chairperson or representation by the Sr. Vice Presidents and Medical Staff on the committee.

EDUCATION:

Professional Development

Hospital personnel are provided cardiac education related to their job specific requirements. Department leadership may also determine additional educational requirements based on outcome measurements and protocol recommendations. Mechanisms of obtaining cardiac related education include: Inservices; Continuing Education; Computer Based Learning and Webcasts. Staff **is** required to provide evidence of compliance upon request or at time of evaluation.

Physicians

All Providers involved in the care of the ACS patient will be appropriately credentialed per the hospital bylaws. Interventional cardiologists who perform PCI undergo a formal credentialing process.

Chest Pain Center Medical Director
The CPC Medical Director will have a minimum of 20 hours of CME hours in cardiac topics in the previous three years.

Chest Pain Center Coordinator
The CPC Coordinator will have a minimum of 20 contact hours annually in ACS or chest pain education in the past three years.

Nurses caring for patients with ACS symptoms (ED, CVL, CCU, ICU, Progressive Care).
Nurses in these areas will have annual education, competencies, or training related to ACS that will include information such as identifying major dysrhythmias, obtaining a 12-lead EKG, education on gender and age-related differences in the symptoms of ACS, and co-morbidities.

All ED nurses who have potential to triage have successfully completed formal triage training related to the ACS patients, including atypical symptoms and receive annual updates.

All nurses will complete annual educational opportunity, competency, or training in the care of the ACS patient.

Allied health personnel who care for the ACS patient will complete annual educational opportunity, competency, or training in the care of the ACS patient.

All employees complete annual education on EHAC, signs and symptoms, early recognition and prevention of ACS.

Physicians will be offered education on signs and symptoms of ACS and early recognition of heart disease on an annual basis.

Pre-hospital Providers (dispatchers, EMT's and Paramedics) will be given the opportunity to participate in education offered on the WFH campus. Special educational offerings may be provided at the agencies of Escambia County EMS and Lifeguard Ambulance Services based on the needs of the agency. Allow opportunities for WFH physicians and staff to participate in EMS ride-alongs.

Community Education

West Florida Hospital offers community education on Early Heart Attach Care (EHAC) and the signs and symptoms of ACS in a variety of ways. BCLS, First Aid, Heart Saver Courses, and Seminars are some examples of the training provided.

CHEST PAIN CENTER PERFORMANCE IMPROVEMENT PLAN:

West Florida Hospital tracks ongoing performance indicators of the ACS patients through monitoring of metrics in the following performance measures:

1. Onset of Patient's symptoms to first EKG with a goal of a documenting a reduction in time. This is reflective of community education, as well as uncontrollable factors such as patient proximity to the hospital.
2. Door to initial EKG time **with a goal of 5 minutes**.
3. Door to physician interpretation of the EKG time **with a goal of 10 minutes**.
4. AMI Core measure outcomes with a goal of 100%.
5. Door to biomarker result with a goal of **door to result time of 60 minutes**.
6. Door to reperfusion time for all STEMI patients, including transfers and **with a goal of 60 minutes.**

The metrics are analyzed to modify processes so that there will be continuous improvement in the care of the ACS patient. The performance measures will be evaluated annually to ensure monitoring of the indicators which have the highest impact on improvement of patient.

The metrics provide the opportunity to give individual feedback to medical practitioners about their specific performance – both areas to improve and areas of high achievement.

EMERGENCY MEDICAL SERVICES

West Florida Hospital resides in the Northeast portion of Escambia County Florida and serves as a referral center for the surrounding counties of nearby Santa Rosa, and the more distant Walton, and Okaloosa. West Florida Hospital receives the majority of EMS patients by ground, primarily from Escambia County EMS, and secondarily from Lifeguard Ambulance Services in Santa Rosa County. A small percentage of patients, usually interfacility transfers, are transported by ground from Walton County EMS and Okaloosa County EMS. WFH received patients by air from LifeFlight and Lifeguard 1. All ground services employee both licensed EMT's and Paramedics. The helicopters employee Flight Nurses, as well. The dispatchers for Escambia County are housed at the Escambia County Communications Center, located at the Escambia County Emergency Operations Center. The dispatchers

for Lifeguard are located at the Santa Rosa County Communications Center located in the Santa Rosa County Emergency Operations Center. Dispatchers are required to have CPR and Emergency Dispatching Certification.

WFH recognizes that pre-hospital care provided by EMS is an extension of the care given to the Acute Coronary Syndrome patient. Therefore, West Florida Hospital will establish and maintain a formal relationship with local EMS providers for the purpose of ongoing improvement to the care of the ACS patient. West Florida Hospital participates regularly in District 1 EMS Advisory Council which meets every other month. District 1 membership consists of pre-hospital representatives from Escambia, Lifeguard, LifeFlight, Air Methods, Walton, and Okaloosa EMS providers, as well as the WFH Emergency Department Medical and Nursing Director and the Chest Pain Center Coordinator and EMS Liaison. Regular agenda items include education, transfer issues, STEMI Alerts, and Stroke Alerts. Any scheduled meetings at Escambia EMS or Lifeguard will have representation from WFH.

WFH has a designated EMS liaison who will collaborate with EMS to create a working relationship that promotes activities that improve the care of the ACS patient. These activities may include performance improvement measure and educational offerings for both EMS personnel and the community.

WFH collaborates with EMS to provide educational offerings to the pre-hospital providers, including dispatchers, EMT's and Paramedics. Joint educational offerings include the opportunities for pre-hospital staff to participate in educational classes on the WFH campus at a free or reduced cost. This includes monthly classes such as BCLS, ACLS, cardiac and stroke specific education, as well as special speaker presentations. All the pre-hospital providers and Pensacola State College Paramedic students have the opportunity to observe in the cardiac catheterization laboratory. In some cases WFH will provide education to the dispatchers, EMT's and Paramedics at their own facilities. The specific needs of the dispatchers, EMT's and Paramedics identified through performance improvement measure and quality assurance will be taken into consideration when planning special education offerings. For example, areas that can not transmit a pre-hospital 12 lead EKG may be offered additional training in the interpretation of 12 lead EKG'S. The EMS Liaison will coordinate these collaborative efforts via communications with the training coordinators and instructors at the agencies and by postings in the WFH EMS lounge.

The WFH Chest Pain Center Coordinator and EMS Liaison will implement processes that facilitate appropriate hand off communications and continuum of care from the pre-hospital environment into the hospital environment. Collaboration will occur between WFH and both Escambia County EMS and Lifeguard Ambulance Service for the purpose of Process improvement. This will be accomplished by case reviews to identify both successful runs and opportunities for improvement, sharing of metrics related to time of symptom onset, time 911 call placed, time of first EKG, time to arrival at WFH and time to reperfusion. The pre-hospital providers with successful run times will be given recognition by posting of their names in the WFH EMS lounge and notification to their Supervisors and Medical Director. The EMS Liaison will bring opportunities for improvement to the attention of the agency's Supervisor and Medical Director and collaboratively develop plans of action to address the opportunities for improvement.

West Florida Hospital will collaborate with EMS to offer community education classes and enhance knowledge of early heart attach care and signs and symptoms of Acute Coronary Syndrome. WFH will provide teaching materials, such as postcards and flyers, to support the community education.

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Current Status: *Active* **PolicyStat ID:** *3610162*

West Florida HEALTHCARE

Effective:	*3/1/2012*
Approved:	*7/5/2017*
Next Review:	*7/5/2018*
Owner:	*Alexa Seely: Sepsis Coordinator*
Policy Area:	*Quality*
References:	*Policy*
Applicability:	*West Florida Hospital*

Sepsis Alert, 21

SCOPE

All licensed personnel who have received training and able to demonstrate competency in the early recognition and management of sepsis.

POLICY

Severe Sepsis and Septic Shock are medical emergencies. Early recognition and implementation of evidence based practices decrease morbidity and mortality in patients with sepsis.

PURPOSE

A. To establish a uniform and consistent guideline for early identification and clinical management of Severe Sepsis and Septic Shock utilizing evidence based practice treatment guidelines. Treatment guidelines follow recommendations from the 2012 Surviving Sepsis Campaign, a group composed from the Society for Critical Care Medicine and the European Society of Intensive Care Medicine.
B. To identify patients who are experiencing severe sepsis or septic shock and intervene in a timely manner according to best practices.
C. To identify the roles and responsibilities of providers in the care of patients experiencing symptoms of severe sepsis or septic shock.

Definitions

A. SIRS- Systemic Inflammatory Response Syndrome (2 of the following 4 characteristics): Temperature > 38°C (100.4°F) or < 36°C (96.8°F), Heart Rate > 90 beats/minute, Respiratory Rate > 20 breaths/minute, and White Blood Cells > 12,000 K/mm3 or < 4,000 K/mm3 or > 10% Bands.
B. Sepsis: Any 2 positive SIRS criteria with a suspected or confirmed infection.
C. Severe Sepsis: (Sepsis with acute organ dysfunction) Organ dysfunction may include, but not limited to, lactic acidosis (Lactic acid > 2 mmol/L), hypotension (SBP < 90 or MAP < 65), deterioration in renal function (creatinine > 2 mg/dL or urine output < 0.5 ml/kg/hour for 2 hours), increase in oxygen demand

(ventilator or BiPap), decline in platelet count (< 100 K/mm3), increase in INR > 1.5, increase PTT (> 60 sec), high bilirubin (>2 mg/dL), or acute alteration in mental status.

D. Septic Shock: Severe sepsis with persistent tissue hypoperfusion or refractory hypotension after fluid resuscitation.

E. Rapid Response Team: A team of qualified clinicians that respond to a perceived change or deterioration of the patient's condition.
   1. Primary nurse: Provide patient history and clinical condition and obtain orders for the sepsis bundle.
   2. Unit charge nurse: Perform interventions as ordered by provider and ensure sepsis bundle is initiated.
   3. Critical care RN: Assist with assessment, administer interventions as ordered by provider, assist with transfer to higher level of care if needed, and ensure sepsis bundle is initiated.
   4. House supervisor: If clinically indicated, will notify the Critical Care Unit of the bed assignment, assist with provider communication and ensure sepsis bundle is completed.
   5. Respiratory therapy: Assist with airway management and obtain arterial blood gas per provider order.
   6. Provider: Will be contacted and respond if available. If responds, provider will assume patient assessment and care. Expedite sepsis bundle orders.

F. Severe Sepsis Presentation Time: Initial recognition time of severe sepsis. The time is based on signs, symptoms, laboratory results that are consistent with the above definitions of severe sepsis/septic shock.

G. Sepsis Alert: Identifies patients that are candidates for the sepsis bundle. Sepsis Alert may be identified via utilization of a sepsis order set, a sepsis alert order, rapid response, or positive nursing sepsis screen.

H. Sepsis Screen: An electronic nursing documentation tool utilized in the ED and In-hospital units to assist with the early identification of sepsis.

I. Broad spectrum antibiotics:
   1. Monotherapy: Meropenem, Ceftriaxone, Cefepime, Levofloxacin, Ampicillin/sulbactam, Piperacillin/tazobactam
   2. Combination Therapy: One of these three: Gentamicin/Tobramycin OR Aztreonam OR Ciprofloxacin Plus One of these: Cefazolin OR Clindamycin OR Vancomycin OR Azithromycin OR Ampicillin

PROCEDURE

West Florida Hospital will utilize the activation of a Rapid Response/Sepsis Alert for all patients who present with acute signs and symptoms of severe sepsis.

A. **Sepsis Alerts for Emergency Department Patients:**
   1. All patients in the ED will be assessed upon arrival, reassessed prior to admission, or when a change in vital signs occur that reflect a positive Systemic Inflammatory Response Syndrome (SIRS), Sepsis, Severe Sepsis and Septic Shock.
   2. The Emergency Room Provider will be notified when the patient has screened positive for severe sepsis.
   3. ED nurse will request to initiate sepsis orders.
   4. Positive Sepsis Screens are reflected on the ED tracker.

B. **Sepsis Alerts for In-hospital Patient (Outside of Critical Care)**:
   1. Sepsis Screens are performed on all patients upon admission to unit, every shift and upon any deterioration in patient's condition.
   2. The Attending Provider will be notified when the patient has screened positive for severe sepsis.
   3. If patient is not in a critical care unit and screens positive for severe sepsis with systolic BP <90 or MAP <65 or pH < 7.3 or Lactic acid ≥ 4 mmol/L, a Rapid Response/Sepsis Alert will be initiated.
   4. Primary care nurse will request to initiate sepsis orders.

C. **Sepsis Alerts for Critical Care Patients**
   1. Sepsis Screens are performed on all patients upon admission to unit, every shift and upon any deterioration in patient's condition.
   2. The patient's Attending Provider will be notified when the patient has screened positive for severe sepsis.
   3. Primary care nurse will request to initiate sepsis orders.

Expected Treatment (Sepsis Bundle)

A. **TO BE COMPLETED WITHIN 3 HOURS** of positive severe sepsis screening.
   - Measure stat lactic acid level
   - Obtain stat blood cultures (prior to administration of antibiotics). Do not delay antibiotic therapy greater than 45 minutes.
   - Administer stat source specific or broad spectrum antibiotics
   - Administer 30ml/kg crystalloid fluid for hypotension (SBP <90 or MAP <65) or lactic acid ≥ 4 mmol/L

B. **TO BE COMPLETED WITHIN 6 HOURS** of positive severe sepsis screening.
   - Re-Measure lactic acid if initial lactic acid was ≥ 2 mmol/L
   - Apply vasopressors (for hypotension that does not respond to initial 30 ml/kg fluid resuscitation) to maintain a mean arterial pressure (MAP) ≥ 65 mm Hg
   - A Physician or Licensed Independent Practitioner will perform a Volume & Tissue Perfusion Assessment if the patient has persistent hypotension following the 30 ml/kg crystalloid fluid bolus or an initial lactic acid of ≥ 4 mmol/L.The assessment must include the review of Complete Vitals (temperatures, heart rate, respiratory rate, and blood pressures), and Cardiopulmonary Exam, and Capillary Refill, and Peripheral Pulses, and Skin Color Exam. Documentation of sepsis focused exam performed indicates that a complete perfusion assessment was completed.

Goals of Treatment

- Maintain Mean Arterial Pressure (MAP) ≥ 65 mm Hg
- Identify and control source of infection
- Maintain urine output ≥ 0.5 ml/kg/hr

Resources

A. West Florida Hospital Intranet- Online Documentation- Sepsis Folder
    1. Sepsis Education
    2. Sepsis Bundle card
    3. Clinical Practice Guidelines
    4. Performance Improvement Goals and Objectives
    5. Sepsis Program Core Team
B. Rapid Response Team Record/Protocol Order (Form No. 854915)
C. Rapid Response Team (RRT) Policy, 23
D. Order Sets
    1. Ped Infant Fever R/O Sepsis
    2. Ped Child Fever R/O Sepsis
    3. Newborn Sepsis
    4. Sepsis Orders
    5. Sepsis ED Treatment
    6. Sepsis Mini Protocol Meds

References

2012 Surviving Sepsis Campaign

All revision dates: 7/5/2017, 11/1/2014, 11/27/2013

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West Florida Hospital Telemetry Policy

Purpose:

To provide a safe, consistent process to ensure continuous cardiac monitoring and documentation guidelines for patients on telemetry at West Florida Hospital.

Scope:

This is a Hospital-Wide policy and applies to all patient areas that are monitored by the Centralized Monitoring Unit (CMU).

Policy:

Continuous cardiac monitoring is available 24 hours a day, 7 days a week, based on physician order for telemetry. Interpretation of cardiac monitoring is the responsibility of licensed nursing professionals. The RN may be assisted by personnel who have completed an approved telemetry/EKG interpretation class to include initial and annual competency.

It is ultimately the nurse's responsibility to ensure that the patient is being appropriately monitored at all times. There should be **minimal** delays in responding to Monitor Technician requests to assess the patient for rhythm changes, or troubleshoot for “leads off” and “replace battery”.

Patients with a continuous telemetry order require IV access unless otherwise ordered.

Procedure:

The responsibilities of the **Registered Nurse** include:

- Ensure the initiation of cardiac monitoring when ordered. Telemetry box should be placed on patient within 30 minutes of order being placed.
- Perform ongoing patient assessment and monitoring.
- Every 12 hours the RN will review and verify the rhythm strip sent by the CMU and will sign the strip with date/time prior to the end of the shift. This information will be used to complete a safe handoff to the oncoming shift.
- If the RN taking care of the patient does not have the required competency to validate rhythm strips, the Assistant Nurse Manager or Charge Nurse of that unit will verify the shift strip and sign as above.
- Each Assistant Nurse Manager and Charge Nurse will be trained in rhythm interpretation.
- Regular documentation regarding patient's rhythm, rate, and/or dysrhythmia~~s~~, will be documented each shift in Meditech by the RN.

- The RN will communicate the patient's rhythm to the Physician during rounding, communicating any rhythm changes and any arrhythmia requiring immediate assessment and intervention. This communication will be documented in Meditech.
- The RN will notify the Monitor Tech of patient change of condition: chest pain, shortness of breath, for placement or removal of cardiac drip, dizziness or palpitations.
- The RN will notify the Monitor Technician presence of pacemaker, AICD, or any history of arrhythmia
- The RN or designee will notify the Monitor Technician when patient will be coming off the monitor for bathing (if ordered by physician), when being transported for procedures or testing, or if they are being discharged.

The responsibilities of the **Monitor Technician** include:

- Initiates cardiac monitoring of the patient, assuring alarms are on.
- Performs baseline admission and ongoing continuous cardiac monitoring of the patient on telemetry.
- Record rhythm strips every 12 hours or with any rhythm change or reported change in patient condition.
- Communicates to the primary nurse changes in patient's rhythm or parameters, when patients are off monitor, or when batteries need to be replaced.
- Utilizes the Telemetry Log for all communications and notifications.
- Observes and reports equipment issues.
- Completes shift handoff report.
- Completes Telemetry Event Assessment and Debriefing when correct procedure for patient monitoring is not performed. The Manager will be given this form to follow up with involved parties.

MONITORING INITIATION GUIDELINES:

When Telemetry is ordered by a physician each nursing unit will notify the CMU by faxing a face sheet. This is done by the HUC, RN, Charge Nurse or designee.

Telemetry must be ordered by the physician and the continued need for telemetry monitoring should be evaluated each day by the physician and/or designee for appropriateness. Physicians will order telemetry according to criteria of levels 1-3 as indicated in CPOE.

Class 1: Telemetry indicated (must be renewed in 72 hours)
Class 2: Telemetry reasonable (must be renewed in 48 hours)
Class 3: Telemetry reasonable (must be renewed in 24 hours)

When placing a patient on remote telemetry, the following process will be followed:

1) the person placing the monitor will call the CMU **from the bedside** to verify two patient identifiers as well as the monitor number to ensure the right monitor is placed on the right patient.
2) Final verification is performed by pressing the *button on the box which communicates to the Monitor Technician that the right patient is paired to the correct telemetry box.

CONTINUOUS MONITORING GUIDELINES:

Continuous cardiac monitoring will be maintained without interruption except for the following:

- Changing telemetry transmitter when needed
- Changing electrodes, leads, and batteries

A **physician order must be obtained** to interrupt monitoring for any other reason. (Including showers-, which should be limited to 15 minutes.

Each unit will fax a phone list to the CMU with nursing Cisco phone numbers within the first 30 minutes of shift change.

- The Monitor Technician will enter the Cisco phone assignments into the Emergin Orchestrator once the fax is received. This will enable the automatic forwarding of all patient alarms to that corresponding RN's room assignment.

Process for notification of issues:

1) If the Monitor Technician has loss of signal for a patient, they will call the patients RN.
2) If the RN does not respond or is unable to find someone to respond for them **within 5 minutes,** the Monitor Technician will call the Charge Nurse to rectify the issue.
3) If the Charge Nurse is unable to rectify the issue within **another 5 minutes**, the Monitor Technician will call the Unit Manager (business hours) or the House Supervisor.
4) If signal has not been restored within 20 **minutes,** the Monitor Technician will call a Rapid Response to the patient's room.

CRITICAL EVENTS MONITORING GUIDELINES:

When the patient's RN receives a critical alarm on their Cisco phone, they will immediately go to the patient's room and initiate the appropriate response.

The CMU staff will also call the patient's RN to notify them using the terminology "critical rhythm event"

A critical event is defined as:

1. ST elevation
2. New onset Atrial Fib or SVT
3. Increasing or frequent bursts of Atrial Fib or SVT
4. Complete Heart Block
5. New onset bradycardia

The RN or Charge Nurse should call CMU to state that they are in the patient's room evaluating the event.

If the event continues for greater than 1 minute without this call, the Monitor Technician will **call a Rapid Response**.

LETHAL EVENTS MONITORING GUIDELINES:

If a Patient Experiences a Lethal Event, a call will be placed to the Charge Nurse to respond to the patient room and then they will call a Rapid Response. Lethal Events include:

1. Asystole
2. Ventricular fibrillation
3. Ventricular tachycardia.

Monitor Technician process for Notification of Events:

1) The CMU Technician will document all escalations on the communication log.
2) For emergent arrhythmias or when unable to determine if rhythm is possibly lethal:
   - The Monitor Technician will follow the chain of command escalation protocol for nursing notification.
   - If patient is having a test, the Monitor Technician will notify the appropriate area of the hospital and the nurse will assess the patient and determines whether a Rapid Response or Code 3 is indicated.

Patient Transport Guidelines:

1) Patient transport will notify the nurse and CMU of destination when transporting patient is off the unit.
2) Transport will document on log sheet the patient's destination location.
3) When patient arrives to destination, the receiving responsible party will call CMU (*44455) for handoff communication, verifying assumption of monitoring.
4) CMU will be notified prior to removing monitoring equipment if patient is put on hardwire monitoring.
5) Prior to leaving diagnostic/procedural area, the patient will be placed back on telemetry transmitter. CMU will be contacted for patient validation using two patient identifiers

for the right patient, right monitor and rhythm clarity.

6) Upon return, to patient's room, patient transport will notify the nurse and CMU of the patient's return and document on log sheet.
7) Patients being transported to a higher level of care or who are considered unstable will be placed on a monitor and will be accompanied by an ACLS certified RN.

DOCUMENTATION & COMMUNICATION GUIDELINES:

Monitor Technician will document as follows for the patient medical record:

1) Routine rhythm analysis, which includes ventricular rate, electronic caliper measurement of PR interval and QRS interval, and rhythm interpretation.
2) Rhythm strips will be printed on admission, every 12 hours at 0300 and 1500, and at discharge. There is an hour window of time for completion of rhythm strips.
3) These strips will be delivered to the respective floors at 0500 and 1700.
4) They will be verified by an RN, signed with the time and date and placed in the patient chart. RN will use this information at shift handoff.

RHYTHM STRIP/EVENT STRIP GUIDELINES:

A rhythm strip will be obtained for any rhythm change from baseline, change in patient status, administration of IV cardiac medications, or upon request.
The Monitor Technician will record the name of the nurse was notified and the time of notification on the communication telemetry log.

A Critical Event Strip printout will be obtained for the medical record to document the following:

- Specific interventions and responses/ patient symptoms and vital signs.
- Administration of medications potentially affecting cardiac rhythm
- Critical and Lethal events, as described previously
- Any Rapid Response/Code 3 events occurring on monitored patients.

The Critical Event rhythm strips will be faxed as soon as possible to nursing units. The Monitor Technician will call the Charge Nurse to notify them of a pending event strip faxed.

Within 15 minutes of any event the telemetry trained RN or Charge Nurse will assess the patient, and notify the physician of patient condition. The RN will sign, date and time the event strip and place in the patient's chart. The RN will document in Meditech the event, intervention and time that the communication to the physician occurred.

PROCEDURE FOR TELEMETRY DOWNTIME:

If telemetry capability should become unavailable, the following should take place:

- The Monitor Technician will call the GE 24-hour hotline immediately to begin troubleshooting the issue.

- The Monitor Technician will notify the Units affected and their Managers or designees, and House Supervisor
- Cardiac Patients will be prioritized for placement on bedside monitors based on patient's risk for cardiac arrhythmias.
- Patients identified as low risk for cardiac arrhythmias will have close observation and nursing care.
- Back up monitors not in use by other departments are to be sent to the affected unit
- High risk patients will be considered for transfer to a higher level of care

If Emergin capability should become unavailable, the following should take place:

The Monitor Technician will call "IT&S Service Desk" (*43500) to report Emergin system failure and request High Priority status.

The Monitor Technician will notify all units affected, mangers or designees, and House Supervisor that the system is disabled.

For all issues identified, the Monitor Technician will call the assigned nurse following the "Process for notification of issues" with escalation as appropriate.

Placement and Discontinuation by CNA's:

- The CNA who is trained may prepare the patient's skin for telemetry, apply the electrodes, attach the transmitter, and change the battery.
- If placing the transmitter to the patient the trained CAN may follow the same verification procedure that the RN does as stated earlier in this policy.
- The CNA can discontinue telemetry under direction of the RN. The transmitter must be cleaned when DC'd with the recommended bactericidal solution

PROCEDURE FOR DISCONTINUATION OF TELEMETRY

- The Monitor Technician will review daily 0800 and 2000 assessing patient criteria to be considered for telemetry discontinuation.
- The House Supervisor will notify the nursing unit's Nurse Manager or designee of patients that may meet discontinuation criteria.
- The patient's nurse will contact the ordering physician to review cardiac status and request consideration of an order for telemetry discontinuation.
- The Chain of Command will be utilized as necessary for the Nursing Directors to escalate needs for telemetry discontinuation to the Chief Medical Officer.

TRIAGE of NEED FOR TELEMETRY

At times, all remote telemetry boxes are in use. During this time a need to "triage" all patients

for necessity to continuing monitoring should occur. If the following criteria has been met, the patient may be considered for telemetry discontinuation:

- Low risk for cardiac arrhythmias or non-cardiac patients.
- Chest pain free for twenty-four hours.
- Arrhythmia-free for twenty-four hours.
- Twenty-four hours post pacemaker or internal cardiac defibrillator (ICD) placement.
- Seventy-two hours post MI if uncomplicated MI.
- Patients who are medically stable and no longer at risk for dysrhythmias.

PROCESS FOR TELEMETRY TRANSMITTER REMOVAL:

When the CMU receives notification of physician's order to discontinue telemetry, the Monitor Technician will run a discontinuation rhythm strip.

1. The Monitor Technician will discontinue monitoring the patient.
2. The nurse or designee disconnects the telemetry transmitter from the patient and removes electrodes.
3. The nurse or designee will clean the telemetry transmitter and leads with the recommended bactericidal solution.
4. The nurse or designee returns the telemetry transmitter to the CMU as appropriate.

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West Florida HEALTHCARE

Effective:	*7/15/1994*
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Next Review:	*3/7/2018*
Owner:	*Margie Campbell: CVICU Di*
Policy Area:	*Nursing Services*
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Codes, I-23

Please Note: Some sections have changed from alpha letters to numbers

SCOPE:

All personnel in the acute care hospital, Pavilion, Rehabilitation Center, Ancillary Building, Medical Center Clinic, and all hospital grounds.

PURPOSE:

To define and clarify all emergency codes for the facility.

POLICIES:

I. **ANNOUNCED CODES**: These codes will be announced by overhead page and beeper notification.

A. ***"Rapid Response Team"*** is to bring critical care expertise to the bedside before a crisis situation develops.

Purpose: The purpose of a Rapid Response Team is to bring critical care expertise to the bedside before a crisis situation develops

Activation:

1. In addition to notifying the patient's physician of the acute change in patient status, the RRT can be activated by the staff nurse after collaboration with the charge nurse.
2. Call 411 to overhead page "Rapid Response Team" to the unit.
3. Initiate the RRT record, found on the crash carts.

Team Members:

The Rapid Response Team is composed of the House Supervisor, a critical care nurse, a respiratory therapist and the patient's primary or charge nurse.

Examples to Activate the Rapid Response Team

4. Acute change in heart rate or blood pressure
5. Sudden respiratory distress

6. Acute alteration in neurological status
7. New or prolonged seizures
8. Severe/crushing chest pain

(For complete policy/procedure see Policy #8 – WFH Nursing Policies, Section 1, Nursing Services, #23 Rapid Response Team).

B. ***"Code 3/Code Blue/Pediatric"*** is an emergency communication alerting trained personnel that a respiratory and/or cardiac arrest has been recognized and that cardiopulmonary resuscitation (CPR) has been initiated.

1. Critical Care Emergency Protocol will be in effect. The nurse may conduct the code up to his/her level of preparation and job description in the absence of the physician.
2. The nurse in charge will assure that the attending (and consulting) physicians are notified immediately of a patient coding.
3. In the absence of a physician, an ACLS R.N. will run the code.
4. Defibrillation may be performed by a Physician or a qualified R.N.
5. In the Rehabilitation Institute, personnel from OT and PT will provide the crash cart for codes that occur in the First Floor of Rehab, up to the location of the Chapel. Rehabilitation personnel will be at the door to direct those individuals who respond to the code to the correct treatment areas. During Therapy Department operational hours (8:00 a.m. through 4:30 p.m., Monday through Friday, excluding holidays) the PT/OT Staff will be responsible for bringing the crash cart to any Code 3 on the First Floor of Rehab, up to the location of the Chapel. Staff should notify the appropriate nursing unit to obtain the patient's chart. A key to the crash cart storage area (PT and OT Gym) will be kept on the narcotic key ring of both units to be used by either of the Rehab charge nurses in obtaining the first floor crash cart after hours or on weekends.
6. In the Pavilion, personnel on the Adult Unit will provide the crash cart for codes that occur in the Pavilion cafeteria or Pavilion lobby area up to the locked doors (i.e. Xerox room).
7. Whenever a crash cart is utilized **for any reason**, except in-services, all forms must be completed.
8. The Emergency Department will provide the crash cart for codes that occur on the first floor of the hospital, up to and including the Chapel, Sleep Lab, and the Ancillary Building, as well as for **all Pediatric Code 3's**.
9. A critical care emergency department nurse is to remain with the patient until transferred to a critical care unit when possible.
10. Satellite facilities not located in the Primary Building**.** In the event of Code 3 situation, the personnel will provide CPR and notify EMS (call 911) to transport the person to the Emergency Department.
11. An AED will be utilized by first responders in public areas where crash carts are not readily available in the Hospital (i.e. lobby areas, cafeteria, etc.)

Initiation of Codes

12. Personnel in the Ancillary Department, Acute Care Hospital, Pavilion, Rehabilitation Institute and Hospice will initiate a Code 3 by dialing 4111 and stating:
    a. "Code 3," or "Pediatric Code 3" (if patient is 0-12 years of age);
    b. "Appropriate area" or "Room Number."
13. ICU, CCU, OH personnel will either press the Code 3 button at the patient's bedside or dial 4111 if the operator does not announce the code immediately.
14. MCC personnel will initiate a Code 3 by dialing 3488 on the Clinic phones, which alerts both MCC operator and WFH operators that a Code 3 situation exists and stating:
    a. "Code 3," or Pediatric Code 3" (if a patient is 0-12);
    b. "Appropriate area" or "floor" in the Medical Center Clinic. MCC departments will call 911 simultaneously to activate EMS.
15. In the areas such as OR, PACU and where personnel are readily available for code situations, the staff may summon them verbally.

Announcing Codes (PBX)

16. **Code 3**: After notification, PBX will immediately open-page six (6) times the following statement: "Code 3 _____" (stating the appropriate area and/or room number).
17. **Pediatric Codes**: PBX Operator will open-page six (6) times the following statement: "Pediatric Code 3 _____" (stating the appropriate area and/or room number).
18. **Code Blue**: In the event the ED physician cannot answer a Code 3, the Emergency Department will notify the operator. The operator will then open- page, "Code Blue _____" (stating the appropriate area/or room number)**.**

Cancellation of a Code 3/Code Blue

19. If a code button is pressed in error or a code is canceled, dial 4111, identify yourself and unit, and ask the operator to cancel the code.
20. When a Code 3/Code Blue is canceled, the operator will open-page six (6) times the following statement: "Code 3 Clear."
21. Code 3 resuscitation, once in progress, may be terminated at the discretion of the physician.

Role of Emergency Department

22. The ED physician and/or ED nurse, when possible, will respond to a Code 3.
23. When an ED physician cannot attend the code, the nurse in charge of the Emergency Department will notify the PBX to call a "Code Blue."
24. If a Pediatric Code 3 is called, the ED physician and the ED R.N. will take the pediatric crash cart to the code. Respiratory Therapy will bring the pediatric ambu bag. Broselow Tapes are available on each pediatric crash cart. An ED nurse **will always** respond to a Pediatric Code 3.

Personnel to Respond to Code 3/Code Blue

25. Emergency Department physicians, when available or any available physician

26. Anesthesia personnel, when available, as needed
27. Administrative Assistant/Nursing.
28. Unit Nursing Staff/Charge Nurse/Patient Care Nurse/Other Unit Staff, as needed
29. ED nurse, ACLS certified (staffing permitting).
30. CCU and ICU nurse, ACLS certified (staffing permitting).
31. EKG technician
32. Respiratory Therapy Technician
33. Laboratory Phlebotomist
34. Chaplain. (When available)

Management of Code 3/Code Blue

35. The first responder will initiate the Code 3 by calling the operator at 4111 or push Code 3 button if available. (Confirm correct room number with operator).
36. Place patient in supine position.
37. Use ambu bag for breathing and initiate BCLS measures.
38. The crash cart with defibrillator will be brought to the appropriate room or area.
39. The patient will be placed on the monitor and ACLS measures performed as qualified staff arrive.
40. Critical care emergency protocol will be in effect.

Pediatric Patients

When a unit admits a pediatric patient, they will notify Supply Chain in order to obtain a pediatric ambu bag and intubation tray, which will be kept on the unit until patient is discharged.

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NURSE ALERT: VENTRICULAR FIBRILLATION IS RELATIVELY UNCOMMON IN INFANTS. THERAPY SHOULD FIRST BE DIRECTED TOWARD ADEQUATE VENTILATION AND OXYGENATION, MAINTENANCE OF CIRCULATION AND CORRECTION OF ACIDOSIS WHEN AN INFANT OR CHILD IS FOUND PULSELESS.

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Patients in Isolation.

41. A "Code 3" called for patients in isolation is conducted as any other code with the exception of the following:
    a. Persons entering the room will comply with the requirements of the specific isolation category.
    b. Disposable equipment will be red bagged and discarded per isolation procedure.
    c. Crash cart will be returned to CSR for reprocessing and restocking.

Code 3 Review Form.

42. A "Code 3" record (#93) will be used during all codes and will become a permanent part of the patient's chart, negating the need for documentation in the medication administration record and physician's order sheet. The "Code 3" record should include the following:

a. Stamp record with sticker or write in name, age and attending physician.

b. The time the arrest was called, date and location – information must be completed on every record, i.e., x-ray room 1 or 4-North – 405.

c. Ventilation – Note time started, types of ventilation and by whom. If intubation was done nasally, it should be recorded as such. Record name of person who was intubated.

d. External massage – document time started.

e. Persons responding – record NAMES of people responding to the Code 3. If possible, give department names, i.e., Jim Jones, Respiratory therapy. Do not list department name only.

f. Blood gases -- note times when blood gases are drawn.

g. EKG -- check yes or no

h. Code Blue -- check yes or no.

i. Medication -- record all medications given indicating name and strength (whenindicated), dose, route (IV or intra cardiac) and time. The divided lines are for the recording of different dosages of the same medication.

EXAMPLE:

	Time	**Amount**
Xylocaine IV	10:00	100 mg

j. All medications drawn up, but not used, must be listed on the Code 3 record and "wasted" written after the name of the drug.

Any medication which is acquired from unit stock drugs must have "unit stock" written after the drug name.

k. Solutions: Record all solutions given per IV infusion, i.e., D5W 250cc.

l. Indicate any medication put in dilution, i.e., Dopamine, Isuprel and note amount of drug in solution. Record time started and stopped and the amount absorbed, Note LTC. Any solution made up, but not used must be indicated using the work "wasted" after the solution.

m. Defibrillation - the time and joules are to be recorded on the Code 3 form each time the procedure is done.

n. Time, pulse - the patient's **condition** at intervals should be recorded with regard to BP, pulse or rhythm in the nurses note section and/or any other space provided.

NURSE ALERT: If patient has a latex allergy, pop the top off any rubber vials prior to use.

Completion of Code 3

43. In the "Outcome of Code 3" Section check one of the boxes at the bottom of the form to indicate if code was successful or unsuccessful and (if applicable) if patient was transferred to another unit. The physician will sign the record or if none present, the nurse conducting the code will sign the record.
44. The nurse completing the Code 3 record signs their name at the bottom left side ofthe Code 3 record at the area titled, "Nurse Completing Record" and documents in the "Patient's Progress Notes" patient assessment preceding the code, the time of initiation of the Code 3 procedure and the time of termination of the Code 3 procedure
45. The white original is placed on the patient's chart in front of the Daily Nursing Record. The yellow bottom portion, Code 3 Record/Review portion, will be completed to identify any problems with supplies, medications, equipment or personnel. The carbon of the Code 3 Record/Review and the stickered miscellaneous charge voucher are sent to Supply Chain with the used crash cart. Supply will be responsible for bringing a new cart to the unit and for sending the cart and forms to Pharmacy for medication replacement and locking of the cart.

Integrity of Crash Carts and Emergency Equipment

46. The Pharmacy department maintains responsibility for the integrity and security of medications on emergency carts. Pharmacy will assure that medications on crash carts are in date. If any cart is opened for any reason, Pharmacy will check the contents of that cart and secure it with a lock prior to it being made available again for use. Pharmacy will store all the locks used for emergency carts.
47. Supply Chain maintains responsibility for the integrity of supplies stored on each Cart.
48. Drugs placed on emergency carts are approved by the Pharmacy & Therapeutics Committee. A list will be made available on the clipboard on each crash cart.
49. An emergency cart will be accessible in each patient care area, with backup carts store in Supply Chain. A Pediatric Crash Cart will reside in the Emergency Room, OR area, and PACU, with a backup in Supply Chain.
50. Medications are stored in a plastic tray in the fifth drawer of each cart. The tray will be secured with a "green" plastic lock. The entire cart will be secured with a chain and a "green" plastic lock. Each tray will contain plastic red locks to secure the tray and cart after being opened.
51. Each emergency cart and each medication tray within each cart has a unique number for tracking purposes. Supply Chain will maintain a log of carts re-supplied, the current location, and expiration dates of supplies maintained on each cart. Pharmacy will maintain a log that contains a page for each tray that documents the cart number in which the tray resides and the expiration date of each item for that tray. Each cart

will bear a label displaying the expiration date of the first medication and supply to expire on that cart.

Procedure

52. Following a "Code 3," or at any time the integrity of the cart is broken, a plastic lock will be **replaced** from the medication tray to secure the medication tray, and a plastic lock is **replaced** to secure the entire cart for transport;
53. Supply Chain personnel will be notified and will exchange the opened cart with a stocked cart;
54. Supply Chain personnel will replace Supply Chain supplies used from the cart, replace the Supply Chain expiration label, then transport the cart with the completed Code 3 yellow sheet to the Pharmacy;
55. A pharmacist will process the used tray, replacing used medications and will document the expiration dates of medications within the tray. A "Crash Cart Replacement List" form is completed, attached to the yellow code sheet and placed in the Pharmacy Billing Coordinator's work bin. A photocopy of the replacement form is kept with Emergency Cart Log
56. The pharmacist will then verify that the drawer locking mechanism is functional and document the results on the Crash Cart Replacement List. Plant Operations will be notified if service is needed.
57. The medication tray will then be secured with a green plastic lock and the cart secured with a green plastic lock.
58. The cart will be labeled with an expiration date that represents the nearest expiration date of all medications in the tray.
59. Supply Chain will then be notified that the cart is ready. The person from Supply and the pharmacist will initial the Supply Chain Log Book recording the number of the new lock. The person from Supply Chain will then take the supplied cart back to Supply Chain.
60. A Pharmacist will check the logbook each month for drugs about to expire. When necessary Pharmacy will exchange the drugs that are about to expire. The replacement drugs should have at least a six-month expiration date if possible. Supply Chain will also review their log and replace supplies as they expire.
61. The carts in the different drug storage areas will be verified as locked and in date at the time of the monthly unit inspection.
62. All departments which maintain crash carts.
    a. Test defibrillators daily. (Refer to Admin Policy I-51.0)
    b. Verify the integrity of the lock daily.
    c. Maintain a record of the checks on the crash cart and defibrillator battery check log (date, results, by whom). Form #750 will be utilized. (Except in CCU, they have their own form due to multiple defibrillators in patient rooms).
63. In addition to the above, Critical Care Units will test Code 3 buttons weekly and a record of the checks is maintained in the PBX Office. Only those defibrillators designated for transporting may be removed from their assigned units. These

transporting defibrillators are located in ED, ICU, CCU, and Open Heart. Nosuction machines are to be removed from their assigned units.

C. **"*CODE G*"** addresses a potential medical situation occurring on the Hospital grounds.

1. **House Supervisor** – A Registered Nurse who serves as a clinical and professional role model, functioning as staffing coordinator for the Nursing Division during assigned shift. Serves as a consultant within the Hospital in the areas of nursing practice, administration and interpretation of policies, medical-legal issues, legal nursing responsibility as indicated by the Florida Nurse Practice Act or other pertinent regulation. Serves as a liaison and acts in the behalf of Hospital Administration and Nursing to assure communication of significant situations and to facilitate the provision of patient care.

In a Code G situation, the following procedure will be implemented:

2. Upon discovery of a person who appears to need medical attention, any Hospital employee will call the Hospital Operator by dialing 4111 (the Hospital's universal emergency phone number) and stating "Code G" and location. The Switchboard Operator will open page "Code G" and location and will initiate beeper notification, including location, to the House Supervisor, Security and House Orderlies.
3. An Emergency Department Registered Nurse and Emergency Department Security personnel will go to the stated location where the nurse will initiate an appropriate triage to determine if an emergency medical condition exists.
4. House Supervisor will report to the scene.
5. The House Supervisor has the authority to initiate measures he or she deems appropriate to provide for the patient's apparent needs, which can include:
   a. Transporting the involved party(s) to the Emergency Department; and/or
   b. Exercise other appropriate alternatives, including calling 911 for response when it is determined this in the patient's best interest.

   See complete policy and procedures to be followed for a potential medical situation occurring on Hospital grounds.

D. **"*CODE BROWN*"** addresses actions to be taken in the event of a tornado watch and/or warning.

General Safety Guidelines for Patient Care Areas

1. All personnel shall review their severe thunderstorm/tornado disaster plans and evacuation plan.
2. Close shades or drapes over all windows.
3. Remove all items not essential for patient care and place in drawers or lockers.
4. Secure non-patient care areas by removing items and placing them in wardrobe.
5. Advise and reassure patients that the above precautions are taken whenever there is a severe weather warning.
6. Lower beds to lowest position. Ensure patients have their nurse call button
7. Provide all patients with a blanket or bedspread, which may be used to protect them if necessary.

8. Move all charts, unit dose medication carts, emergency carts, etc. to an inside room.
9. Prepare equipment that may be needed to move patients in the event of a Tornado Warning, including:
   - Blankets
   - Wheelchairs
   - Linens
   - Patient care equipment

General Safety Guidelines for Patient Care Areas

10. Close all blinds, shades and drapes.
11. Remove loose objects from desk and counter tops and windowsills.
12. Secure all wheeled carts in your work area.

If a tornado warning is issued, the following procedures shall be instituted:

13. Personnel will begin to move patients to corridors.
14. Place blankets, linens and mattresses on the floor of safe areas to provide a place for patients to lie down.
15. Move patient care equipment needed to care for patients to corridors.
16. Maintain appropriate space in corridors for personnel to move safely among Patients.
17. Close all doors.
18. Personnel shall assist patients in lying flat or crouching down with head covered with blankets. All personnel shall also assume the prone or crouching positions and keep their heads covered.

When the "All Clear" is given, the following procedures shall be instituted:

19. All personnel shall assist in restoring their work areas to normal operations.
20. Personnel shall assess their department for damage or safety hazards and report them to the area supervisor.
21. After patient rooms have been evaluated for damage and safety hazards, patients may be moved back to their rooms. If a patient's room is uninhabitable, alternate accommodations shall be made.

Emergency Response

22. All casualties will be treated according to the Disaster Plan.
23. In the event the Hospital is damaged, a partial or total evacuation shall be determined by the Chief Executive Officer. Refer to the Hospital Evacuation Plan.
24. Each department shall maintain the on-call system in the event relief staff are unable to report to their designated shifts.

E. **"*CODE M*"** is the process for obtaining manpower in an emergency necessitating the physical management of a patient.

1. Code M is initiated by dialing **4111**.

2. In an extreme emergency, the Sheriff's Department is to be contacted for assistance. The Administrative Assistant/Nursing, or his/her designee, must initiate the call to the Sheriff's Department after conferring with the nurse in charge.
3. Law Enforcement personnel responding to the Code must have weapons secured.

Team Members

4. RN in charge of unit.
5. Switchboard Operator
6. Unit Staff
7. Designated Personnel (Plant Operations Personnel; Administrative Assistant/ /Nursing; Security; Environmental Service personnel; House Orderly; Transporters)

Procedure

8. Check physician's order, if appropriate, to aid in planning intervention.
9. Determine the appropriate intervention to be used in view of patient's behavior.
   . Call physician if any question regarding involuntary status or if restraint order or medication order is needed.
   a. In extreme emergency, ask the Administrative Assistant/Nursing, or his/her designee, to contact the Sheriff's Department for assistance, and assume command of the situation after conferring with the nurse in charge.
10. Have staff member call Switchboard Operator to page "Code M".
11. Give specific directions to staff in order to carry out intervention. **Team effort is essential**.
    . Assign staff member to obtain needed medication.
    a. If seclusion room is to be used, have personnel prepare room.

Responsibilities of Switchboard Operator. Page "Code M" three (3) times, identifying the Pavilion and/or nursing unit only.

Responsibilities of Staff

12. Staff Member on Stand-By:
    . Stand at entry location to allow responding staff to enter area.
    a. Remind personnel to remove articles such as glasses, watches, name tags, pens, etc.
    b. Have Law Enforcement personnel secure weapons.
    c. Hold excess staff on a stand-by basis not allowing excess staff, other patients, or visitors to congest the area.
13. Staff Responding to Code M: Follow directions of the nurse on standby.
14. Staff Member with Patient:
    . Tell patient what is being done and why.
      - Remember that the patient is aware of what you are saying and doing and will remember it.
      - Use brief explanations.

- Do not lie to patient or try to bargain with him/her. Do not promise things you cannot do.
- Approach the patient speaking in a low, firm, calm tone of voice.

a. Attempt to verbally assist the patient in regaining control.
b. If patient does not respond positively to verbal measures, attempt to physically restrain the patient in the safest possible manner.
c. Explain to staff what is to be done and each responsibility, i.e., how patient will be transported and who will give medicine.
d. Check pockets and remove all articles. May need to undress patient and redress patient in hospital gown. Remove shoes, belts, jewelry, glasses, cigarettes and any other articles that might be dangerous.
e. After placing in seclusion room, follow policy for seclusion room. **(Pavilion/Rehab only)**
f. If restraints are used, follow policy for restraints.
g. Document appropriate notes on" Code M" Record (Pavilion only) or in Meditech.

Important points to include are:

- Events preceding Code M.;
- Patient's behavior;
- The rationale and authorization for use of seclusion room and/or restraints;
- Document all articles removed for the patient and disposition of each article;
- Any medications given;
- Persons participating in the patient's management.

h. Continue observation of patient with follow-up documentation as indicated.
i. Follow-up with Involuntary Procedure if this has not been done (Pavilion Only)

STAFF ALERT: VIOLENCE IS A RESPONSE TO A SITUATION IN WHICH A PATIENT FEELS HELPLESS IN VIEW OF A PERCEIVED THREAT. APPROACHING THE SITUATION PROFESSIONALLY CAN PREVENT THE PATIENT FROM FEELING MORE NEED TO DEFEND HIMSELF/HERSELF AND STRIKE BACK.

F. **"Code Pink"** indicates that infant abduction is suspected, has been attempted or has occurred.

In a Code Pink, the following procedure will be implemented:

1. Upon discovery of the suspected/attempted or actual abduction, the Hospital employee discovering the event will call the Hospital Operator by dialing 4111 (the Hospital's universal emergency phone number) and stating, "Code Pink", the location and exit utilized, if on the Family BirthPlace. The Switchboard Operator will open page, "Code Pink" and location and will initiate beeper notification, including location and exit utilized (if on Family BirthPlace Unit), to the House Supervisor, Family BirthPlace Department Director, Director of Plant Operations, Director of Environmental Services, and all three (3) Security guards. The Hospital Operator will

then contact the Medical Center Clinic Operator, the Administrator On-Call, and the Marketing Director to alert them of the situation.

2. The House Supervisor, Family BirthPlace Department Director, Director of Plant Operations, Director of Environmental Services, and the Inside Security Guard will report to the scene of the incident. At least the Inside Security Guard will utilize the stairwell nearest the exit location as stated on the "Code Pink" announcement.
3. The first of the following people to report to the scene will serve as a Code Pink Coordinator, until such time as all three (3) are present: House Supervisor, Family BirthPlace Department Director, and Administrator On-Call. The Code Pink Coordinator's primary purpose is to ensure that the procedures, as outlined in the Infant Protection Plan (found in V-18.0 of the Administrative Policy Manual) are followed.

G. **"*Code Red*"** addresses the actions to be taken in the event of fire.

1. Do not shout "fire," state "Code Red"
2. Think "R-A-C-E"

"R" Rescue people from the vicinity. Close the door.

"A" Alarm activation.

. Pull the fire alarm box located:
a. Pick up the phone and dial 4111.
b. State Code Red and your location.

"C" Contain the fire

c. Close all doors.
d. Check to see that the fire exits are clear.

"E" Extinguish if you can do so safely, go to the area with fire extinguisher and attempt to extinguish.

3. Evacuate. Employees may evacuate patients to the next set of fire doors.
4. Assist Fire Safety team and fire department, if building evacuation is necessary.
5. Department oxygen shut off valves are to be turned off by Plant Operationspersonnel at the direction of the unit charge nurse.
6. If outside of assigned area, report back to your area.

. Close all doors and windows.
a. Station one person at the telephone.
b. Be prepared to lend assistance.
c. Check for signs of smoke or fire in your area.
d. Do not call the operator until 'code red clear" is announced.
e. Reassure patients and visitors.

(For complete policy/procedure see MOX Library Safety Management Program #13 Fire Safety Plan)

H. **"Code Green/Situation 100"** addresses the mass casualty/internal ore external disasters Level 1, II, III.

Condition I - (Up to 15 casualties)
Condition II - (Estimated 16-30 casualties)
Condition III - (Estimated 31 or more casualties)

1. See (and know where) your departmental disaster plan for departmental specific instructions.
2. Know where to report for a Code Green.
3. Do not use the telephone unless absolutely necessary.
4. Visitors and families of disaster victims or hospital personnel will be directed to and will remain in the hospital cafeteria.

(For complete policy/procedure see Mox Library Safety Management Program – Disaster Plan and/or Nursing Services Policy Section 1 Nursing Services - # 7 Disaster Plan).

I. " **Code Silver"** addresses the process to provide assistance to staff members, patients, and/or visitors, who are confronted by an individual brandishing or claiming to possess a weapon, or one who has taken hostages within the healthcare facility or within its property.

When **4111** is called to initiate the **Code Silver,** an overhead announcement will be made announcing the location. The Operator will call 911 and notify selected individuals.

Staff members should not attempt to intervene or negotiate, but seek shelter, behind locked doors if possible and remain out of public view until the **"Code Silver, All Clear"** is announced.

Security will report to the Code Silver area and lock down the doors to the area and post a Security Guard at the entrance. Security will keep everyone out of the area and will relinquish primary responsibility for security to the first representative of Law Enforcement to arrive on the scene. Law Enforcement will have security authority at this time.

For complete policy refer to Safety Management Plan – Emergency Management Plan.

J. **SILENT CODES**: These codes are **not announced by overhead page**. Key personnel will be notified by the Hospital Operator and/or the Administrator On Call.

"Code Yellow" addresses the process for securing and locking down an area within the facility or the entire facility

1. A lockdown is called by the hospital administrative person on call in response to a violent situation within or an external threat of violence or terrorism. The hospital was in lockdown with limited access during recent hurricanes.

   (For complete policy/procedure see Mox Library – Adm. Policy – VII Facility Management – VII-25 Facility Lockdown)

"Code Orange" addresses the process to respond to hazmat/Bioterrorism alert either internal or external.

2. Situation 100 level 1, 2 or 3. This is a Hazmat or Bioterrorism alert
   . Call 4111 if aware of a spill
   a. The operator will notify the administrator
   b. Evacuate the area, if possible, contain the spill

   (For complete policy/procedure see Mox Library – Administrative Policy – V-Safety – V-20 HazMat Emergency Response)

K. **"Code Black"** addresses the process for a bomb threat.

1. When warning of a bomb threat is received by telephone, you should:
   . Prolong the conversation as much as possible
   a. Take notes such as:
      1. Background noises
      2. Voice characteristics of the caller
      3. Ask where & what time the bomb will explode
      4. Caller's familiarity with the facility
      5. Ask what the bomb looks like
      6. Exact words of the caller
2. Immediately have someone call PBX-4111 "Code Black" no overhead page.
3. If time permits, notify the **first available** of the following Hospital Officials ONLY:
   . President/CEO
   a. Chief Operating Officer
   b. Administrator on-call(evenings & weekends)
   c. Plant Operations Director
   d. The House Supervisor
4. **Be Alert for:**
   . Unusual packages (tubular or cylindrical)
   a. A package that does not "belong"
   b. Unnecessary articles/clutter should be removed
   c. People who act in an unusual manner or people who enter the hospital with packages and leave empty-handed
5. **If a bomb is found**:
   . DO **NOT** TOUCH IT
   a. CLEAR THE AREA
   b. If applicable, close the room door
   c. Notify Plant Operations Director and when assistance arrives, offer cooperation

(For complete policy/procedure see Mox Library – Safety Management Program – Bomb Threat.)

FORMS:

Crash Cart Form #700, Code Documentation Form #93, CSR Log, Pharmacy Log

REFERENCES:

BCLS standards from American Heart Association, ACLS from American Heart Association.

All revision dates:	2/24/2010, 2/21/2006, 12/27/2004, 10/14/2003, 9/30/2002, 10/17/2000, 9/12/2000, 5/23/2000, 1/19/1999, 10/22/1998, 1/20/1997, 7/15/1994

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West Florida HEALTHCARE

Effective: *4/26/2016*
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Next Review: *3/31/2018*
Owner: *Kathryn Lauderdale*
Policy Area: *Pharmacy/Clinical Services Group (Facility)*
References:
Applicability: *West Florida Hospital*

Material Safety Data Sheets (Msds)

POLICY:

Material Safety Data Sheets (MSDS) shall be made available to all employees of the pharmacy via HazSoft (Superior MSDS Management), to insure that they can protect themselves from hazardous chemicals in the work area. The MSDS shall include the following information as updated by the vendor:

1. Substance manufacturer's name.
2. Hazardous ingredient/identity information.
3. Physical/chemical characteristics.
4. Fire and explosive hazard data.
5. Reactivity data.
6. Health hazard data or first aid data.
7. Precautions for safe handling and use.
8. Protective equipment needed when working with the substance.

Material Safety Data Sheets are available through the any Network computer, on the hospital home page. Each employee has the responsibility to become familiar with the information source through the PC site.

Availability of the site is communicated to all staff. The information is arranged alphabetically and may be searched in the program.

See Hazardous Materials and Waste Program Policy on PolicyStat

All revision dates:

4/26/2016

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Next Review:	*5/2/2018*
Owner:	*Ramona Arnold*
Policy Area:	*Diagnostic Imaging*
References:	*Policy*
Applicability:	*West Florida Hospital*

Radiation Protection/Safety Program, V - 1

The basis for the radiation protection program will comply with the current Chapter 64E-5, Florida Administrative Code requirements. Reference to the current code should be performed for any clarification or questions that may arise. The following items shall serve as a general overview of current policy to ensure radiation safety and evidence of compliance.

ROOMS:

All radiographic rooms shall be constructed to current code with a minimum of 1/16 lead equivalent installed in all exterior walls (To a height of 7 feet), ceilings, and floors, as applicable/mandated by current code. This lead requirement shall also apply to interior walls/barriers as required to provide shielding to radiation workers during radiographic and/or fluoroscopic examinations.

In addition this same shielding requirement will apply to any electrical outlets, view boxes, or other equipment/structures that penetrate the wall surfaces to ensure that the lead barrier is not breached.

Area monitoring will be used outside radiation rooms, as needed, to ensure that radiation dosages to the general public do not exceed acceptable levels as stated in current State/Federal policies.

EQUIPMENT:

All equipment shall be installed by OEM qualified installers according to manufacturer specifications. All portable x-ray machines and mobile c-arms will be maintained according to manufacturer's specifications to ensure beam confinement and control of dosages.

The center of any radiation machine/table shall not be installed within 2 feet of any wall in order to provide sufficient radiation protection and allow access for service/inspection personnel.

Wall mounted bucky units/cassette stands shall have no less than 1/16 lead equivalent shielding as backing if placed on any exterior wall or wall that is to serve as a radiation barrier.

Annual inspections are to be performed with proper documentation to ensure compliance with current code and radiation output parameters.

RADIATION DOSAGE MONITORING DEVICES:

Personal monitoring devices shall be provided for all workers who routinely may receive dosages greater than 10-milli rads/month or as specified under current ALARA policies. Badges shall be worn at lapel level and outside lead aprons. Additional devices (example: ring badges) shall be provided, as necessary, for those personnel that require monitoring of hands/extremities, and shall be worn in accordance to standard radiation practices. Badges are to remain on site and be stored away from sources of radiation, which would alter actual dosages received. Documentation of received dosages to be maintained per current 64E-5 policy.

Monitoring devices for pregnant personnel detailed in separate pregnancy policy, as specified by current Chapter 64E-5 code.

LEAD PROTECTIVE DEVICES:

Lead aprons, thyroid shields and gloves will be worn as protective devices and used in combination with other barriers/shielding that may be part of the radiation equipment. These devices shall be stored in accordance with manufacturer's recommendations. Shielding devices shall be inspected and results documented on an annual basis to ensure integrity of the shielding and at those times when damage is suspected as evidenced by visual inspection, improper handling techniques or other incidents that would cause damage.

RADIATION WORKERS/PERSONNEL:

All persons operating radiation equipment must be at least 18 years of age, meet the current minimum standards as specified under State/Federal law and have a valid certification/license. Personnel shall work under the direction of a radiologist or other qualified physician, as determined by state law and facility practice requirements.

Personnel should remain behind a fixed radiation barrier, whenever possible, during radiographic exposures. During those instances where a barrier is not available or that personnel must be in the room during radiographic/fluoroscopic exposures, all persons are to wear lead aprons/shielding having no less that current lead equivalency rating, and utilize other shielding/barrier devices, (lead gloves, fluoro apron shielding, thyroid shields, eye-wear/leaded glass, etc.) as appropriate for the examination/procedure.

During procedures/examinations that require restriction of patient motion or other instances where the patient cannot maintain proper position to obtain a diagnostic image, appropriate immobilization devices should be used.

Only after the use of these devices is determined to be inadequate or inappropriate for that specific instance should personnel hold the patient during exposures. Lead aprons, gloves, shielding, etc. should be worn by all persons required to be within the area and who are deemed to be medically necessary for the performance of the exam. Name, date, and exam(s) performed will be noted to document source of additional dosage.

As a general policy, only the patient should be within the room or those who are deemed medically necessary by nature of procedure or exam conditions.

No persons under the age of 18, shall be present in a room during any radiographic/fluoroscopic exposures.

When studies require the use of portable x-ray/mobile c-arm devices, such as portable exams and operative procedures, all persons not medically required should be asked to leave the immediate area. Remaining personnel shall wear lead aprons and other devices, as appropriate, to limit excessive exposure.

The radiation beam should be restricted to the minimum size required for the exam and limited in duration to ALARA. When a mobile fluoroscopic unit is being used during a prolonged procedure, the beam should be energized only for the time necessary to visualize structures and be turned off at all other times. Continuous fluoro is not to be performed without periodic termination of the beam.

This policy to be reviewed annually and at such times that necessitate a change/revision as required by State/Federal requirements or as may be necessary due to changes within the facility.

Radiation Safety Program Supplement

The following is response to the requirements set forth in **Chapter 64E-5 Florida Administrative Code as Addendum/Attachments:**

RADIOGRAPHIC EXPOSURES:

Item#1: Monitoring records attached to reflect dosages received during procedures where personnel are not positioned behind a fixed protective barrier. All personnel are required to wear lead/protective aprons, personal dosimetry outside the apron at lapel level, and utilize appropriate shielding, as stipulated under the current 64E-5 code requirements. No personnel should be in the room except those deemed as medically necessary.

Item#2: Monitoring records attached to reflect dosages received during the limited number of times that a patient must be held during a procedure. Prior to holding patients, personnel are to utilize appropriate positioning/motion restricting devices. On those limited occasions where holding of patients is the only viable alternative, all personnel are required to wear lead/protective aprons, personal dosimetry outside

the apron at lapel level, and utilize appropriate shielding, as stipulated under the current 64E-5 code requirements. No personnel should be in the room except those deemed as medically necessary.

Item#3: Monitoring records attached to reflect dosages received during procedures where personnel are not positioned behind a fixed protective barrier. All personnel are required to wear lead/protective aprons, personal dosimetry outside the apron at lapel level, and utilize appropriate shielding, as stipulated under the current 64E-5 code requirements. No personnel should be in the room except those deemed as medically necessary.

Item#4: See attached personnel/ area monitoring records that verify dosage levels for members of the general public do not exceed dose limits as determined by current State/Federal statute(s). [records maintained in each sub-department area and by Radiation Safety Officer/designee

Item#5: Provision requirement met, as indicated, that any wall bucky or cassette stand that is located on an outside wall has at least 1/16 inch lead equivalent shielding.

Item#6: Provision requirement met, as indicated, that the center of the table for all radiation machines is at least 2 feet from any wall.

FLUOROSCOPIC EXPOSURES:

Item#7: Monitoring records attached to reflect dosages received during procedures where personnel are not positioned behind a fixed protective barrier. All personnel are required to wear lead/protective aprons, personal dosimetry outside the apron at lapel level, and utilize appropriate shielding, as stipulated under the current 64E-5 code requirements. No personnel should be in the room except those deemed as medically necessary.

Item#8: Monitoring records attached to reflect dosages received during the limited number of times that a patient must be held during a procedure. Prior to holding patients, personnel are to utilize appropriate positioning/motion restricting devices. On those limited occasions where holding of patients is the only viable alternative, all personnel are required to wear lead/protective aprons and gloves, personal dosimetry outside the apron at lapel level, and utilize appropriate shielding, as stipulated under the current 64E-5 code requirements. No personnel should be in the room except those deemed as medically necessary.

Item#9: Provision applied that only the patient and those persons deemed as medically necessary are present in the room during fluoroscopic procedures. All persons will wear appropriate lead shielding, as specific by 64E-5 requirements.

Item#10: See attached personnel/area monitoring records that verify dosage levels for members of the general public located outside each fluoroscopic x-ray room do not exceed dose limits as determined by current State/Federal statute(s).

Item#11: See attached personnel/area monitoring records which verify dosage levels for members of the general public located outside each high level fluoroscopic x-ray room do not exceed dose limits as determined by current State/Federal statute(s).

RADIOGRAPHIC AND FLUOROSCOPIC EXPOSURES:

Item#12: Provision applied that minors do not participate in making radiographic and fluoroscopic exposures. Minors, for purposes of this provision, are determined to be persons under the age of 18 years old or as specified by current statute(s).

Item#13: Provision applied that states that the radiation protection program is to be evaluated annually during the month of January.

Item#14: Provision applied that the radiation protection program will be re-evaluated when changes occur that could affect dose and that all documentation/filing requirements will be directed to the appropriate governing agencies, as required by current statute(s).

Item#15: Provision applied that this document will be kept until registration is terminated.

All revision dates: 2/1/2012

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INFECTION CONTROL

The Infection Control department serves several purposes within the hospital. We are a resource when you have questions about anything related to infections, isolation, or other related topics. We also collect data about infections that occur in the hospital. If you have any questions, please feel free to call the department. This section will educate you about…

If you have any questions, please ask:

Karen Urquhart, RN
Infection Control Nurse

Ext. 3215 or beeper # 406-0306

Hand Hygiene

Hand Hygiene is especially important in the hospital because some patients are very weak and can easily develop infections. Germs are invisible to the naked eye and can be found almost anywhere. In October 2002, the Center for Disease Control (CDC) updated the hand hygiene guidelines. These guidelines are part of The Joint Commission National Patient Safety Goals.

Handwashing: the single most important technique to prevent spread of infections!

- Lather hands with soap and water. Antimicrobial soap for general handwashing.
- Rub your hands together vigorously for at least 20 seconds.
- Rinse hands under running water in a downward position
- Dry hands using a clean, dry paper towel and discard towel.
- Use another clean, dry paper towel to turn off the faucet. Make sure you wash under rings and fingernails.

Alcohol hand gel is available in all patient care areas, visitor waiting rooms and the cafeteria. It is 99% effective against germs. It is used between patient contacts or after touching contaminated articles (linen, equipment) if hands are not visibly soiled. **This product is not to replace handwashing. Alcohol hand gel is not to be used in C-difficile contact isolation rooms. Wash hands with antimicrobial soap and water at sink.**

Artificial nails to include gels, overlays, acrylic, and shellac are **NOT** to be worn in patient care areas, and should be removed prior to reporting to duty. Nails are to be kept clean and trimmed to ¼" long with no chipped polish. Limiting the amount of jewelry and keeping fingernails short will make handwashing more effective.

Hospital approved lotion is the only lotion to be used at **all** times. Other types of lotions have emollients that break down the barrier of gloves.

Glove Removal

While gloves DO NOT replace handwashing, they can help protect you from germs. It is important to remember that your hands should always be washed **after gloves are removed**.

To prevent contamination of your hands while removing gloves follow the following steps:

1. Peel one glove off from top to bottom and hold the glove in the gloved hand.
2. With the ungloved hand, peel the second glove off from the wrist, being careful to avoid touching the outside of the glove.
3. Dispose of the gloves in the proper trash container promptly.
4. Wash your hands.

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Exposure Control Plan

What is the Exposure Control Plan?

OSHA requires all hospitals to develop an Exposure Control Plan to educate the staff about blood borne pathogens (diseases spread through blood). Please reference Management of Exposures to Blood, IC 2.03 for further information related to this topic.

What are blood borne pathogens?

Blood borne pathogens are bacteria, viruses, and other microorganisms that cause infections and are spread by blood. Examples are:

Human Immunodeficiency Virus (HIV)
Hepatitis B
Hepatitis C
Syphilis
Malaria

What Are Your Responsibilities?

You should know the Safety Kardex and reference Policy Stat on the Intranet Homepage for Infection Control related resources. It is designed to protect all employees who in the course of their work may come into contact with blood and/or other potentially infectious materials such as body fluids, secretions, tissue and excretions. Follow the practices and policies and notify your manager, house supervisor and employee health nurse with all concerns.

What Are the Hospital's Responsibilities?

We must maintain the Exposure Control Plan, provide PPE and Engineering Controls that are appropriate for your job, clean or dispose of PPE at no charge to the employee, offer Hepatitis B Vaccination, and provide post-exposure follow-up.

What is Your Exposure Category?

Category I: Any employee who has the potential to contact blood, body fluids, during their routine job duties. (Physician, Nurse, housekeeper, therapist, lab personnel)

Category II: Employees who do not have the potential to contact infectious materials during their routine job duties but employment may require unplanned category I tasks/procedures. (Health Unit Coordinators)

Category III: Employees that have no exposure to blood or body fluids. (secretary, schedulers)

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Biomedical & Biohazardous Waste

Biomedical Waste includes:

- Human blood, blood products, lymph fluid, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, and amniotic fluid.
- Anything caked with biomedical waste that may flake off during handling.
- Any non-absorbent item that is contaminated with biomedical waste.
- Absorbent materials soaked to capacity with biomedical waste.
- Non-liquid human tissues and body parts.

Disposal of Biomedical waste:

- Sharps (needles, scalpels, etc.) should be placed in designated sharps containers. Sharps containers must be replaced when they are 2/3rd full.
- Linen contaminated with blood/body fluids should be placed in yellow linen bags.
- All other Contaminated waste should be placed in a **red** Biomedical waste container.

Linen

ALL linen will be bagged in a yellow linen bag at the place of use. The linen bags **must** be closed and placed in the linen chute or designated container. Linen should not be placed in pillowcases or red bags. Linen must not be left unbagged.

Biomedical (Blood, Body Fluid) Spills

Lab will respond to all of their own spills.

Nursing floors will contain biomedical spills and call Environment Services for clean up.

1. Apply gloves, gowns, etc. as needed.
2. Cover spill with paper towels and spray with disinfectant.
3. Using dry paper towels, wipe up spill.
4. Clean area again with approved hospital detergent-disinfectant.

Cleaners

A hospital approved disinfectant that will kill most bacteria, viruses, and fungi will be used as a general cleaner disinfectant.

What if you are exposed?

If an employee has an exposure to blood or body fluids they will be counseled and offered post exposure testing that includes HIV, HBV, HCV, and alt..

If you get exposed to blood, body fluids, etc.

1. Wash the area with soap and water. (Flush the eyes with water)
2. Notify your supervisor.

3. Fill out an Occurrence Screen in Meditech. Must be done within the shift the incident occurred.
4. Call Employee Health immediately. If Employee Health is closed, page the House Supervisor. It is important to get testing done on the source patient ASAP to determine treatment, if indicated, for the employee.
5. Complete drug screen in 3rd floor Lab.

If you get exposed to a patient with an infectious disease (TB and Meningitis), contact Employee Health.

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Standard Precautions

Standard Precautions are used for all patients all the time. Standard Precautions means that PPE should be worn to protect you from all body substances. PPE should be chosen based on the task or procedure being performed and potential for contact. Standard precautions should be used when there is potential contact with blood, body fluids, secretions, or excretions (excluding sweat).

Personal Protective Equipment (PPE):

Gloves: We provide several types of gloves for employee use. Gloves should be worn to protect your hands if there is a chance that your hands may contact blood, body fluids, secretions, excretions, soiled linen, or dirty equipment. Exam gloves are single use and should not be reused.

> Vinyl exam gloves are provided in each patient room and other patient care areas. Use vinyl gloves instead of latex to help reduce unnecessary exposure to latex.
>
> Cleaning gloves are provided for all environmental personnel. These gloves should be used during cleaning. These gloves will protect you from bloodborne pathogens and cleaning chemicals. They should be wiped with disinfectant to remove contamination. Glove liners and other types of gloves are provided as needed.

Gowns: Gowns should be used whenever splashing may occur. Gowns will prevent fluids from coming into contact with your skin or clothing.

Masks: Masks are used to protect the nose and mouth from fluids. We provide several types of masks. Some masks have plastic eye shields that also protect the eyes.

Goggles/face shields: Goggles and plastic face shields provide the most effective way to protect your eyes from splashes.

Bag-Mask device is available on top of the crash cart as the barrier device in CPR.

Engineering Controls: The hospital provides tools to help reduce unnecessary exposures. Examples are sharp containers, needleless IV systems, blunt tip needles and self-sheathing needles.

Hepatitis B Vaccine: The Hepatitis B vaccine (HBV) is provided to all category 1 and 2 employees.

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Isolation Precautions

Airborne Precautions are used for TB, Avian Flu, Measles and early eruptions of Herpes zoster. These precautions protect you from infections that can travel significant distances through the air or are extremely contagious.

N-**95 HEPA Respirators or Powered Air Purifying respirators (PAPR)** must be worn for TB patients. These patients must be in a negative-pressure room (218, 414, 416, 418, 449, 549, ICU 14, 15, 16, ER 11, 12 & PACU Isolation Room). All employees must be fit tested and receive training before a respirator can be used.

Droplet Precautions are used for diseases transmitted by droplets that can be generated by the patient during coughing, sneezing, talking or the performance of aerosolizing procedures. For example: SARS, meningitis, influenza and MRSA in sputum. Wear a regular surgical mask for close patient contact.

- Note: If performing an aerosolizing procedure on an influenza patient, a N95 mask must be worn. Aerosolizing procedures to include: Respiratory treatments, suctioning and intubation.

Contact Precautions are used for infections that are spread through direct (person-to-person) or indirect (person-to-environment) contact. You should always wear gloves and wash your hands with antimicrobial soap before and after caring for these patients. Patients with certain types of bacterial wound infections, gastrointestinal infections, and Herpes Zoster eruptions that are dried and not draining will fall into this type of isolation. Gowns **MUST** be worn if there is close contact with the patient or bed linen. Alcohol hand gel **MUST NOT** be used when a patient is on isolation for clostridium difficile.

Implementation:

Signs will be posted on the patient's door stating the type of isolation and required PPE: Airborne (Pink), Droplet (Orange) and Contact (Yellow). PPE should be stocked for each patient. If you have any questions, call Infection Control or the House Supervisor. Strict Personal Protective Equipment usage is necessary when entering patient room as stated on isolation sign. A **DO NOT USE** sign for alcohol hand gel must be placed over the alcohol hand gel in rooms with C-difficile patients.

Patient Transport: When patients are transported, they should have the isolation precautions maintained. **Patients** on airborne or droplet precautions **should** be transported **wearing** a surgical mask. Patients on contact precautions must be transported on a stretcher or wheelchair covered with a clean sheet or other physical barrier. Healthcare workers should not wear personal protective equipment (PPE) to transport a patient. Using appropriate barriers on the patient is sufficient to protect the healthcare worker. The receiving department should be informed before the patient is transported and isolation precautions must be maintained until the patient returns to his/her room. Prior to transporting isolation patients, make sure the orange isolation sticker is placed on the front of the patient chart.

Isolation Policies IC 5.01, 5.01A, and 5.01B are available in the Infection Control Manual in the Meditech Library and on the WFH Intranet under online documentation. These policies list the conditions and the type of isolation required.

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RISK MANAGEMENT

Sandy Hill, Risk Manager

Ext: 4859

Areas of Potential Liability for Healthcare Workers

Increasingly, healthcare workers are being named as defendants in medical malpractice claims. As in any negligence action, the plaintiff must show that the defendant breached a duty of care to the plaintiff and that this breach was the proximate cause of the plaintiff's injury. Following are the major areas of potential liability:

Following the Chain of Command: WFH has an established policy on "Chain of Command". The Chain of Command principle allows and requires a healthcare worker to notify his/her superiors whenever he/she believes that a patient's condition is not being adequately addressed. For example, if a nurse believes a physician is not responding appropriately to a patient's condition, the nurse must notify the next person in the chain of command. In this case the chain of command could include the nurse's direct superior, i.e. unit nurse manager, then house supervisor, the Chief Nursing Officer, Administrator on call, or the Medical Director. Failure to follow the chain of command with resulting patient harm or injury is deemed as negligence.

Prevention of Injuries: Healthcare workers have a duty to prevent injuries to patients and provide a safe and secure environment. Examples of common injuries to patients which might be deemed as a result of a healthcare worker's negligence include injuries resulting from a) falls, b) misuse of restraints, c) misuse of equipment, d) misuse of medications, e) decubiti and other skin injuries, f) use of improper methods of transferring and transporting patients, etc.

Monitoring of Patient's Condition: This is one of the most frequent causes of healthcare workers being named in malpractice claims. Nurses and others are responsible for monitoring their patients. Failure to do so may constitute negligence. Along with the duty to monitor their patient's healthcare workers also have the duty to promptly report and significant changes in a patient's condition to the patient's physician and to thoroughly document in the patient's record the fact that he/she did notify the patient's physician and the content of information communicated to the physician.

Communicating Information to Physicians: Healthcare workers have a duty to communicate relevant data about a patient to the treating physician regardless of the time of day, instructions from the physician that he/she is not to be called, possible physician backlash for calling him/her, how busy the healthcare worker's day is, etc. Furthermore, a healthcare worker has the responsibility to follow the chain of command if the treating physician does not respond to a call or page in a timely manner.

Following Physician's Orders: Healthcare workers may be liable for failing to properly follow a physician's orders for a patient. If a healthcare worker is unclear about the nature or intent of a physician's order, he/she should seek clarification prior to carrying out the order. Also, it is prudent for healthcare workers to double-check the chart before carrying out an order to make sure that the order has not been discontinued or changed.

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Prevention of Medical Errors

The Joint Commission Standard LD.5.2 requires healthcare facilities to select at least one high-risk process for proactive risk assessment each year. This choosing of a specific process is to be based, at least in part, on information provided by the Joint Commission concerning the most frequently occurring types of sentinel events.

Sentinel Event Definition

- Event that has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's, client's or resident's illness or underlying condition.
- Or the event is one of the following (even if the outcome was not death or major permanent loss of function):
  - Suicide of a patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge.
  - Abduction of any patient receiving care, treatment, and services.
  - Infant abduction or discharge to the wrong family;
  - Rape;
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
  - Surgery on the wrong patient or body part.
  - Unintended retention of a foreign object in a patient after surgery or other procedure.

A suspected sentinel event needs to be entered into the Risk Management Module and a telephone call made to the Risk Management Department.

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Occurrence Reporting System

SCOPE: Policy encompasses West Florida Hospital including Rehabilitation Institute and Pavilion and applies to all employees, visitors, physicians and patients.

PURPOSE: To ensure a system for Occurrence Reporting which results in a systematic procedure to (1) detect, report, collate, analyze and summarize incidents; (2) develop appropriate measures to minimize the risk of injuries and adverse incidents to patients; (3) identify areas of actual/potential hospital liability and exposure and (4) assist in the management of claims for the facility.

POLICY: All Medical Staff members, West Florida Hospital employees and other agents have an affirmative duty (legal obligation) to report incidents and occurrences to the Risk Manager using the Online Occurrence Reporting System in the Risk Management Module of Meditech. **FAILURE TO REPORT INCIDENTS MAY RESULT IN SUSPENSION OR TERMINATION OF EMPLOYMENT.**

1. **WORK-RELATED INJURIES OR ILLNESS:**
   A. **All employee** work injuries or exposures/illness must be reported via the Employee Report Section of the Risk Management Module. Employees are responsible for reporting work-related medical conditions to Employee Health prior to seeking non-emergency medical assistance, evaluation or treatment by a physician. All follow-up visits for work-related injuries should be coordinating with Employee Health. (Refer to Administrative Policies: Workers' Compensation V-10.0 through V-10.4 and Transitional Duty V-11.0 through V-11.4).
   B. **Volunteers** are not covered under Workers' Compensation. If a volunteer is injured, treatment given directly by the Hospital is charged to Policy/Discount (Account #500206). Other treatments should be covered by the Volunteer's health insurance plan. In unusual circumstances, the Hospital may pay expenses up to $1,000 charged to Volunteer Services (Account #525317). Reporting should be made on an Occurrence Screen via the online reporting system under the Non-Patient category of the Risk Management Module.
   C. **Private duty personnel, independent contractors and students** are not Hospital employees. Therefore, the Hospital is not responsible for injuries received by them while performing their duties. While the Hospital provides initial exposure protocol testing by Employee Health (when necessary), these individuals are responsible for payment of all other healthcare services received at our Hospital. Reporting will be made on an Occurrence Screen via the online reporting system under the Non-Patient category of the Risk Management Module.

2. **NON-PATIENT INJURIES OR OCCURRENCES:**
   A. **VISITOR –** If a visitor sustains an injury while on the premises of West Florida Hospital, it is the option of that visitor to decide whether or not to be seen in the Emergency Department or seek health care following the accident or injury. Visitor incidents are reported on the Non-Patient Occurrence Screen via the online reporting system under the Non-Patient category of the Risk Management Module. Whether or not the visitor is charged for the emergency visit is a decision of the Risk Manager and Hospital Administration and no guarantee of payment should NOT be offered initially without express approval of one of these individuals.
   B. **FACILITY OCCURRENCES:** Occurrences or incidents unrelated to a specific patient or entity as identified above area also to be reported on the Non-Patient Occurrence Report utilizing the Online Occurrence Reporting System in the Risk Management Module of the Hospital's

Meditech program. Since the Occurrence System is a name driven system, all occurrences will be entered under the pseudonym of "Joe Facility".

3. **PATIENT INJURIES OR OCCURRENCES:**

   A. Any incident related to a patient or his/her care should be reported on a Patient Occurrence Screen utilizing the Online Occurrence Reporting System in the Risk Management Module of the Hospital's Meditech System.

PROCEDURE:

OCCURRENCE SCREENS:

1. An "Occurrence Screen" is a factual written statement regarding a particular incident, which details the time and location of the occurrence as well as all persons directly involved and their titles. The "Occurrence Screen" also includes the nature of the event and a description of any injuries. The screen should also contain a listing of witnesses to the event.

   A. **Responsibility for completion:**
   The employee having knowledge of the facts or the employee who observed the incident performs preparation of the report. All Occurrence Screens should be completed totally and fields are made "mandatory" in such a way as to prohibit the person reporting the incident from filing the report until all required fields have been completed. (See attached educational packets for end-users, employees and managers). Healthcare providers should document those facts concerning the occurrence, which are pertinent to the patient's care in the medical record. (i.e. actual medication given should be recorded in MAR as well as any treatment rendered, results of monitoring, or patient changes per appropriate nursing documentation protocols).

   B. **Documentation in the Medical Record:**
   The "Occurrence Screen" is a confidential report of an incident or adverse event and is **not a part of the medical record.** Also, no notation that an Occurrence Screen was completed is to be made in the body of the medical record.

   C. **Confidentiality of the "Occurrence Screen":**
   The Online Occurrence Screen Reporting system in the Risk Management Module is designed in such a way that the ability to "print" an occurrence screen is limited only to the Risk Manager and/or his/her designee. **OCCURRENCE SCREENS ARE NEVER TO BE COPIED.**

   The "Occurrence Screen" is a totally confidential work tool to be used for hospital reporting purposes only and is therefore a statutorily protected document. **NEVER** discuss or release any information contained in the report unless authorized by the Risk Manager or CEO. Anyone requesting such information should immediately be referred to the Risk Manager.

   D. **Timeliness of Reporting:**
   The Risk Manager must receive the "Occurrence Screen" within (3) calendar days. The Online Occurrence Reporting System facilitates this process by making all reports

accessible to the Risk Manager as soon as the individual completing the online "Occurrence Screen" has filed their portion of the report.
Occurrence Screens may be filed "after-the-fact" as soon as an occurrence is identified. If an incident is of significant gravity, it should be reported immediately to the Risk Manager or to the Administrative Assistant/Nursing after business hours. The Nursing Supervisor may contact the Risk Manager or Risk Manager Designee. Phone numbers and/or beeper numbers for these individuals are available through the operator as well as the In-house telephone directory.

E. **Access to Occurrence Screens:**
Only authorized end-users have access to complete an Occurrence Screen. The manager of that department may review occurrence screens for a specific department only. Managers do not have access to reports completed anywhere except on their unit. Once an Occurrence Screen has been completed and sealed by the Risk Manager, access to that Occurrence Screen is prohibited by any other individual.
Visitors, patients, families and healthcare surrogates are not required to sign or verify the report, and it should not be reviewed by them, nor, should they be given a copy. If they wish to provide input, they may do so by providing a written copy of their comments, observations to Risk Manager.

F. **Serious Incident Evaluation:**
In the instance of an actual or potentially serious injury, all investigations will be coordinated and directed by the Risk Manager.

3. **RISK MANAGEMENT/QUALITY IMPROVEMENT ACTIONS:**
The Risk Manager or designee will review all occurrence screens and request appropriate follow-up actions when necessary. If an occurrence report raises an actual or potential quality of care issue, the information will be referred to Quality Improvement for peer review processing and recommendations in accordance with the applicable Quality Improvement policies and procedures.

4. **CATEGORIES WHICH ARE CONSIDERED HOSPITAL OCCURRENCES:**
The following is a general list of categories that are considered Hospital Occurrences:

A. Events that are not consistent with routine patient care when compared to accepted standards.
B. Violation of established policies and procedures that involve patient care.
C. An accident to an employee, visitor or patient with or without injury.
D. An event with injury that is considered a potential claim or lawsuit.
E. Mishaps due to faulty or defective supplies or equipment or unsafe environmental conditions.

F. Unexpected adverse results of professional care and treatment, which necessitates additional hospitalization or a significant change in patient treatment regimens.
G. Patient, visitor or employee property loss or damage.

5. **EXAMPLES OF SPECIFIC OCCURRENCES WHICH REQUIRE COMPLETION OF AN OCCURRENCE SCREEN:**
Some specific occurrences that require the completion of an Occurrence Screen may include, but are not limited to:

A. Patient Falls – all types.
B. Treatment or Testing Related Incidents – including procedure variations by nursing, medical or technical staff, equipment problems leading to actual or potential patient injury, nosocomial decubiti formation, severe IV infiltrations or any IV-related phlebitis, or any complications or adverse patient occurrences as a result of treatment or testing.
C. Other Incidents – including patient-induced injuries, safety or security problems, pressure (decubitus) ulcers, which develop after admission, missing or damaged patient property, patient/family complaints, which include threat of legal action and visitor, related incidents.
D. Medication Variations – errors in medication administration, delays greater than one hour from scheduled dosing time, missed or extra doses, unresolved narcotic discrepancies or violations of narcotics sign off policies and procedures.
E. Equipment malfunction or breakdown.

6. **EQUIPMENT FAILURE/PRODUCT DEFECT:**
If equipment, instruments or products used for patient care are involved in an incident, accident, injury or near injury:

A. Equipment should be removed immediately, tagged with information about the problem, and Supply Chain notified.
B. Notify Risk Management and complete an Occurrence Screen, noting the serial number or identification number on the equipment.
C. Depending on the severity of the incident, material evidence may be sequestered by the Risk Manager.

Protocol for sequestering equipment:

A. When a patient is injured and a piece of equipment is involved, the equipment should simply be unplugged. No dials or settings should be touch. All packaging and accessories should also be collected and sent to Risk Management along with the equipment.
B. The equipment or product should not be returned to the manufacturer without the approval of the Risk Manager or CEO.

7. **TRANSFERS FROM OUTSIDE AGENCIES:**

If a patient is transferred from another agency and any of the following are noted, an

Occurrence Screen must be completed and forwarded to the Risk Management Department:

A. Patient received in an unstable condition.
B. Patient in active labor.
C. Receiving physician not contacted by the transferring physician and an agreement made to accept the patient.
D. Transfer mode and/or personnel utilized for transport were not qualified to meet needs of the patient during transfer process;
E. Memorandum of Transfer form did not accompany the patient from referring facility and transferring hospital did not provide copies of appropriate medical records of the patient's examination and treatment at the transferring hospital.

DEFINITIONS:

ADVERSE OR UNTOWARD INCIDENT:

According to Florida Statute § 395.0197 (2001) and Florida Administrative Code 59A-10.002 (2001)(5), an adverse or untoward incident for reporting purposes is defined as an event over which healthcare personnel could exercise control and:

(a) Is associated in whole or in part with medical intervention as described in below under the term medical intervention, rather than the condition for which such intervention occurred, and
(b) Is not consistent with or expected to be a consequence of such medical intervention; or
(c) Occurs as a result of medical intervention to which the patient has not given his informed consent; or
(d) Occurs as a result of any other action or lack thereof on the part of the facility or personnel of the facility; or
(e) Results in a surgical procedure being performed on the wrong patient; or
(f) Results in a surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries, and procedures to remove foreign objects remaining from surgical procedure; and
(g) Causes injury to a patient as defined below under injury.

An incident is also defined by West Florida Hospital as an event or occurrence, which is not consistent with the routine operation of the hospital, the routine care of a patient or the expected results of the care administered to a patient. This includes incidents or occurrences with or without injury involving patients, visitors or employees as well as an occurrence, which could evidence employee/physician negligence or incompetence.

INJURY:

An "injury" for the purposes of reporting to the Agency is any of the following outcomes when caused by an adverse incident:

(a) Death; or

(a) Brain damage; or
(b) Spinal damage; or
(c) Permanent disfigurement; or
(d) Fracture or dislocation of bones or joints; or
(e) Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition; or
(f) Any condition requiring surgical intervention to correct or control; or
(g) Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care; or
(h) Any condition that extends the patient's length of stay; or
(i) Any condition that results in a limitation of neurological, physical, or sensory function, which continues after discharge from the facility.

MEDICAL INTERVENTION:

Medical Intervention means actions of any health care facility or personnel of the facility, in the provision of health care.

REFERENCES: Florida Statute §395.0197 Internal Risk Management Program

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Patient Notification of Medical Errors

West Florida Hospital strives to promote an atmosphere of honesty and respect as pertains to keeping patient informed in all aspects of their care. There are times when medical errors occur in an institution. At times these errors can result in injury or harm to a patient. Should this occur, it is of utmost importance to assure that information is relayed by an appropriate individual, is done in the most appropriate setting and includes all of the information necessary for the patient/family to make informed decisions. To ensure consistency in this process we have established guidelines for providing information to patients and/or families/significant others when:

- A significant medical error occurs in the patient's care and results in harm, or
- Unanticipated outcomes have resulted from care, treatment and services that have been provided and the patient or family must be knowledgeable about these outcomes to participate in current and future decisions affecting their care.

The facility will notify patients and/or the patient's families when significant medical error occurs as soon as possible after the error is discovered, with the direction of the Chief Executive Officer (CEO) in consultation with the Chief of the Medical Staff.

The Chief Executive Officer (CEO), in consultation with the attending or covering physician, and the Chief of the Medical Staff, has the primary responsibility for initiating the procedures that 1) determines whether an event meets hospital-defined level of significance for notification, and 2) results in the patient and/or family being informed of the event.

The patient's attending or covering physician will have the primary responsibility for ensuring that the patient is informed. Other practitioners, such as the patient's primary care nurse, may be designated to perform notification. The Patient Care Team, made up of the nurse manager, clinical pharmacist, and case manager, will also be involved in notification and should be fully prepared to answer or readily obtain an answer to any questions the patient and/or family may have about the incident. So in addition to the patient's physician, the patient's nurse, a pharmacist, or a manager should be present to help answer questions. The patient and/or family should be notified in a private place. Ideally, they should receive prompt notification. Time should be provided for staff to respond to patient/family questions and concerns, if any should arise in the course of this discussion.

At a minimum, the patient and/or family should be informed about:

- The known nature of the error that occurred
- Any known possible repercussions the error may have on the patient's care and on short- and long-term health, and the proposed plan to respond to these changes should they occur.
- Point of contact for further questions and/or follow-up.
- Avenue of recourse
- Case Manager
- Risk Managers

- External agencies / list of names and address of professional review boards)
- VP Medical Affairs

After notification, a physician progress note will be made in the medical record and signed by the practitioner who notified the patient of the error as well as any other caregivers present for the discussion. Also, an occurrence screen should be prepared and submitted.

If the patient's clinical condition or care may be negatively impacted by notification after the event, then this discussion should be held with the appropriate family members, if possible. Otherwise, the notification may be deferred until a more appropriate time. The reason for deferring more than 24 hours must be documented in the physician progress notes. If the error is reported or discovered after discharge or completion of services at facility, the patient and/or family should be notified as soon as information about the error and its impact on the patient's health has been determined, as well as any actions that need to be taken by the patient/family member. At that time, the attending physicians will dictate/write an addendum to medical record regarding notification of patient/family member.

If the incident is the subject of litigation (or potential litigation), legal counsel for the facility may be consulted with respect to the process of notifying the patient and the information to be disclosed, and the procedures may be altered as a result of counsel's advice in that particular case.

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Advance Directives, Living Wills, & DNR Policies

1. Upon admission to the hospital each patient shall be asked if they have an Advance Directive.
2. If the patient is incapacitated, the patient's next of kin or guardian will be asked if the patient has executed an Advance Directive and if so, they will be told to bring the Advance Directive to the hospital. This request should be documented in Meditech. (Advance Directive Intervention will be "completed.")
3. The following information will be copied and put in the medical record:
    - Designation of Healthcare Surrogate/Proxy, or
    - Living Will, or
    - Medical or Durable Power of Attorney

Living Wills, Advance Directives, Healthcare Surrogate Designations and Medical Durable Power of Attorney are valid, unless the patient states that they have been changed, amended, revoked at any time.

DNR – DO NOT RESUSCITATE

1. Signed by MD
2. Definition – during cardiac and/or respiratory arrest patient will not be resuscitated.

HEALTHCARE SURROGATE

1. Signed by patient and witnessed.
2. Definition – a legal document by which a person appoints another person (called agent, attorney-in-fact, or surrogate) to act on his/her behalf to make medical decisions for the patient if the patient should become temporarily or permanently unable to make these decisions.

LIVING WILL

1. Signed by patient
2. Definition – a witnessed document in writing or a witnessed oral statement voluntarily made by the person that expresses the person's instructions concerning life-prolonging procedures only when that person is terminally ill, in an End Stage condition, or in a persistent vegetative state. It is called a Living Will because it takes effect while the patient is still living.
3. Explanation - When the patient's condition is such that any other treatment is futile, the patient can decide to stop further medical care and accept only care that will make him more comfortable. A Living Will goes into effect only when the patient is too sick or injured to speak for himself and when doctors believe he will not survive without the use of machines or aggressive treatment. If there is a reasonable chance that the patient can be restored to health, the Living Will won't apply.

   A Living Will can be cancelled or changed at any time.

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Ethics Committee (Bio-Ethics)

PURPOSE: The committee shall serve as an educational resource in the Hospital to encourage, facilitate and coordinate education in bio-ethics for members of the Hospital staff, professional and nonprofessional, and the community. This Hospital Administration Committee serves in an advisory capacity when consulted to assist physicians, other healthcare professionals and patients and their families in making bio-ethical decisions. The Committee may make recommendations on policies concerning bio-ethical issues to Administration.

CONFIDENTIALITY: All discussions and deliberations, which pertain to particular patient's circumstances, shall be treated as strictly confidential. All reports, documents, minutes, etc. will be maintained in accordance with hospital policy.

PROCEDURE TO INITIATE BIO-ETHIC CONSULTATION: **The** Bio-Ethics Committee recognizes the right of the patient or the patient's designated representative to participate in the consideration of ethical issues that arise in the care of the patient. The Committee will maintain consultation teams composed of members of the Committee. Response to consultation requests will be timely (within 24 hours or the next working day) between the initiation of the request and initial review.

Requests for bio-ethics consultation may be made by patient/families, patient-designated representatives, physicians, nursing staff, and ancillary staff.

CONSULTATION: The Team Leader will notify the team members to assist with the consultation. The Team may review the patient's medical record and hold discussions with the patient/family or patient's surrogate, the physician, and the requester, as needed.

The Team will work in an advisory capacity to assist in the resolution of the ethical concern. The team will provide educational material and discussion to caregivers and the patient or patient-designated representative to assist in an understanding of ethical issues surrounding the case.

A summary note will be made in the physician progress notes upon completion of the consultation.

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General Facts on Organ Donation and Transplantation

LifeQuest Organ Recovery Services, the federally designated organ procurement organization (OPO) for northern Florida is responsible for all organ donor referrals.

LifeQuest is based in Gainesville and has four satellite offices: Jacksonville, Tallahassee, Panama City and Pensacola.

The mission of LifeQuest is three-fold:

To offer families the option of donation

To recover organs for transplant

To educate the community on the importance of organ donation

The organ donation process involves several steps, including:

Making a referral: House Supervisor refers a potential organ donor to LifeQuest.

Obtaining consent: Only after a patient has been declared brain dead and the family has been notified of the death will we begin discussion about donation.

Placing the organs: After the family has given consent for donation, the procurement coordinator will consult the waiting lists to determine which potential transplant recipients will be offered the organs.

Recovering the organs: Once the transplant centers accept the offers of the various organs, an operation time will be arranged.

Patients awaiting organ transplants in the United States must be listed on the national waiting list, which is maintained by the United Network for Organ Sharing (UNOS).

Individuals can sign a donor card and carry it in their wallet or sign up to be an organ donor when they renew their driver license. Most importantly, individuals need to talk to their family about their decision to become a donor.

For more information on organ donation, please call (800) 535-GIVE.

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The Joint Commission On-site Survey Process

In 2006, The Joint Commission has changed the method of site surveying that they will do for the triennial accreditation. Previously, the accreditation organization sent surveyors who looked very thoroughly at the implementation of set hospital standards. The process required weeks of preparation and many felt that the "ramp-up" required to get ready for the survey provided an unrealistic setting to see how patient care was actually being done. The new on-site survey process evaluates more reality and the old process evaluated more potential problems.

The new survey agenda will be looking at the organization through the eyes of a patient. The survey will include patient tracer activities, which means the surveyor will examine all aspects of a patient's experience traced through the organization from his admission to discharge. They look at continuity of care, how well the caregivers' work together, and the quality of patient safety to determine how the organization is performing. After doing several patient tracers, the surveyors will also do system tracers, which means they will examine a specific system which include, but are not limited to medication management and infection control. They will examine the entire medication management system/tracer and infection control system/tracer within the hospital focusing on how the processes within these systems work. The priority focus areas (PFA), those processes and systems that impact quality of care and safety of care in a healthcare organization are communication, staffing, information management, and credentialed practitioners at West Florida Hospital.

Staff will be asked to talk to the surveyors. They may be asked about a protocol or procedure and would answer questions about what they have done concerning the specific care of the patient being traced. They may also be asked what is your role to protect the safety of out patients? The site surveyor will then interpret the staff's answers in relation to the specific standard that is being evaluated. If the information given by the staff is not enough to help the surveyor understand WFH processes, further questions will be asked.

The Joint Commission also performs Disease-Specific Care surveys to provide certification to a hospital for one or more disease-specific care program. WFH has maintained the Disease Specific Care Certification for its Stroke Program.

Joint Commission: Hospital Accreditation Standard

Any employee who has concerns about the safety or quality of care provided in the hospital may report these concerns to the Joint Commission:

E-Mail:
complaint@jointcommission.org

Fax:
Office of Quality Monitoring
(630) 792-5636

Mail:
Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630-792-5000

No disciplinary action will be taken by the hospital if an employee reports concerns to The Joint Commission. All staff are encouraged to use the Chain of Command for immediate action to resolve concerns.

E. M. T. A. L. A.

Emergency Medical Treatment and Active Labor Act 42 U.S. C. Section 1395 and F.S. 395-1041

The E. M. T. A. L. A law states that a patient, including a born-alive infant or pregnant woman in labor, who presents to a hospital with dedicated emergency department requesting emergency treatment must have an appropriate Medical Screening Exam (MSE) by an ER physician, another physician or other Qualified Medical Personnel (QMP) without regard to the person's ability to pay. The qualified medical personnel are Physician Assistants, A.R.N.P.'s, Certified Nurse Midwives and qualified labor and delivery nurses in consultation with the attending OB physician.

At West Florida Hospital, the Emergency Department and the Family Birthplace labor and delivery unit are the designated sites for a Medical Screening Exam.

The law requires that signage about E.M.T.A.L.A. must be present and visible in the designated sites and must be in English and Spanish.

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FMECA

West Florida Hospital will also identify patient safety events and high-risk processes that may be selected for this annual risk assessment. The process that we use to analyze and proactively correct potential problems is called FMECA. Failure mode and effects and criticality analysis (FMECA) is a disciplined approach used to identify possible failures of a product or service and then determine the frequency and impact of the failure. Failure mode and effects and criticality analysis (FMECA) is also the tool used to recognize and evaluate the potential product or process failure and its causes associated with the designing and manufacturing of a product. FMECA was developed in the 1960's in the aerospace industry to enhance safety and to increase customer satisfaction.

There are 10 steps in the FMECA process. By moving through each of these steps, WFH can determine root causes of potential or real problems and develop methods to prevent these root causes from occurring in the future. The employee needs to be aware of the availability of this process and that the hospital management team desires to utilize this process to improve care and prevent problems.

10 Steps of the FMECA Process:

1. Review the Process
2. Brainstorm potential failure modes
3. List potential effects of each failure mode
4. Assign a severity rating for each effect
5. Assign an occurrence rating for each failure mode
6. Assign a detection rating for each failure mode and/or effect
7. Calculate the risk priority number for each effect
8. Prioritize the failure modes for action
9. Take action to eliminate or reduce the high risk failure modes
10. Calculate the resulting RPN as the failure modes are reduced or eliminated

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Current Status: *Active* **PolicyStat ID:** *2551868*

West Florida HEALTHCARE

Effective:	*12/31/2016*
Approved:	*12/31/2016*
Next Review:	*12/31/2018*
Owner:	*Alison McGrath: QI Admin Assistant*
Policy Area:	*ADA (Facility)*
References:	*Model Policy*
Applicability:	*West Florida Hospital*

Accommodating Persons who are Blind or have Low Vision

PURPOSE STATEMENT:

To develop a plan that accommodates individuals pursuant to Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Patient Protection and Affordable Care Act (2010) and the Americans with Disabilities Act of 2008 which prohibits discrimination on the basis of disability in the delivery of healthcare services. The regulations implementing the Acts require that people who are blind or have low vision be provided with auxiliary aids at no cost to allow them an equal opportunity to participate in and benefit from healthcare services. The decision as to the method to be used for communication requires the input of the patient and their choice must be given weight. Failure to properly assess and subsequently provide a reasonable accommodation is punishable by fine to the provider.

WEST FLORIDA HOSPITAL is committed to compliance with federal and state laws prohibiting discrimination on the basis of disability. WEST FLORIDA HOSPITAL recognizes its legal obligation to ensure effective communication with persons with disabilities and makes every effort to pro-actively assess communication needs as well as providing the most compassionate care.

This policy requires development of a plan that accommodates individuals who are blind or have low vision by providing auxiliary aids at no cost to allow them an equal opportunity to participate in and benefit from healthcare services.

RESPONSIBLE PERSONS:

All WEST FLORIDA HOSPITAL staff.

DEFINITIONS:

- **Auxiliary aid. The term auxiliary aids refers to those auxiliary aids necessary to ensure effective communication with persons with disabilities and providers so that persons with language needs are not excluded, denied services, segregated, or otherwise treated differently than other persons because of the absence of auxiliary aids.**
- **Effective communication**. Communication sufficient to provide individuals that may be blind or have low vision with substantially the same level of services received by individuals who are not blind or have low vision.

- **Language Assistance Services**. Oral and written language services needed to assist individuals who may be blind or have low vision to communicate effectively with staff and to provide such persons meaningful access to and equal opportunity to, participate fully in the services, activities, or other programs.
- **Low Vision**. Even with eyeglasses, contact lenses, medicine or surgery, a person does not see well.
- **Meaningful Access**. Language assistance that results in accurate, timely, and effective communication at no cost to the individual who may be blind or have low vision. Meaningful access denotes access that is not significantly restricted, delayed or inferior as compared to programs or services provided to persons who are not blind or have low vision.
- **Qualified Reader**. A qualified reader is a person who is able to read effectively, accurately, and impartially using any necessary specialized vocabulary.

POLICY STATEMENT:

WEST FLORIDA HOSPITAL will take appropriate steps to ensure persons with disabilities, including persons who may be blind or have low vision, have an equal opportunity to participate in our services, activities and other benefits. The procedures outlined below are intended to ensure effective communication with patient involving medical conditions, treatment, services, and benefits. All necessary auxiliary aids and services shall be provided free of charge.

WEST FLORIDA HOSPITAL staff will be provided notice of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques. WEST FLORIDA HOSPITAL staff will inform patients who are blind or with low vision and any relatives of patients that may be blind or have low vision that have been designated as healthcare decision makers of the availability, at no cost to them, of auxiliary aids..

PROCEDURE:

A. **Equity Compliance Coordinator**

The Equity Compliance Coordinator (previously known as the 504 Coordinator) is responsible for the applicable aspects of Section 504 of the Rehabilitation Act of 1973 (28 U.S.C. 794), Section 1557 of the Patient Protection and Affordable Care Act (2010) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12181) including changes made by the ADA Amendments Act of 2008 (P.L. 110-325).

The Equity Compliance Coordinator is responsible for the coordination of the required accessibility training, including effective communication techniques for all staff members annually. They will conduct regular reviews of the language access needs of the patient population as well as the monitoring and updating of the implementation of this policy as needed.

B. **Identification and Assessment of Need of Persons who may be Blind or have Low Vision**

WEST FLORIDA HOSPITAL will identify the language and communication needs of persons who may be blind or have low vision as needed to ensure effective communication.

All staff may use the "**Notice of Auxiliary Aids for Persons who may be Blind or have Low Vision**" to inform such persons of services and determine what auxiliary aids may be needed to effectively communicate.

If language services are declined by the patient (or anyone involved in making medical decisions) staff will then use the "**Waiver of Auxiliary Aids**" to not only document the refusal but also to serve as notice to the patient (or person involved in making medical decisions) that they may still request a free auxiliary aids at any time.

The "**Notice of Auxiliary Aids for Persons who may be Blind or have Low Vision**" and/or the "**Waiver of Auxiliary Aids**" will be saved to the patient's medical record.

C. **Providing Notice to Persons who May be Blind or have Low Vision**

WEST FLORIDA HOSPITAL shall inform persons that may be blind or have low vision of the availability of qualified language

assistance, free of charge. A nondiscrimination statement will be posted at intake areas and other points of entry, including but not limited to the emergency room, outpatient areas, etc. Notification will also be provided through outreach documents.

D. **Obtaining Auxiliary Aids**

The Equity Compliance Coordinator or other designee is responsible for obtaining auxiliary aids needed for effective communication. Any and all agencies under contract (or with other arrangements made) for auxiliary aids will be listed in SECTION VI; the POLICY IMPLEMENTATION section contained within this policy.

E. **The Use of Family or Friends for Professional Language Services**

Family members or friends will not be used for language assistance unless specifically requested by the patient and only after an offer of free qualified auxiliary aids is offered and documented by the use of the "**Notice of Auxiliary Aids for Persons who are Blind or have Low Vision.**"

Persons that request (or prefer) the use of a family member or friend for qualified readers or other language assistance must take into consideration issues of competency, confidentiality, privacy and conflicts of interest. A "**Waiver of Auxiliary Aids**" will be used if any language services or auxiliary aids are provided by persons not procured specifically by the West Florida Hospital.

If a family member or friend is not competent or appropriate for any of the previous reasons then auxiliary aids must be provided to ensure effective communication.

Minor children or other patients will not be used to interpret in order to ensure the confidentiality of information and effective communication.

F. **Providing Written Translation**

The Equity Compliance Coordinator will coordinate the translation of vital documents into alternative formats as needed which shall be provided free of charge to persons who may be blind or have low vision.

G. **Monitoring Language Needs and Implementation**

The Equity Compliance Coordinator will assess changes in the demographics, types of services or other needs that may require the modifications to the implementation of this policy. Regular assessment of the effectiveness of these procedures, equipment necessary for the delivery of qualified language services and the complaint process will be conducted.

I. **POLICY IMPLEMENTATION**:

Language Services Associates, LP. Contact Jim Pastore, 800-305-9673, ext. 55315

II. **COMPLAINT PROCESS:**

It is the policy of WEST FLORIDA HOSPITAL not to discriminate on the basis of a person's disability. An internal grievance procedure has been adopted to provide for the prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (28 U.S.C. 794), Section 1557 of the Patient Protection and Affordable Care Act (2010) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12181) including changes made by the ADA Amendments Act of 2008 (P.L. 110-325).

Any person who believes he or she has been subjected to discrimination on the basis of his or her disability may file a grievance under this procedure [or under the regular WEST FLORIDA HOSPITAL grievance policy]. It is against the law for WEST FLORIDA HOSPITAL to retaliate against anyone who files a grievance or participates in the grievance process.

The Equity Compliance Coordinator will make appropriate arrangements so that persons who may be Blind or have low vision are provided other accommodations if needed to participate in the grievance process.

1. Complaints concerning language assistance must be submitted to the Equity Compliance Coordinator within 30 days of the date the patient becomes aware of the alleged discriminatory act.
2. The complaint shall be in writing, containing the name and address of the person filing the complaint. The complaint must also state the problem or action alleged to be discriminatory and the remedy or relief sought.
3. The Equity Compliance Coordinator shall conduct a thorough investigation providing an opportunity for all relevant evidence to be submitted as it relates to the alleged discriminatory act.
4. Every effort will be made to issue a written decision no later than 30 days after the complaint has been filed. All records of grievances will be maintained by the Equity Compliance Coordinator.
5. The person filing the grievance may appeal the initial decision by writing to the , RISK MANAGER within 15 days of receiving the initial decision. The RISK MANAGER will make every effort to issue a final written decision to the appeal within 30 days of the appeal being filed.

The filing of a complaint of discrimination based on a person's disability does not prevent the filing of a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

Undue Hardship

"Undue Hardship" refers to actions that create significant difficulty or expense to the West Florida Hospital. In this respect, West Florida Hospital reserves the right to assess patient requests for accommodations. Undue Hardship will be determined on a case-by-case basis. The following considerations will be weighed in West Florida Hospital's assessment of whether a requested accommodation creates an "Undue Hardship":

a. Range of available accommodations and sufficiency of available accommodations to address request at issue;
b. The net cost of the accommodation, including the overall financial resources compared to the size of the West Florida Hospital;
c. Nature and extent of the accommodation;
d. Type of construction required;
e. Impact or accommodation upon the operation of the West Florida Hospital; and/or
f. No adverse outcome in patient care.

I. **DOCUMENTATION:**

The staff member will document in the medical record that assistance has been provided, offered or refused by the use of the "**Notice of Auxiliary Aids for Persons who may be Blind or have Low Vision**" which may be attached to this policy.

A "**Waiver of Auxiliary Aids**" may be used if any language services are refused by the patient (or person involved in healthcare decisions).

RESOURCES:

- Language Services Providers (approved by HPG).
- Comprehensive Accreditation Manual for Hospitals, 2000.
- Rehab Act of 1973, Section 504.
- American Disabilities Act of 1990 (42 U.S.C. 12181), including changes made by the ADA Amendments Act of 2008 (P.L. 110-325).
- 28 CFR Part 36, revised as of July 1, 1994 entitled "Non Discrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities". (http://www.ada.gov/regs2010/titleIII_2010/titleIII_2010_regulations.htm

Explanation of Document (for providers and staff)

WEST FLORIDA HOSPITAL's *Accommodating Persons who are Blind or have Low Vision* policy requires that auxiliary aids be provided free of charge to patients (and persons involved in healthcare decisions) who may be blind or have low vision in order to ensure patient safety and effective communication between the patient and provider.

Patients have the right to refuse auxiliary aids and request that a family member (or friend) provide language services. An offer of free auxiliary aids must be offered and documented in the medical record by the use of the *Notice of Language Assistance Services for Persons Who are Blind and have Low Vision.* The potential risks of not using auxiliary aids must be explained to the patient (or person involved in making medical decisions) by the use of the *Waiver of Auxiliary Aids* which will be documented in the medical record.

Patients must sign the *Waiver of Auxiliary Aids* each and every time qualified language services are refused by the patient (or person involved in making medical decisions) and this *Waiver* must be saved to the medical record.

Providers may request, at their discretion, that a qualified medical interpreter is used despite the signing of the *Waiver*.

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Current Status: *Active* **PolicyStat ID:** *2551879*

Effective:	*12/31/2016*
Approved:	*12/31/2016*
Next Review:	*12/31/2018*
Owner:	*Alison McGrath: QI Admin Assistant*
Policy Area:	*ADA (Facility)*
References:	*Model Policy*
Applicability:	*West Florida Hospital*

Accommodating Persons Who are Deaf or Hard of Hearing

PURPOSE STATEMENT:

To develop a plan that accommodates individuals pursuant to Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Patient Protection and Affordable Care Act (ACA 2010) and the Americans with Disabilities Act of 2008 which prohibits discrimination on the basis of disability in the delivery of healthcare services. The regulation implementing the Acts requires that persons who are deaf or hard-of hearing be provided with auxiliary aids at no cost to allow them an equal opportunity to participate in and benefit from healthcare services. The decision as to the method to be used for communication requires the input of the patient and their choice must be given weight. Failure to properly assess and subsequently provide a reasonable accommodation is punishable by fine to the provider.

WEST FLORIDA HOSPITAL is committed to compliance with federal and state laws prohibiting discrimination on the basis of disability. WEST FLORIDA HOSPITAL recognizes its legal obligation to ensure effective communication with persons with disabilities and makes every effort to pro-actively assess communication needs as well as providing the most compassionate care.

This policy requires development of a language access plan that accommodates individuals who are deaf or hard-of-hearing by providing free auxiliary aids in order to ensure equal opportunity to participate in and benefit from healthcare services.

RESPONSIBLE PERSONS:

All WEST FLORIDA HOSPITAL staff.

DEFINITIONS:

A. **Auxiliary aid. Auxiliary aids may include video remote interpreting (VRI) or face-to-face sign-language interpreters, flash cards, communication boards, telephone amplifiers, a TDD/TTY, braille, taped and large print materials, and reading to the patient/surrogate decision-maker. Lip reading, note writing, and use of finger spelling or gestures may also aid communication but are not a replacement for interpreters.**

B. **Effective communication**. Communication sufficient to provide individuals that may be deaf or hard-of-hearing with substantially the same level of services received by individuals who are not deaf or hard-of-hearing.

C. **Interpretation**. The act of listening to a communication in one language (source language) and orally converting it to another language (target language) while retaining the same meaning.

D. **Language Assistance Services**. Oral and written language services needed to assist individuals who may be deaf or hard-of-hearing to communicate effectively with staff and to provide persons who are deaf or hard-of-hearing meaningful access to and equal opportunity to, participate fully in the services, activities, or other programs.

E. **Meaningful Access**. Language assistance that results in accurate, timely, and effective communication at no cost to the individual who may be deaf or hard-of-hearing. Meaningful access denotes access that is not significantly restricted, delayed or inferior as compared to programs or services provided to persons who are not deaf or hard-of-hearing.

F. **Qualified Interpreter**. A qualified interpreter (or translator) is an interpreter who has had their specialized vocabulary (medical or legal terminology) proficiency assessed.

A qualified interpreter is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary. No certification is needed to be a qualified interpreter and certified interpreters are not automatically qualified interpreters despite their training and certification. An interpreter's qualification is based on his/her ability to communicate effectively in a specific situation such as in a healthcare setting using complex medical terminology and processes.

POLICY STATEMENT:

WEST FLORIDA HOSPITAL will take appropriate steps to ensure persons with disabilities, including persons who may be deaf or hard-of-hearing, have an equal opportunity to participate in our services, activities and other benefits. The procedures outlined below are intended to ensure the effective communication with patients involving medical conditions, treatment, services and benefits. All necessary language assistance services shall be provided free of charge.

WEST FLORIDA HOSPITAL staff will be provided notice of this policy and procedure. Staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques. WEST FLORIDA HOSPITAL staff will inform patients who may be deaf or hard-of-hearing and any family member or friend of the patient who is participating in treatment discussions and decision-making that is deaf or hard-of-hearing of the availability, at no cost to them, of language services in order to effectively communicate.

PROCEDURE:

A. **Equity Compliance Coordinator**

The Equity Compliance Coordinator (previously known as the 504 Coordinator) is responsible for the applicable aspects of Section 504 of the Rehabilitation Act of 1973 (28 U.S.C. 794), Section 1557 of the Patient Protection and Affordable Care Act (2010) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12181) including changes made by the ADA Amendments Act of 2008 (P.L. 110-325).

The Equity Compliance Coordinator is responsible for the coordination of the required accessibility training, including effective communication techniques for all staff members annually. They will conduct regular reviews of the language access needs of the patient population as well as the monitoring and updating of the implementation of this policy as needed.

B. **Identification and Assessment of Persons who may be Deaf or Hard-of-Hearing**

WEST FLORIDA HOSPITAL will identify the language and communication needs of persons who may be deaf or hard-of-hearing as needed to ensure effective communication.

All staff may use the "**Notice of Language Assistance Services for Persons who may be Deaf or Hard-of-Hearing**" to inform such persons of services and determine what language assistance services may be needed.

If language services are declined by the patient (or anyone involved in making medical decisions) staff will then use the "**Waiver of Language Assistance**" to not only document the refusal but also to serve as notice to the patient (or person involved in making medical decisions) that they may still request a free qualified interpreter at any time.

The "**Notice of Language Assistance Services for Persons who may be Deaf or Hard-of-Hearing**" and/or the "**Waiver of Language Assistance**" will be saved to the patient's medical record.

C. **Providing Notice to Persons who May be Deaf or Hard-of-Hearing**

WEST FLORIDA HOSPITAL shall inform persons who may be Deaf or Hard of Hearing of the availability of free qualified language

assistance. A nondiscrimination statement will be posted at intake areas and other points of entry, including but not limited to the emergency room, admitting and outpatient areas. Notification will also be provided through outreach documents.

WEST FLORIDA HOSPITAL utilizes relay services for external telephone with TTY users. Calls are accepted through a relay service. The state relay service number is 800-305-9673, ext. 55315

D. **Obtaining a Qualified Interpreter**

The EQUITY COMPLIANCE COORDINATOR or designee is responsible for obtaining a qualified interpreter when needed to effectively communicate. **Any and all agencies under contract (or with other arrangements made) for professional language assistance will be listed in SECTION VI; the POLICY IMPLEMENTATION section contained within this policy.**

E. **The Use of Family or Friends for Professional Language Services**

Family members or friends will not be used for language assistance unless specifically requested by the patient and only after an offer of free qualified language assistance is offered and documented by the use of the "**Notice of Language Assistance Services for Persons who are Deaf or Hard of Hearing.**"

Persons that request (or prefer) the use of a family member or friend as interpreters must take into consideration issues of competency, confidentiality, privacy and conflicts of interest. A "**Waiver of Language Assistance**" will be used if any language services are provided by persons not procured specifically by the West Florida Hospital.

If a family member or friend is not competent or appropriate for any of the previous reasons then a qualified interpreter must be provided to ensure effective communication.

Minor children or other patients will not be used to interpret in order to ensure the confidentiality of information and effective communication.

F. **Providing Written Translation**

The EQUITY COMPLIANCE COORDINATOR will coordinate the translation of vital documents into alternative formats as needed which shall be provided free of charge to persons who may be deaf or hard-of-hearing.

G. **Monitoring Language Needs and Implementation**

The EQUITY COMPLIANCE COORDINATOR will assess changes in the demographics, types of services or other needs that may require the modifications to the implementation of this policy. Regular assessment of the effectiveness of these procedures, equipment necessary for the delivery of qualified language services and the complaint process will be conducted.

I. **POLICY IMPLEMENTATION**:

Language Services Associates, LP. Contact Jim Pastore, 800-305-9673, ext. 55315

II. **COMPLAINT PROCESS:**

It is the policy of WEST FLORIDA HOSPITAL not to discriminate on the basis of a person's disability. An internal grievance procedure has been adopted to provide for the prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (28 U.S.C. 794), Section 1557 of the Patient Protection and Affordable Care Act (2010) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12181) including changes made by the ADA Amendments Act of 2008 (P.L. 110-325).

Any person who believes he or she has been subjected to discrimination on the basis of his or her disability may file a grievance under this procedure [or under the regular WEST FLORIDA HOSPITAL grievance policy]. It is against the law for WEST FLORIDA HOSPITAL to retaliate against anyone who files a grievance or participates in the grievance process.

The EQUITY COMPLIANCE COORDINATOR will make appropriate arrangements so that persons who may be deaf or hard-of-hearing are provided other accommodations if needed to participate in the grievance process.

1. Complaints concerning language assistance must be submitted to the EQUITY COMPLIANCE COORDINATOR within 30 days of the date the patient becomes aware of the alleged discriminatory act.
2. The complaint shall be in writing, containing the name and address of the person filing the complaint. The complaint must also state the problem or action alleged to be discriminatory and the remedy or relief sought.
3. The EQUITY COMPLIANCE COORDINATOR shall conduct a thorough investigation providing an opportunity for all relevant evidence to be submitted as it relates to the alleged discriminatory act.
4. Every effort will be made to issue a written decision no later than 30 days after the complaint has been filed. All records of grievances will be maintained by the EQUITY COMPLIANCE COORDINATOR.
5. The person filing the grievance may appeal the initial decision by writing to the RISK MANAGER within 15 days of receiving the initial decision. The RISK MANAGER will make every effort to issue a final written decision to the appeal within 30 days of the appeal being filed.

The filing of a complaint of discrimination based on a person's disability does not prevent the filing of a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

Undue Hardship

"Undue Hardship" refers to actions that create significant difficulty or expense to the West Florida Hospital. In this respect, West Florida Hospital reserves the right to assess patient requests for accommodations. Undue Hardship will be determined on a case-by-case basis. The following considerations will be weighed in West Florida Hospital's assessment of whether a requested accommodation creates an "Undue Hardship":

a. Range of available accommodations and sufficiency of available accommodations to address request at issue;
b. The net cost of the accommodation, including the overall financial resources compared to the size of the West Florida Hospital;
c. Nature and extent of the accommodation;
d. Type of construction required;
e. Impact or accommodation upon the operation of the West Florida Hospital; and/or
f. No adverse outcome in patient care.

DOCUMENTATION:

The staff member will document in the medical record that assistance has been provided, offered or refused by the use of the "**Notice of Language Assistance Services for persons who are Deaf or Hard of Hearing**" which may be attached to this policy.

A "**Waiver of Language Assistance**" may be used if any language services are refused by the patient (or person involved in healthcare decisions).

RESOURCES:

- Language Services Providers (approved by HPG).
- Comprehensive Accreditation Manual for Hospitals, 2000.
- Rehab Act of 1973, Section 504.
- American Disabilities Act of 1990 (42 U.S.C. 12181), including changes made by the ADA Amendments Act of 2008 (P.L. 110-325).
- 28 CFR Part 36, revised as of July 1, 1994 entitled "Non Discrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities". (http://www.ada.gov/regs2010/titleIII_2010/titleIII_2010_regulations.htm

Explanation of Document (for providers and staff)

WEST FLORIDA HOSPITAL's *Accommodating Persons who are Deaf or Hard of Hearing* policy requires that a qualified medical interpreter be provided free of charge to patients (and persons involved in healthcare decisions) who may be Deaf or Hard of Hearing in order to ensure patient safety and effective communication between the patient and provider.

Patients have the right to refuse a qualified medical interpreter and request that a family (or friend) provide interpreting services. An offer of free qualified language assistance must be offered and documented in the medical record by the use of the *Notice of Language Assistance Services for Persons Who are Deaf or Hard of Hearing.* The potential risks of using an interpreter that is not qualified must be explained to the patient (or person involved in making medical decisions) in the person's primary (or preferred) language by the use of the *Waiver of Language Assistance* which will be documented in the medical record.

Patients must sign the *Waiver of Language Services* each and every time qualified language services are refused by the patient (or person involved in making medical decisions) and this *Waiver* must be saved to the medical record.

Providers may request, at their discretion, that a qualified medical interpreter is used despite the signing of the *Waiver*.

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Current Status: *Active* **PolicyStat ID:** *2551889*

West Florida HEALTHCARE

Effective: *12/31/2016*
Approved: *12/31/2016*
Next Review: *12/31/2018*
Owner: *Alison McGrath: QI Admin Assist*
Policy Area: *ADA (Facility)*
References: *Model Policy*
Applicability: *West Florida Hospital*

Accommodating Persons with Service Animals

I. PURPOSE

To develop a plan that accommodates individuals pursuant to Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Patient Protection and Affordable Care Act (2010) and the Americans with Disabilities Act of 2008 which prohibits discrimination on the basis of disability in the delivery of healthcare services.

WEST FLORIDA HOSPITAL is committed to compliance with federal and state laws prohibiting discrimination on the basis of disability. **WEST FLORIDA HOSPITAL** recognizes its legal obligation to accommodate service animals and makes every effort to pro-actively assess the accommodation needs as well as providing the most compassionate care.

Service animals are dogs (or miniature horses) that are individually trained to assist people with disabilities. The Americans with Disabilities Act (ADA) definition of service animals is any "dog individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability." The work or tasks performed by a service animal must be directly related to an individual's disability.

This policy requires the development of a plan to ensure that persons using service animals have an equal opportunity to participate in and benefit from healthcare services. This policy specifically differentiates "service animals" from "therapy animals," and describes types of service dogs, as well as sets behavioral guidelines.

II. RESPONSIBLE PERSONS

All WEST FLORIDA HOSPITAL staff.

DEFINITIONS

A. **Disability**. A person must meet the statutory definition of having a "disability," under federal, state and/or local laws. These statutes recognize the following broad categories of disabilities:

- A sensory, mental, or physical impairment that substantially limits one or more major life activities (such as walking, seeing, hearing, speaking and breathing, working, learning, caring for one's self, performing manual tasks, etc.).
- A sensory, mental or physical condition that is medically cognizable or diagnosable.

A. **Handler**. A person with a service or therapy animal.

B. **Individualized Assessment**. An individualized assessment of a service animal must be made by the Equity Compliance Coordinator (previously referred to as the 504 Coordinator) or other designee prior to excluding the service animal and is based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration,

and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids will mitigate the risk. [28 C.F.R §36.208(b); 28 C.F.R. §35.139(b)]

C. **Pet/Comfort Animal**. A domestic animal kept for pleasure or companionship. Pets are generally not permitted in the WEST FLORIDA HOSPITAL. Permission may be granted by Administration for a pet to be in a campus West Florida Hospital for a specific reason at a specific time.

D. **Service Animal**. Any dog (or miniature horse) individually trained to do work or perform tasks directly related to the disability that the individual has. A service animal meets the definition of a service animal regardless of the terminology used to describe it. A service animal is sometimes also called an assistance animal. (A non-inclusive list of more common types of service animals is below).

If there is a question about whether an animal is a service animal, contact the Equity Compliance Coordinator.

E. **Therapy Animal**. An animal with good temperament and disposition, and who has reliable, predictable behavior, selected to visit people with disabilities or people who are experiencing the frailties of aging as a therapy tool. The animal may be incorporated as an integral part of a treatment process. A therapy animal has not been trained to assist an individual with a disability with work or tasks. The therapy animal does not accompany a person with a disability all the time, unlike a service animal that is always with its handler. Thus, a therapy animal is not a service animal.

F. **Service Animal in Training**. A dog or miniature horse, undergoing training to become a service animal. A trainee will be housebroken and fully socialized. To be fully socialized means the animal will not, except under rare occasions, bark, yip, growl or make disruptive noises; will have a good temperament and disposition; will not show fear; will not be upset or agitated when it sees another animal; and will not be aggressive. A trainee will be under the control of the handler, who may or may not have a disability. If the trainee begins to show improper behavior, the handler will act immediately to correct the animal or will remove the animal from the premises. There is no federal obligation to accommodate service animals that are still in training.

- TYPES OF SERVICE ANIMALS

There are many different types of services animals. A non-inclusive list of some of the most common service animals is below:

- A **guide service dog** is trained to assist in navigation and other tasks for a person who is legally blind or has low vision.
- An **alert service dog** is trained to alert a person with significant hearing loss or who is deaf when a sound occurs, such as a knock on the door.
- A **mobility service dog** is trained to assist a person who has a mobility or health disability. Duties may include carrying, fetching, opening doors, ringing doorbells, activating elevator buttons, steadying a person while walking, helping a person up after a fall, etc. Mobility service dogs sometimes are called assistance animals.
- A **seizure response service dog** is trained to assist a person with a seizure disorder. The animal's service depends on the person's needs. The animal may go for help, or may stand guard over the person during a seizure. Some animals have learned to predict a seizure and warn the person.

I. POLICY STATEMENT

Service animals will be permitted in all areas of the WEST FLORIDA HOSPITAL open to the public in accordance with both the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (Section 504) and other applicable federal and state laws and regulations prohibiting the discrimination on the basis of a person's disability.

A service animal must be permitted to accompany a person with a disability almost everywhere.

Reasonable modifications must be made to policies, practices and procedures when necessary to accommodate patients (or persons involved in the medical decisions) with a service animal. Generally, this means the waiving of a no animal policy to permit

the use of a service animal.

Service animals will be permitted to accompany an individual with a disability to all areas of the WEST FLORIDA HOSPITAL where patients are normally allowed to go, except where the accommodation of the animal would result in a fundamental alteration of the services offered.

Service animals assist with many different tasks, including, but not limited to, assisting individuals who are blind or have low vision with navigation and other tasks, alerting individuals who are deaf or hard-of-hearing to the presence of people or sounds, providing non-violent protection or rescue work, pulling a wheelchair, assisting an individual during a seizure, alerting individuals to the presence of an allergen(s), providing assistance with balance and stability to individuals with mobility disabilities, and helping persons with behavioral health and neurological disabilities by reminding them to take medications or assisting them when they are symptomatic. If an animal meets this definition, it is considered a service animal regardless of whether it has been licensed or certified by a state or local government or a training program.

PROCEDURE

A. **Requirements for Staff**

1. Staff cannot ask about the nature of the person's disability, require (or request) any 'proof' of the animal's training (or any other certification) as any inquiry violates various nondiscrimination laws, including the ADA.

If it is NOT readily apparent that the dog is a service animal staff must ONLY ask:

a. **IF THE ANIMAL IS REQUIRED BECAUSE OF A DISABILITY? and**
b. **WHAT WORK OR TASK HAS THE ANIMAL BEEN TRAINED TO PERFORM?**

1. Staff CANNOT pet, play with or try to distract the service animal in any way.
2. Staff CANNOT feed or care for the service animal, including toileting.
3. Staff CANNOT charge or require an individual to pay a surcharge in order to accommodate a service animal.
4. Staff should NEVER attempt to separate the service animal from the person with the qualified disability.
5. Staff should ALWAYS remember that the service animal is a working animal and should make every effort to minimize activities that may startle the animal.

A. **Requirements of Service Animals and Their Handlers**

1. **Leash**: The service animal must be on a leash, harness or tether at all times, unless either the handler is unable because of a disability to use the harness, leash or other tether; or the use of a harness, leash or tether would interfere with the service animal's safe, effective performance of the work or task which the service animal was trained to perform. The service animal must still remain under the control of the handler even if the service animal is not on a harness, leash or tether.
2. **Under Control of Handler**: The handler must be in full control of the animal at all times. The care and supervision of a service animal is solely the responsibility of its handler. If a service animal must be separated from the handler to avoid a fundamental alteration or a threat to safety, it is the responsibility of the handler to arrange for the care and supervision of the animal during the period of separation.
3. **Cleanup Rule**: The handler must always carry supplies sufficient to clean up the animal's feces. Marked service animal toileting areas should be used when provided.

4. **Feeding and Other Care**: The handler must provide the service animal with food, water, and other necessary care or make other arrangements for the care of the service animal. **Under no circumstances shall the staff or volunteers care for the service animal**.

A. **When a Service Animal Can Be Asked to Leave**

A person with a disability may only be asked to remove their service animal immediately from the premises if the service animal is out of control and the handler does not take effective action to keep it under control; or the service animal is not house broken.

B. **Individualized Assessment**

Individuals with disabilities shall be permitted to be accompanied by their service animal in all areas where members of the public and/or patients are permitted to go. However, it may be appropriate to perform an **individualized assessment** to exclude the service animal from areas such as the operating rooms and burn units where a sterile environment is critical to the services provided.

This assessment shall be based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence to ascertain: the nature, duration and severity of the risk; the probability that a potential injury will actually occur; and whether any reasonable modifications of policies, practices or procedures or the provision of auxiliary aids or services will mitigate the risk.

If it is determined, through an individualized assessment, that the service animal cannot be accommodated; staff shall, upon the request of the patient, arrange for visits between the service animal and the handler in an area of equivalent privacy and amenities.

C. **Visitors with Service Animals**

Service animals are generally permitted where visitors are permitted unless an individualized assessment is made to exclude a service animal.

Visitors with service animals may not be permitted to access areas that employ greater than general infectious-control measures or when a patient is immunosuppressed. If a determination is made that a service animal cannot be accommodated in a certain area by the use of an individualized assessment; then the visitor will be offered additional accommodations including but not limited to transferring the patient to another comparable room when available to allow unrestricted access. Only if additional accommodations are not available will the visitor be given the option of removing the animal or having friend, family or accompanying persons remove the animal so the visitor may continue with the visit.

D. **Emergency Situations**

In the event of an emergency, the Emergency Response Team (ERT) that responds should be trained to recognize service animals and to be aware that the animal may be trying to communicate the need for help. The handler and/or animal may be confused from the stressful situation. The ERT should be aware that the animal is trying to be protective and, in its confusion, is not to be considered harmful. The ERT will make every effort to keep the animal with its handler. However, the ERT's first effort is toward the handler; this may necessitate leaving an animal behind in certain emergency evacuation situations. When doing so is possible, the ERT will transport the service animal to a safe location to await being reunited with its handler.

COMPLAINT PROCESS:

It is the policy of WEST FLORIDA HOSPITAL not to discriminate on the basis of a person's disability. An internal grievance procedure has been adopted to provide for the prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (28 U.S.C. 794), Section 1557 of the Patient Protection and Affordable Care Act (2010) or the Americans with Disabilities Act of 1990 (42 U.S.C. 12181) including changes made by the ADA Amendments Act of 2008 (P.L. 110-325).

Any person who believes he or she has been subjected to discrimination on the basis of his or her disability may file a grievance under this procedure [or under the regular WEST FLORIDA HOSPITAL grievance policy]. It is against the law for WEST FLORIDA HOSPITAL to retaliate against anyone who files a grievance or participates in the grievance process.

1. Complaints concerning accommodations of a service animal must be submitted to the Equity Compliance Coordinator within 30 days of the date the patient becomes aware of the alleged discriminatory act.
2. The complaint shall be in writing, containing the name and address of the person filing the complaint. The complaint must also state the problem or action alleged to be discriminatory and the remedy or relief sought.
3. The Equity Compliance Coordinator shall conduct a thorough investigation providing an opportunity for all relevant evidence to be submitted as it relates to the alleged discriminatory act.
4. Every effort will be made to issue a written decision no later than 30 days after the complaint has been filed. All records of grievances will be maintained by the Equity Compliance Coordinator.
5. The person filing the grievance may appeal the initial decision by writing to the RISK MANAGER within 15 days of receiving the initial decision. The RISK MANAGER will make every effort to issue a final written decision to the appeal within 30 days of the appeal being filed.

The filing of a complaint of discrimination based on a person's disability does not prevent the filing of a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD)

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Current Status: *Active* **PolicyStat ID:** *2551884*

West Florida HEALTHCARE

Effective:	*12/31/2016*
Approved:	*12/31/2016*
Next Review:	*12/31/2018*
Owner:	*Alison McGrath: QI Admin Assistant*
Policy Area:	*ADA (Facility)*
References:	*Model Policy*
Applicability:	*West Florida Hospital*

Accommodating Persons with Limited English Proficiencies (LEP)

PURPOSE STATEMENT:

To develop effective guidelines, consistent with Section 504 of the Rehabilitation Act of 1973 (28 U.S.C 794), Section 1557 of the Patient Protection and Affordable Care Act (2010) and Executive Order 13166 which requires persons with limited English proficiency (LEP) have "meaningful access" to healthcare services. Recipients of federal financial assistance are prohibited from discriminating based on a person's primary (or preferred) language, among other things, failing to provide meaningful access to individuals who have limited English proficiency (LEP). Federal fund recipients must also provide the translation of vital documents as part of their language assistance services when necessary to ensure the patient's access to important written information. Failure to properly assess and subsequently provide a reasonable accommodation is punishable by fine to the provider.

WEST FLORIDA HOSPITAL is committed to compliance with federal and state laws prohibiting discrimination on the basis of disability. WEST FLORIDA HOSPITAL recognizes its legal obligation to ensure effective communication with persons with disabilities and makes every effort to pro-actively assess communication needs as well as providing the most compassionate care.

This policy requires the development of a language access plan that accommodates persons with LEP in order to ensure them meaningful access to participate in and benefit from healthcare services.

RESPONSIBLE PERSONS:

All WEST FLORIDA HOSPITAL staff.

DEFINITIONS:

A. **Effective Communication**. Communication sufficient to provide the individual who may have limited English proficiency with substantially the same level of services received by individuals who are not limited in English proficiency.

B. **Interpretation**. The act of listening to a communication in one language (source language) and orally converting it to another language (target language) while retaining the same meaning.

C. **LEP** is the acronym for both "limited English proficiency" and "limited English proficient." The U.S. Census Bureau's operational definition for LEP is a patient's self-assessed ability to speak English less than "very well." Individuals who do not speak English as the primary (or preferred) language and who have limited ability to read, write, speak, or understand English. Individuals who are LEP may be competent in English for certain types of communication (like speaking) but still be LEP for other purposes (like reading or writing).

D. **Language Assistance Services**. Oral and written language services needed to assist individuals who are LEP to communicate effectively with staff and to provide individuals who are LEP meaningful access and equal opportunity to participate fully in the services, activities, or other programs.

E. **Meaningful Access**. Language assistance that results in accurate, timely, and effective communication at no cost to the individual who is LEP. Meaningful access denotes access that is not significantly restricted, delayed or inferior as compared to programs or services provided to persons who are proficient in the English language.

F. **Primary Language**. An individual's primary language is the language in which the individual most effectively communicates.

G. **Qualified Interpreter or Translator**. A qualified interpreter (or translator) is an interpreter who has had their specialized vocabulary (medical or legal terminology) proficiency assessed.

H. **Translation**. The replacement of written text from one language (source language) to an equivalent written text in another language (target language).

I. **Vital Documents**. A document will be considered vital if it contains information that is critical for obtaining federal services and/or benefits, or is required by law.

POLICY STATEMENT:

WEST FLORIDA HOSPITAL will take reasonable steps to ensure that persons with LEP have meaningful access and an equal opportunity to participate in services, activities, programs and any other benefits offered.

This policy also provides for the communication of information contained in vital documents. **All necessary qualified language assistance shall be provided free of charge**. Language assistance will be provided through the use of qualified interpreters with local organizations or contracted national vendors as well as video remote interpreting (VRI) and telephonic interpreting.

WEST FLORIDA HOSPITAL staff will be provided notice of this policy and procedure and will be trained on effective communication techniques. Staff will inform patients (and persons involved in decision making) who may be LEP, of the availability, at no cost, of qualified language assistance.

PROCEDURE:

A. **Equity Compliance Coordinator**

The Equity Compliance Coordinator (previously known as the 504 Coordinator) is responsible for the applicable aspects of Section 504 of the Rehabilitation Act of 1973 (28 U.S.C. 794), Section 1557 of the Patient Protection and Affordable Care Act (2010) and Executive Order 13166.

The Equity Compliance Coordinator is also responsible for the coordination of the required accessibility training, including effective communication techniques for all staff members annually. The Coordinator will oversee the required translation of vital documents and the postings of notices of nondiscrimination and associated 'taglines' in various languages spoken in the local area.

The Equity Compliance Coordinator will conduct regular reviews of the language access needs of the patient population as well as the monitoring and updating of the implementation of this policy as needed.

B. **Identification of Persons who may be LEP**

WEST FLORIDA HOSPITAL will identify the language and communication needs of persons with LEP as needed to ensure effective communication. If necessary, staff may use a language identification card (or "I speak" cards – which are available at www.lep.gov) or posters to determine the preferred language of the patient (or person involved in healthcare decisions).

All staff may use the "**Notice of Language Assistance Services**" to inform such persons of services and determine what language services may be needed.

If language services are declined by the patient (or anyone involved in making medical decisions) staff will then use the "**Waiver of**

Language Assistance" to not only document the refusal but also to serve as notice to the patient (or person involved in making medical decisions) that they may still request a free qualified interpreter at any time.

The "**Notice of Language Assistance Services**" and/or the "**Waiver of Language Assistance**" will be saved to the patient's medical record.

C. **Providing Notice to Persons who May be LEP**

WEST FLORIDA HOSPITAL shall inform persons who may be LEP of the availability of qualified language assistance, free of charge, by providing written notice in the primary (or preferred) language of the patient (or person involved in making medical decisions). The **Taglines** will be posted in fifteen (15) languages spoken in the community served. At a minimum, notices and signs will be posted at intake areas and other points of entry, including but not limited to the emergency room, admitting and outpatient areas. Notification will also be provided through outreach documents.

D. **Obtaining a Qualified Interpreter**

The Equity Compliance Coordinator or other designee is responsible for obtaining a qualified interpreter when needed to ensure effective communication. **Any and all agencies under contract (or with other arrangements made) for professional language assistance will be listed in SECTION VI; the POLICY IMPLEMENTATION section contained within this policy.**

E. **The Use of Family or Friends for Professional Language Services**

Family members or friends will not be used for language assistance unless specifically requested by the patient and only after an offer of free qualified language assistance is offered and documented by the use of the "**Notice of Language Assistance Services**". Persons that request (or prefer) the use of a family member or friend as interpreters must take into consideration issues of competency, confidentiality, privacy and conflicts of interest. A "**Waiver of Language Assistance**" will be used if any language services are provided by persons not procured specifically by the West Florida Hospital.

If a family member or friend is not competent or appropriate for any of the previous reasons then a qualified interpreter may be provided to ensure effective communication.

Minor children or other patients will not be used to interpret in order to ensure the confidentiality of information and effective communication.

F. **Providing Written Translation**

The Equity Compliance Coordinator will coordinate the translation of **vital documents** into the appropriate frequently encountered languages as needed. The translation of other written materials, as well as the written notice of availability of translation services, shall be provided free of charge to persons who may be LEP.

G. **Monitoring Language Needs and Implementation**

The Equity Compliance Coordinator will assess changes in the demographics, types of services or other needs that may require the modifications to the implementation of this policy. Regular assessment of the effectiveness of these procedures, equipment necessary for the delivery of qualified language services and the complaint process will be conducted.

I. **POLICY IMPLEMENTATION**:

Language Services Associates, LP. Contact Jim Pastore, 800-305-9673, ext. 55315

II. **COMPLAINT PROCESS:**

It is the policy of WEST FLORIDA HOSPITAL not to discriminate on the basis of a person's preferred or primary language. An internal grievance procedure has been adopted to provide for the prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1974 (29 U.S.C. 794), Section 1557 of the Patient Protection and Affordable Care Act or the U.S. Department of Health and Human Services regulations implementing the Acts.

Any person who believes he or she has been subjected to discrimination on the basis of his or her primary or preferred language may file a grievance under this procedure [or under the regular WEST FLORIDA HOSPITAL grievance policy]. It is against the law for WEST FLORIDA HOSPITAL to retaliate against anyone who files a grievance or participates in the grievance process.

The Equity Compliance Coordinator will make appropriate arrangements so that persons who may be LEP are provided other accommodations if needed to participate in the grievance process.

1. Complaints concerning language assistance must be submitted to the Equity Compliance Coordinator within 30 days of the date the patient becomes aware of the alleged discriminatory act.
2. The complaint shall be in writing, containing the name and address of the person filing the complaint. The complaint must also state the problem or action alleged to be discriminatory and the remedy or relief sought.
3. The Equity Compliance Coordinator shall conduct a thorough investigation providing an opportunity for all relevant evidence to be submitted as it relates to the alleged discriminatory act.
4. Every effort will be made to issue a written decision no later than 30 days after the complaint has been filed. All records of grievances will be maintained by the Equity Compliance Coordinator.
5. The person filing the grievance may appeal the initial decision by writing to the RISK MANAGER within 15 days of receiving the initial decision. The RISK MANAGER, ADMINISTRATOR] will make every effort to issue a final written decision to the appeal within 30 days of the appeal being filed.

The filing of a complaint of discrimination based on a person's LEP does not prevent the filing of a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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I. **DOCUMENTATION:**

The staff member will document in the medical record that assistance has been provided, offered or refused by the use of the "**Notice of Language Assistance Services**" which may be attached to this policy.

A "**Waiver of Language Assistance**" may be used if any language services are refused by the patient (or person involved in healthcare decisions).

RESOURCES:

1. Language Services Providers (HPG approved.
2. Rehab Act of 1973, Section 504 (29 U.S.C. 794).

3. 28 CFR Part 36, revised as of July 1, 1994 entitled "Non Discrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities". (http://www.ada.gov/regs2010/titleIII_2010/titleIII_2010_regulations.htm
4. Effective Communication Resources for Health Providers: http://www.hhs.gov/civil-rights/for-individuals/special-topics/hospitals-effective-communication/limited-english-proficiency/index.html
5. Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs: Federal Coordination and Compliance Section of the Civil Rights Division of the U. S. Department of Justice.

Explanation of Document (for providers and staff)

WEST FLORIDA HOSPITAL's *Accommodating Persons who are Limited English Proficient (LEP)* policy requires that a qualified medical interpreter be provided free of charge to patients (and persons involved in healthcare decisions) who may be LEP in order to ensure patient safety and effective communication between the patient and provider.

Patients have the right to refuse a qualified medical interpreter and request that a family (or friend) provide interpreting services. An offer of free qualified language assistance must be offered and documented in the medical record by the use of the *Notice of Language Assistance Services.* The potential risks of using an interpreter who is not qualified must be explained to the patient (or person involved in making medical decisions) in the person's primary (or preferred) language by the use of the *Waiver of Language Assistance* which will be documented in the medical record.

Patients must sign the *Waiver of Language Services* each and every time qualified language services are refused by the patient (or person involved in making medical decisions) and this *Waiver* must be saved to the medical record.

Providers may request, at their discretion, that a qualified medical interpreter is used despite the signing of the *Waiver*.

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Safe Medical Devices

What is a "medical device?"

Any device or apparatus used to prevent, relieve, or treat a disease or affect the structure or function of the body.

Example: IV infusion pumps, monitors, syringes, pacemakers

What is the purpose of the Safe Medical Device Act of 1990?

The act sets reporting and tracking requirements for the hospital as a device user.

When should a device be reported?

Whenever information suggests that a medical device has or may have caused or contributed to the serious illness, injury, or death of a patient.

How do you report a device that may have harmed the patient?

1. Notify your supervisor
2. Complete an occurrence report
3. Call the Risk Manager and Equipment Safety Officer IMMEDIATELY!
4. Contact Bio-Medical Services

What precautions should be taken with a device, which may have harmed a patient?

1. After contacting Bio-Medical Services, **DO NOT** change any of the settings or any of the components of the device.
2. **ALL** parts of disposable devices must be saved; any wrapping should be retrieved and retained with the device.

Why are certain medical devices tracked in the hospital?

To locate devices and users of the devices immediately in case of a product recall.

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Electrical Hazards in a Hospital

INTRODUCTION:

The advent of a tremendous amount of electrical and electronic equipment used for the delivery of patient care in the hospital brings with it the potential risk of exposing patients to electrical shock and hazards resulting from faulty equipment. To ensure safety in the delivery of care to patients, we must have a basic understanding of electrical safety.

ELECTRICALLY SUSCEPTIBLE PATIENTS:

The following constitute patient who can be very vulnerable to electric shock:

Debilitated patients: These patients, due to medical condition, develop a low physical resistance.

Patients who have had a major loss of skin resistance due to wet dressings or sweating: When the skin is wet, resistance is reduced and current flows more easily through a wet surface.

Patients with indwelling conductive catheters with externally exposed intercardiac leads: Conductive catheters such as pacemakers wires serve as a direct pathway to the heart and can easily carry minute amounts of current.

Patients with electrolyte imbalances: Hypersensitivity of the nervous system can result due to electrolyte changes and can therefore increase susceptibility to shock.

Patients with abraded skin or skin punctures: The natural resistance is lowered making these patients more vulnerable to shock. The skin provides for an external path for the flow of current and diverts current away from the internal organs. This capacity is reduced in these groups of patients.

COMMON ELECTRICAL HAZARDS FOUND IN A HOSPITAL:

The less sophisticated electrical devices found in a hospital are common sources of electrical hazards.

Bulbs: These can be particularly hazardous when a bigger watt bulb on a lamp is substituted for the size recommended by the manufacturer.

Power Cords: Fraying could result from incorrect handling such as yanking cords from outlets. Handling power cords with damp or wet hands is very dangerous. Also, dragging cords over a wet surface when they are not designed for exposure to wet areas can be just as hazardous.

K-Pad: Overheating resulting in burns to the patient is a hazard encountered with the use of K-Pads.

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Ways of Eliminating or Preventing Electrical Hazards

Use common ground

Periodic leakage current checks

Regular checks of seldom used equipment

Use of 3-prong plugs

If a plug is damaged, label it and send it for repair

Prevent use of “cheater” adapters

Refer all malfunctioning equipment to Plant Ops (ext. 4888)

Have Plant Ops check out all new equipment prior to use

Use of extension cords

Do not simultaneously touch electrical equipment and patient

Tag all faulty equipment

Know how to operate equipment prior to use

Dry hands adequately before handling any electrical equipment

PREPARATION IN THE EVENT OF POWER FAILURE:

Know the location of red emergency outlets.

Know how to manually operate equipment in the event of power failure.

Remember: Emergency outlets should not be used for equipment such as vacuum cleaners, office machines, etc. They are intended to be used only for life-sustaining equipment.

Know how to install batteries in equipment that can be run by battery.

Alkaline batteries can be disposed of in general trash. Lithium batteries must be collected and sent out for disposal. Do not throw in trash can.

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EMPLOYEE HEALTH

Pamela Swann, Occupational Health Nurse

Ext: 5117

Employee Health and Safety

A. SAFETY

Employees must observe and practice the hospital's safety rules in every phase of work. These safety rules are explained to employees during initial orientations and on-going in-services and education programs such as the A.M.E.N. Employees are required to participate in the safety effort of this hospital by working safely and attending safety training sessions. Injuries to employees are reviewed on a regular basis to identify safety hazards. Employees, who may have an occurrence or suffer an injury, must report it to their supervisor **immediately,** no matter how insignificant it may seem.

B. OCCURRENCE REPORTING

To ensure that proper attention is given and appropriate action taken when an occurrence involving an employee occurs at work, specific procedures must be followed. If an employee should suffer an illness or injury on the job, **no matter how minor**, the employee must report to the individual in charge of the working area immediately after injury or illness occurs, before reporting to Employee Health (examples: needle punctures, cuts, abrasions, sprains, illness that occurs from previous exposures to patients with communicable diseases).

An "Employee Occurrence Notification" must be completed before the end of shift. The Employee Health Nurse should be notified. If Employee Health is closed, page the House Supervisor. The Employee Health Nurse is responsible for maintaining all Employee Occurrence Reports and records.

C. MEDICAL CARE

Employees are responsible for reporting work related medical conditions to the Employee Health Nurse **prior** to seeking non-emergency medical assistance, evaluations or treatment by any healthcare provider.

The Employee Health Nurse will direct the employee to a medical provider.

The authorized physician will determine the work status of the employee at each visit. The employee must bring this to the Employee Health Nurse after their appointment. If the employee is directed to the Emergency Department a "Return to work Determination" form will be given to the employee.

All prescriptions, tests, treatments, visits must be approved by the Employee Health Nurse.

Certain treatments, procedures, tests require utilization review (precertification).

ALL FOLLOW UP VISITS FOR WORK RELATED INJURIES OR ILLNESS WILL BE COORDINATED WITH THE EMPLOYEE HEALTH NURSE.

The employee will be responsible for communicating with the appropriate department head or supervisor their work status and follow up appointments.

D. TRANSITIONAL DUTY

In the event there are restrictions placed on the employee following a workplace injury that prevent him/her from performing his usual duties, the employee may be placed in the Transitional Duty Program. This is a temporary program until the employee (lasting no longer than 6 months) can return to full duty. The Employee Health Nurse, who is responsible for work assignments and program qualifications, places employees in transitional duty positions. The employee will be instructed to follow up with the Employee Health Nurse **weekly** until the case is closed.

E. POLICY/PROCEDURE COMPLIANCE

Everyone is expected to follow the safety policies and procedures of this facility (see the Safety Manual). Only each individual employee can alter his/her daily conduct that can prevent an injury to himself/herself or a fellow employee; therefore, insistence or adherence to safety procedures is to reinforce safe work habits. Failure on the part of employees to comply with the safety guidelines may result in disciplinary action up to and including discharge.

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Preventing Slips, Trips and Falls

Falls in the hospital occur to visitors, volunteers, patients and employees. Help prevent falls by keeping the floor clean and dry. If you see a spill, stop and get help. If it is a small spill, clean it up. If it is too large, have someone call the Environmental Services Department for clean up. DO NOT LEAVE A SPILL UNATTENDED! Place wet floor signs to alert anyone in the area that the floor is wet.

Some of the ways to prevent falls are:

- Observing for leaking equipment- IV tubing, ventilators, respiratory equipment, mop buckets, floor scrubbers, any patient care items that have fluids
- Do not discharge medication out of a syringe or IV tubing onto the floor
- Properly dispose of liquids/secretions from medical equipment
- Wear slip resistant shoes
- Use the umbrella covers located at all entrances keep floors dry
- Cover food and drinks, especially when leaving the cafeteria
- Keep cords off of the floor and out of walkways. If cords must be on the floor temporarily, they should be secured with tape
- Do not place liquids in trash cans, it will leak in the plastic
- When filling cups, coffeepots, etc, observe for spills on the floor
- Remove any visible debris on the floor

Keep your workspace clean and dry

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Rolling Chair Safety

Rolling Chairs come in handy by allowing us to swivel and move easily in our work stations. However, people are sometimes hurt by falling from chairs. This usually results in bumps, bruises, strains and sprains, which can sometimes be treated easily. However, it is important to take adequate precautions to prevent injuries before they occur.

Do's and Don'ts for rolling chair use…

Do:

- ✓ Always keep base of the chair completely on the floor
- ✓ Swivel the chair seat rather than twisting your back reaching to the side.
- ✓ Take care when sitting in a chair with rollers. Make sure it does not roll out from under you.
- ✓ Sit all the way back in your chair and make sure the seat supports your weight evenly. Also make sure the backrest properly supports your spine.
- ✓ Use your chair at the correct height. Your feet should be flat on the floor and knees maintained at 90 degrees.
- ✓ Report any chair damage to your supervisor or maintenance department.

Don't:

- ➢ Don't use your chair for moving from one area to another. Get up and walk!
- ➢ Don't lean so far back in your chair that the wheels or legs lift up off the floor. Leaning can cause the chair to slip out from under you, cause structural damage, or can loosen important connections that can cause the chair to fall apart.
- ➢ Don't roll over uneven surfaces such as cords or carpet thresholds.
- ➢ Never put all your weight at the very front edge of the chair. If you are too far forward, the chair can tip over.
- ➢ Do not climb on any office chair. Use an approved ladder or step stool if needed.

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Safeguarding Your Back!!

A major occupational hazard for many healthcare workers is lower back pain or injury. Even if your back feels O.K., you may be doing things to injure it:

You may have poor posture.

You may be out of shape or overweight

You may move incorrectly

Some ways you may reduce the strain on you back include:

Push instead of pull whenever possible! Not only are you safer, but you can also move more with less effort.

Avoid carrying loads away from your body with your arms extended. The closer to your body you can carry your load, the less likely you are to injure your back.

Don't twist while you lift. Back injuries are more likely to occur if you twist while you lift. Twisting your body means that your spine is not correct alignment. You should not twist while you lift. Instead, pivot your hips, keep your shoulders in line and shift your weight. Keep that spine aligned!

Assess the size of the load. *Can you safely lift it or do you need help?*

Safety is a personal responsibility!!

Injuries to healthcare workers caused by patient transfer/lifting activities directly affects the quality of life for our employees and also results in a dramatic increase in costs for providing patient care. It is crucial that healthcare workers practice safe lifting, transporting and proper lifting techniques at all times. Mechanical lifts are a key component in this effort. Equipment is not located in ED, Family Birthplace and OR.

SARA 2000 is a standing and repositioning aid, for patients up to **400** pounds.

MAXIMOVE is for totally dependent, non-weight bearing patients and is used for all types of transfers and is also used to weigh patients. Maximum weight is **420** pounds.

LIFT WALKER is designed for ambulation training, located in RIWF and Acute PT

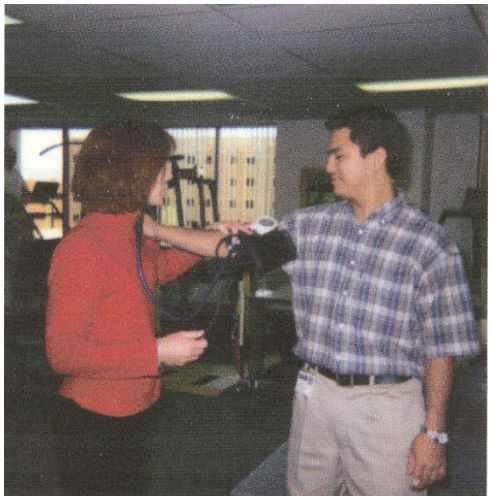
MAXISLIDE is designed for repositioning patients in bed and sitting patients up to the bedside to prepare for transfer.

STEDY is to assist the patient that can stand with assistance to move in the room, restroom or hallway. Maximum weight **250**. Located on 4N only.

Ceiling Lifts – ICU and 2N. Maximum weight **600** pounds. 4N has one ceiling lift with a maximum weight of 1000 pounds.

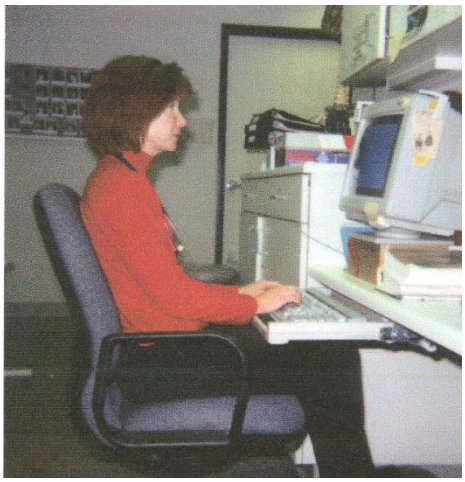
There are many different type of SizeWize equipment available for patients through Supply Chain.

What is Ergonomics?



In simple term, it means improving the fit between your body and an activity

Why You Should Care



If you don't pay attention to ergonomics, the activities you do today may – over time – lead to a cumulative trauma disorder. Commonly called MSDs (Musculoskeletal disorders), this group of physical problems usually affects soft tissues (muscles, tendons, and nerves) and joints. Although MSDs most frequently affect the back and wrists, your whole body is actually at risk. MSDs can damage finger, elbows, and shoulders, as well as the neck and arms, and even the legs. Left untreated, a MSD may limit your range of motion or reduce your ability to grip objects.

Symptoms of a MSD

MSDs often begin with a feeling of discomfort. You may notice swelling or muscle fatigue that doesn't go away with rest. A muscle may ache, as if it's been overused or slightly strained. Some people feel tingling or numbness. You may wake up at night with the sensation of pins and needles, like when you've slept on your arm too long. At first the discomfort may come and go. But with time, symptoms may become constant. Muscle weakness and nerve problems may develop. Fortunately, by applying ergonomic principles, you can reduce symptoms or avoid these problems altogether.

Avoiding Problems

If you're feeling fit, ergonomics may not seem important. But, over time, strain and overuse can add up to slow down your body. Apply ergonomic principles on and off the job. By doing so, you'll reduce excess wear and tear, making a MSD less likely to occur.

At Work

Using ergonomic principles on the job reduces your risk of developing a work-related MSD. A few simple changes are often all it takes.

At Home

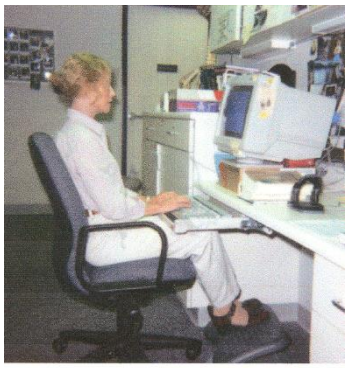
Apply ergonomic principles to everything you do. Live a little smarter. Don't think of ergonomics only at work. After all, a MSD will limit more than your job abilities. Discomfort intrudes on home life, too. What if you couldn't lift your child or carry a pan from the stove to the table? Even simple, everyday activities – like buttoning a shirt may be difficult with a full-blown MSD.

Take Ergonomics Personally

Each person's body deals with risks differently. Five people might do the same exact tasks, but it's possible that only one may develop a MSD. What if you're that one? No one can predict. That's why it's important to take responsibility for yourself. Be willing to make changes that reduce *your* risk of injury.

Reduce Risks: Correct Posture Problems

Standing, sitting, and moving incorrectly all increase your risk of MSDs. Why? Because posture problems overwork your body. They strain your muscles and tendons and stress your joints. With a little adjustment, however, you can correct most posture problems. Whatever you do, try to stay near neutral position and work within easy reach. Tasks take less force when you work from a stable base.



Keep your wrists straight whenever you can.

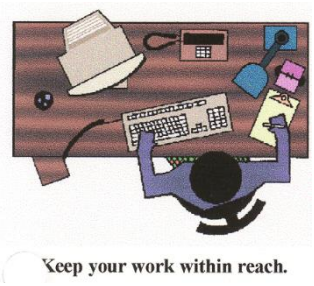
Avoid twisting your wrists too far to either side.

Avoid bending your wrists too far up or down.

Stay Near Neutral

Whether you're standing or sitting, neutral position places the least amount of stress on your body. To find neutral, line up your ears, shoulders, and hips. Keep your head upright and relax while you do this. If you're holding your breath or your shoulders are creeping toward your ears, try again. Your shoulders should be level, with your arms near your sides. You can rest your body by returning to neutral as often as possible.

Work Within Reach



Keep your work within 14 to 18 inches of your body, depending on your size. Reaching too far can be awkward. It also reduces your muscle power, so you need to use more force. Never lock a joint by extending it until it can't go any farther. Also, avoid reaching overhead or behind your back, if you can. If you can't, return to neutral as soon as possible.

A Stable Base

Proper posture reduces strain on soft tissue. When you're in neutral position, your bone structure supports you and provides a stable base to move from. As a result, your movements carry more power, and muscles and tendons don't need to work overtime just to keep you upright. To stay close to neutral, try the tips below.

Face your work. If you need to change direction, move your whole body instead of twisting.

Position yourself so you don't have to stretch or slouch to reach your materials. You should be able to move your forearms straight out from your body to work.

Grasp with your whole hand instead of with just your fingers.

When seated, keep your feet flat on the floor or on a foot support. When standing, put a foot up on a ledge or stool to take pressure off your back.

Clear away clutter between you and your work.

Use task lighting so you don't have to lean over to see your work.

Reduce Risks: Take Good Habits Home

Reducing your risk of job-related injuries is important. But don't stop using ergonomic principles just because your day is over. Activity-related risk factors may be present with anything you do. Have you considered your posture when you're working at a home computer? How about when you watch TV? Anytime you're not near neutral position, you may be straining muscles or joints. And don't forget your personal risks. Your health and habits follow you everywhere.

Be Aware

Whether you're driving in traffic or mowing the lawn, look out for activity-related risk factors. Posture, force, repetition, environment, duration, and recovery time – these risk factors will follow you home. So take good habits home, too. No matter what you're doing, work within reach. Also, don't forget to pick the best tools for the job. This may mean using an electric mixer instead of a wooden spoon, or standing on a stepladder instead of overreaching.

Communication Counts

When it comes to applying ergonomic principles on the job, don't feel foolish about asking for help. If you're at risk for a MSD or if you're already noticing symptoms, don't just "grin and bear it." Talk with your supervisor. Can the risk be controlled? Maybe a co-worker has a suggestion. If you need a medical evaluation, be sure to answer your healthcare professional's questions fully.

Share Concerns With Your Supervisor

If you think your job puts you at risk for a MSD, let your supervisor know. Think through your risk factors. If you know a way to reduce your risk, suggest your idea. You may already have tried a makeshift control measure that works – wrapping a tool handle with tape to improve the grip, for example. By sharing concerns with your supervisor, you can work together to find a better way of getting the job done.

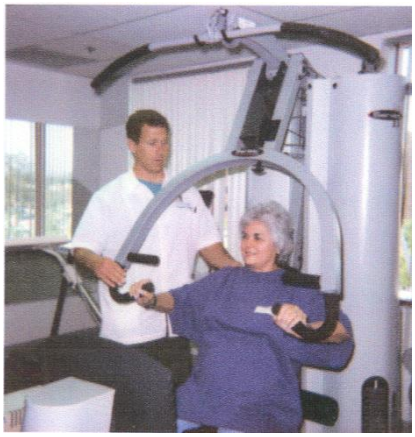
Exchange Ideas With Co-workers

Do you share a workstation, or are you a part of a group of employees doing the same job? If so, your co-workers may also be aware of MSD risks. Exchanging ideas about work flow, tools, and equipment may be helpful. Perhaps you can find a way of rotating tasks throughout the shift. Using different muscle groups is one of the best ways to reduce repetition and duration.

Reduce Risks: Rearrange your Workstation

You'll probably find that improving your posture requires adjusting your work area, as well as your body position. This is because the way you do a task is affected by where you do it and the tools you use. After all, this is what ergonomics is all about.

Pick the Right Tools



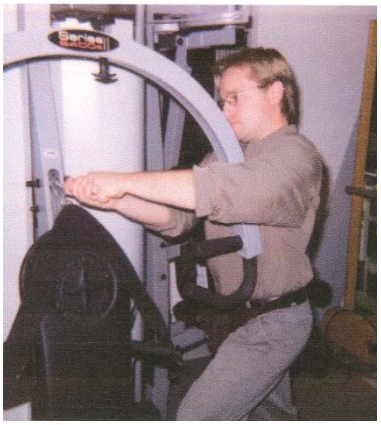
Use the tool that's correct for the job. This reduces force and, possibly, the number of repetitions needed to do the task. Tool handles should extend the length of your hand to avoid pressing into your palm. Keep tools in good repair. The work may go faster, and you'll probably use less force.

A Successful Setup

Whenever you can, make choices that reduce your risk of MSDs. For example: adjust your work height to suit the task being done. For general tasks such as computer keyboard use – the keyboard should be approximately elbow height or slightly lower.

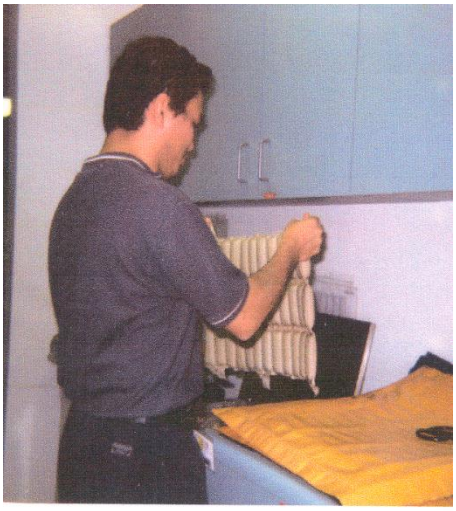
Organize Your Work Area

Once you've found neutral position, set your work area up to help you stay aligned. Direct lighting to shine on your tasks. Raise or lower the work surface, so your movements are as comfortable and powerful as possible. Position tools and materials you use most often within easy reach. And think about your tasks. You can reduce wasted motion by placing incoming and outgoing work in order.



Prepare for the Environment

When work conditions are less than ideal, be prepared. Wear personal protective equipment to reduce the effects of drafts or cold temperatures. Reduce your risk of vibration by using low-vibration tools or by padding tools with vibration –absorbing materials. Dampening mats, cushions, gloves, and shock-absorbing shoes also help.



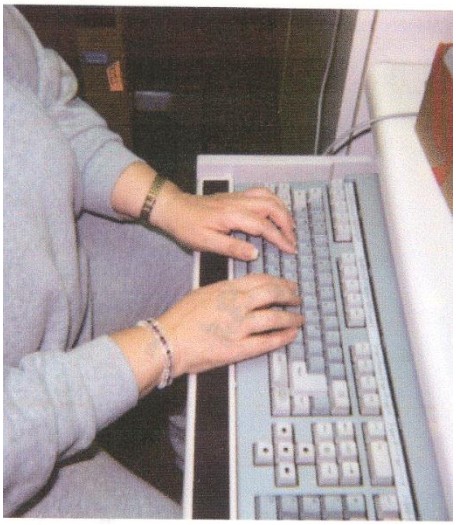
Identify the Risks

No one can predict who'll get a MSD. In fact, most people never develop one. Even so, you should recognize and reduce any activity-related or personal risk factors.

Activity-Related Risk Factors

The risk factors defined below may be linked with work and home activities. Since each risk factor increased your chances of developing a MSD, think carefully. Are you at risk for any of the following?

Posture is a problem when you slouch or when you bend, twist, or reach too far. Awkward postures overwork soft tissues and joints. In addition, anybody position can be a risk if it's held so long that muscles tense up and blood flow is reduced (static posture).



Force is pressure or strain on the body. You create force when you grip or when you poll, push, or lift heavy materials. Contact force occurs when you lean or press against a hard surface or sharp edge.

Repetition is doing the same task or using the same set of muscles over and over again.

The environment is your surroundings, including cold temperatures, vibration, and lighting.

Duration is the length of time you are exposed to a risk factor. The longer the duration, the higher your risk.

Recover time is the amount to time the body needs to rest after performing a repetitive task or being in an awkward posture. Recovery time becomes a risk when the time between activities is not enough to allow the body to recover.

Personal Risk Factors

Some risk factors aren't activity related. Instead they are due to your health and general well-being. Many of these risk factors, such as body weight and fitness level, can be controlled. Others, specifically previous injuries, cannot. These risks are with you for life. And since old injuries sometimes weaken soft tissue3s, they may multiply the effects of any activity-related risks.

Exercises for Minibreaks

Exercises help to relax tight muscles, reduce stress, and lessen the sense of general fatigue that can set in when sitting and concentrating for long periods of time. Choose from the exercises below and do them during the day – right at your desk or computer.

Deep Breathing

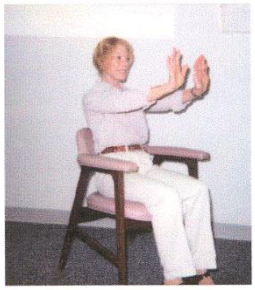
Breathe in slowly through the nose. Hold for 2 seconds and then exhale through the mouth. Repeat cycle several times.

Upper Back

With arms folded at shoulder height, push elbows back. Hold a few seconds. Repeat 5-15 times.

Wrist

Hold your hands in front of you Raise and lower your hands to stretch the muscles in the forearm. Repeat several times.

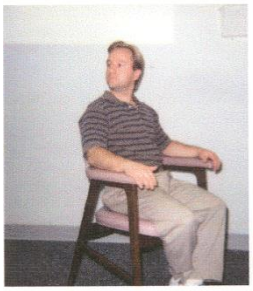


Lower Back

While sitting, slowly bend your upper body between your knees. Hold for a few seconds, then sit up and relax.

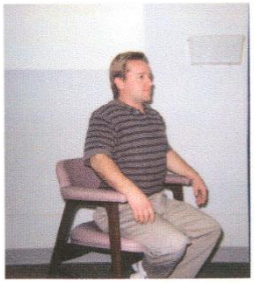
Head & Neck

Turn head slowly from one side to the other, holding each turn for the count of three. Repeat 5-10 times.



Shoulders

Roll shoulders forward 5 times using a wide circular motion. Then roll shoulders backward 5 times. Repeat cycle 5-10 times.

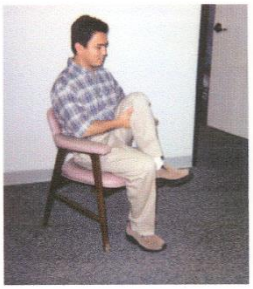


Fingers & Hands

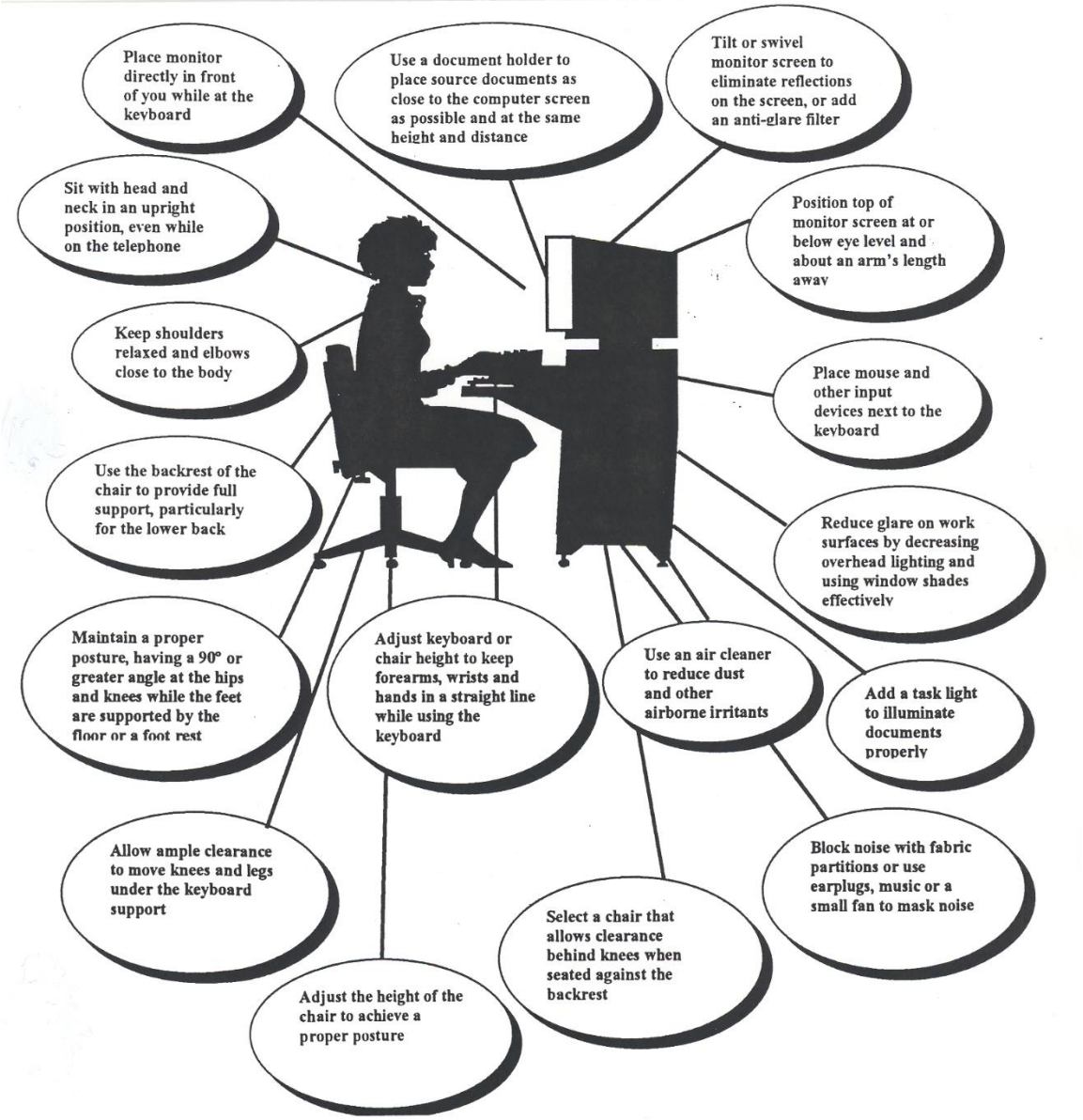
Make a tight fist with your hands. Hold for a second. Then spread your fingers apart as far as you can. Hold for 5 seconds.

Legs

Grasp the shin of one leg and pull slowly toward your chest. Hold for 5 seconds. Then do the other leg. Repeat several times.



Ways to Improve Ergonomics of Work Station



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Hospital Security

Of necessity, the hospital is open at all times. This presents a security challenge. While the Security Department has certain, specific responsibilities, the cooperation of all employees is essential if security risks are to be minimized.

The Security Safety Subcommittee defines a "Security Incident" as any incident that causes harm to employees, visitors, patients or property or has the potential to do so.

Employee Responsibilities:

Be alert to the entry of unauthorized persons in any area. If you see someone who does not appear to be an employee, or even an employee who might be outside his/her regular work area, please offer assistance in directing him/her to his/her destination. Report any suspicious or unusual activity to your supervisor.

Personnel Identification:

*All employees should wear employee identification badges while on duty.

*Vendors and sales representatives will have identification badges issued through Supply Chain.

*Contract construction and service workers will have identification badges issued through Plant Operations.

*Visitors will be identified by the absence of any identification badge.

* All students must wear their school identification badges at all times while doing clinical

rotation.

General Security Responsibilities/Information:

Patients and employees are asked not to bring excessive amounts of money or valuables with them to the hospital. If you observe a patient with what you consider to be an excessive amount of money or valuables, please contact your supervisor.

Employees should secure cash and other valuables in lockers, desk drawers or other secure space while at work.

Consult your unit/department specific security policies, if applicable. This is especially important in security sensitive areas such as the Pavilion, Pharmacy, Emergency Department, and The Family BirthPlace.

Protect any computer/door passwords or combinations. Never share this information with anyone.

Security escort services are available for transportation to parking lots. To access this service, please follow the following procedure:

Call 698-6916 verbalize your request and location.

As a last resort, dial “0” and have the PBX operator contact the Outside Officer and convey your request.

The last employee to leave a work area at the end of the work shift should be sure that all doors are locked and the area is secure.

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Respectful Workplace Policy

DEPARTMENT: **Human Resources**	**POLICY DESCRIPTION:** Respectful Workplace
PAGE: 1 of 3	**REPLACES POLICY DATED:**
EFFECTIVE DATE: January 1, 2017	**REFERENCE NUMBER:** HR.ER.059

SCOPE: Applies to the treatment of all employees, applicants, volunteers, students, contract staff, and employees under an employment agreement; medical staff, and temporary staff authorized to work on the premises; and any other persons or firms doing business for or with the business entity.

PURPOSE: To create and sustain a Healthy Work Experience and to define these actions that preserve or impede this experience. Further, to outline responsibilities and requirements for reporting violations of this policy.

DEFINITIONS: HEALTHY WORK EXPERIENCE

A respectable person acts and speaks in a manner that preserves the safety, dignity, autonomy, self-esteem and civil rights of others. In doing so, the respectful person considers the audience, setting, and tone prior to expressing his or her thoughts in words or actions. The goal is to do this in a constructive manner and in an appropriate setting so as not to impede on providing the utmost quality of care to our patients and creating a healthy work experience.

Employees have the right under Section 7 of the National Labor Relations Act to express their concerns, whether positive or negative, regarding their terms and conditions of employment. We expect employees to exercise those rights in a respectful and courteous manner that does not negatively affect the delivery of safe, effective, efficient, and compassionate care to our patients. This maintains a Healthy Work Experience for employees, volunteers, contract staff, physicians or any other person doing business with or for our business entity.

Examples of Respectable Actions

1. Providing constructive feedback regarding an employee's work, demeanor, or actions.
2. Addressing concerns about the work environment in non-patient care areas.
3. Engaging the appropriate manager or HR Business Partner to report or describe a concern with a colleague.
4. Providing patient care updates in a private setting with a compassionate tone.
5. Creating an atmosphere of inclusion when addressing or referencing anyone of a different nationality, color, race, religion, sex, or gender identity.
6. Assisting a coworker who needs support fulling his or her job duties when it is needed to provide ongoing, proactive patient care and safety.

Examples of Non-respectable Actions

1. Incivility: the acts of rude and discourteous conduct, gossiping and spreading rumors, the use of profane or obscene language in a demeaning or offensive way, and inappropriately refusing to assist a coworker.
2. Bullying: the combination of repeated, unwanted harmful actions intended to humiliate or offend the recipient by abusing or misusing of power, creating feelings of defenselessness and injustice, and undermining an individual's inherent right to dignity. Bullying can also include workplace mobbing, which is a form of bullying aimed at an individual from a work group.
3. Violence: the threat or use of verbal or physical harm or force against an individual that reduces or eliminates his or her sense of being safe or actual safety.
4. Retaliation: the act of retaliating by seeking revenge against another for opposing or reporting offensive actions.
5. Intimidation: the use of demeaning and undermining comments and actions with the intention to compel or deter another coworker from taking appropriate action or to cause distress to another by withholding support.

RESPONSIBILITIES:

1. Management is responsible for creating a Healthy Work Experience that promotes physical and psychological well-being. When members of the health care team do not feel safe, the work environment is left vulnerable, and everyone's safety is compromised and serious problems in the workplace can occur.
2. Relationships marred by disrespectful behavior have a negative impact on the quality and safety of care delivered. The establishment of positive, respectful relationships is crucial to preventing these behaviors; reference Equal Employment Opportunity Policy, HR.ER.013, and Code of Conduct. Respect is promoted through communication, collaboration, support, and fairness, each of which is foundational to establish healthy relationships with others.

REQUIREMENTS:

1. If an employee experiences disrespectful behavior, the incident should be promptly reported to management. If an employee believes it would be inappropriate to discuss the matter with his/her manager, the employee may bypass the manager and report the incident directly to the HR Business Partner. Employees may also contact the Employee Relations COE or the Ethics Line at 1-800-455-1996 at any time.
2. The manager must immediately notify the HR Business Partner. The HR Business Partner will perform an investigation into the complaints immediately upon notification of any reported incidence in violation of this policy. Complaints will be kept confidential to the extent possible.
3. Employees will be subject to disciplinary action, to include possible termination of employment, for any act offense of this policy or retaliation for the reporting of such offenses; reference Discipline, Counseling, and Corrective Action Policy, HR.ER.008.
4. Any form of retaliation against any employee for filing a *bona fide* complaint under this policy or for assisting in a complaint investigation is prohibited.

DISCLOSURE:

If there is any conflict between the information in this policy and a Collective Bargaining Agreement (CBA), the CBA prevails for covered employees.

REFERENCED POLICIES:

1. Code of Conduct
2. Discipline, Counseling and Corrective Action, HR.ER.008
3. Equal Employment Opportunity, HR.ER.013
4. Incivility, Bullying, and Workplace Violence, ANA, July 2015
5. National Labor Relations Act, Section 7

PROCESS MAPS:

1. To be completed at a future date

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Current Status: *Active* **PolicyStat ID:** *2598513*

West Florida HEALTHCARE

Effective:	*4/1/2010*
Approved:	*9/16/2016*
Next Review:	*9/16/2017*
Owner:	*Mike Barrow: Director, Plant Operations*
Policy Area:	*Facility Management*
References:	*Policy*
Applicability:	*West Florida Hospital*

Theft and Violence in the Workplace (SS.001), V-28

SCOPE:

Employees of HCA-affiliated subsidiaries including, but not limited to hospitals, ambulatory surgery centers, outpatient imaging centers, physician practices, Parallon Workforce Management Solutions, service centers, Corporate Departments, Groups, and Divisions (collectively, "Affiliated Employers" and individually, "Affiliated Employer").

PURPOSE:

To provide guidelines in an effort to establish a work environment as free from the threat of violence and theft as is reasonably possible for employees, physicians, patients, volunteers, contractors, visitors and customers who should be treated with courtesy and respect at all times.

POLICY:

1. Facilities must implement the Company's Model Safety and Security Program.
2. Employees must report to their supervisors, security staff or human resources representative any suspicious workplace activity, situations or incidents relating to security that they observe or that they become aware of whether involving other employees, former employees, physicians, patients, volunteers, contractors, visitors or customers, and all such reports should be presented to the Director of Security.
3. Affiliated Employers will not tolerate threats or acts of violence, aggressive behavior, offensive acts, threatening or offensive comments or remarks. Every specific or implied verbal or physical threat of violence, or act of violence, must be treated seriously.

   Facility administration may restrict or prohibit weapons in the workplace even if the individual possesses a valid concealed weapons permit issued by the state. The permit possessing individual has the right to lock the firearm inside a private motor vehicle. Under some conditions federal, state, or local law enforcement officers are permitted to carry weapons in certain areas or for specific purposes.
4. Facility Administration has the authority to search any facility property which includes property of any nature owned, controlled or used by the facility, including but not limited to parking lots, offices, desks, file cabinets, and lockers. Facility Administration specifically reserves the right to search personal property which has been brought onto the premises, including but not limited to vehicles, handbags, briefcases, packages, clothing and other personal items. In addition, an employee, physician, patient, volunteer, contractor, visitor, or customer may be requested by Facility Administration to submit to a search of his/her person. Facility

Administration may respond as deemed appropriate in the event anyone may refuse a search or may show a lack of cooperation during a search.

PROCEDURE:

1. Risk Reduction

   Human Resources will undertake certain efforts in the employment background investigation process to reduce the risk of hiring individuals with a history of theft or violent behavior.

   Each facility shall designate and communicate a point of contact in its safety plan. The facility's Safety and Security Committee will ensure appropriate inspections of the premises are conducted in an effort to evaluate and determine vulnerability to workplace violence or hazards and follows up with necessary corrective action. The facility's Safety and Security Committee will ensure an appropriate individual will conduct a review of occurrence reports, workers compensation claims and security reports, analyze trends and rates of injury caused by violence in the workplace, and track changes in workplace controls as they occur.

2. NotificationSafety and security in the workplace is every employee's responsibility. Employees are asked to be alert to unauthorized persons in any area of the facility. Employees are urged to offer assistance in directing or escorting the person to his/her destination. Employees are expected to inform their supervisors, security staff, human resource representative, another member of management or the facility's Ethics and Compliance Officer of behavior exhibited by any person(s) which could be a sign of a potentially dangerous situation. Such behavior might include:
   - Discussing weapons or bringing them to the workplace.
   - Displaying overt signs of extreme stress or agitation, resentment, hostility or anger.
   - Making threatening remarks.
   - Sudden or significant deterioration of performance.
   - Displaying irrational, intimidating, aggressive or inappropriate behavior.
   - Reacting to questions with an antagonistic or overtly negative response.
   - Reacting harshly to changes in policy and procedure.
   - Personality conflicts with co-workers.
   - Obsession or preoccupation with a co-worker or supervisor.
   - Attempts to sabotage the work or equipment of a co-worker.
   - Blaming others for mistakes and circumstances.

   If an employee receives or perceives a threat or if an employee is the victim of violence while on the premises, he or she should immediately report it to a supervisor, security staff or human resource representative. The police or appropriate law enforcement agency may also be contacted.

3. Enforcement

   Employees may report violations and raise any questions regarding their responsibilities under this policy in good faith without fear of reprisal.

   All threats will be promptly investigated. No employee will be subjected to retaliation, intimidation or disciplinary action as a result of reporting a threat in good faith under this policy.

Any employee accused of committing or threatening violence or any employee found to be carrying a weapon on Company property or during Company business will be suspended immediately, pending the outcome of an investigation by the Security Director and Human Resources.

If following an appropriate investigation it is determined that this policy has been violated, appropriate corrective action, up to and including termination, will be taken.

4. Post Incident Response

Affiliated Employers will provide support to an employee who is a victim of violence in the workplace that includes treatment, individual counseling, and paid time to pursue prosecution.

- Treatment is provided through the workers compensation program or the Texas Employee Health and Safety Program Benefits Plan (EHSP).
- Employees will be paid at base rate for time to pursue prosecution.
- Counseling services are provided through the Employee Assistance Program (EAP).

An employee who is a victim of violence other than a felony defined by the jurisdiction may pursue prosecution at the employee's discretion and will be supported as described above.

Affiliated employers with an employee who is a victim of violence defined by the jurisdiction as a felony will assist the employee in pursuing prosecution as described above. Additionally, the affiliated employer may engage legal counsel when doing so is considered appropriate.

5. Training

Affiliated Employers will provide training opportunities intended to make employees aware of workplace violence risk reduction efforts and the support available to an employee who is a victim of violence in the workplace. This training is presented:

- At the time of orientation for new employees.
- Periodically through Code of Conduct training.
- Regularly by supervisors and/or the facility's Safety Committee or manager responsible for safety and security.

Security staff will receive training on the appropriate use of force in an effort to provide physical protection within the parameters of policy, and their specific job requirements. Skills include situation/response analysis, psychology of deterrence, attack management, security tactics, and a clear definition of responsibility and authority. Training should aid in presenting a respectable and competent presence in routine operations, provide the security personnel with skills for use in unusual and emergency situations, and provide management with a logical and consistent framework for planning, response, control, and after-action analysis and justification.

Clinical staff in security sensitive areas such as the Emergency Department and Critical Care areas should receive crisis prevention/intervention training that teaches staff to respond effectively to the warning signs of escalating aggressive behavior, and addresses how staff can deal with their own stress, anxieties, and emotions when confronted with these challenging situations. Training should focus on preventing disruptive behavior by communicating with individuals respectfully and with concern for their well-being, but should also teach appropriate physical intervention where necessary.

6. Property

   All personal belongings should be protected by keeping them out of sight or inaccessible. Affiliated Employers are not responsible for the loss or theft of personal items.

   Supplies and equipment should be stored in approved areas and security measures are to be observed.

   Supplies, equipment, material, or property belonging to the facility, other employees, patients, volunteers, contractors, visitors or customers may not be removed from the premises by an employee without authorization.

REFERENCES:

All revision dates: 11/28/2012

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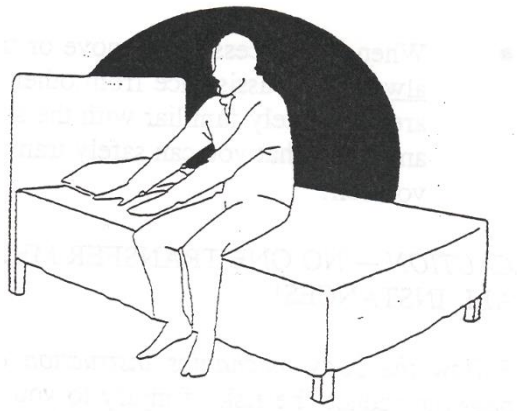
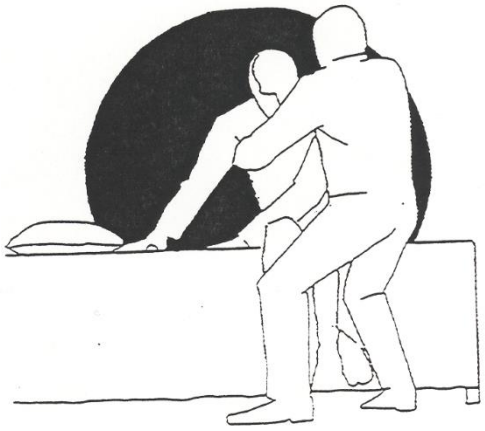
Safe Lifting Techniques



One Person Assist

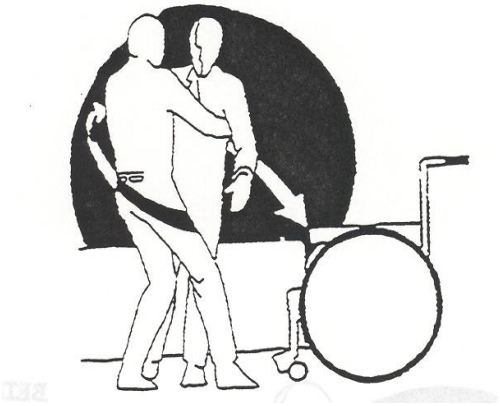
Assist per patient's needs. Can patient:

A.) Push up to short sitting, as shown? IF SO, then:



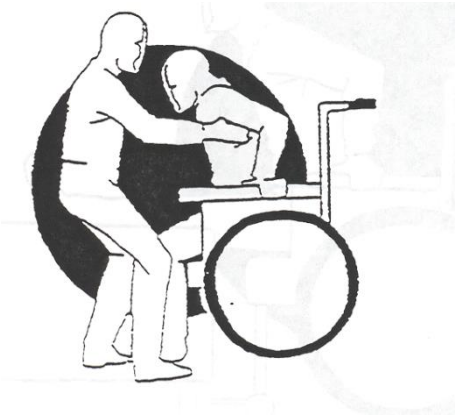
B.) You can help by boosting patient's trunk with your arm: "1-2-3-move."

C.) Support your knee at bed as you shift your weight to rear leg.



Stand to Sitting/Assist

Wheelchair is close to bed. Wheels locked, footrests up. Get set. Then, "1-2-3-move." You pivot as patient steps to chair (on strong leg).



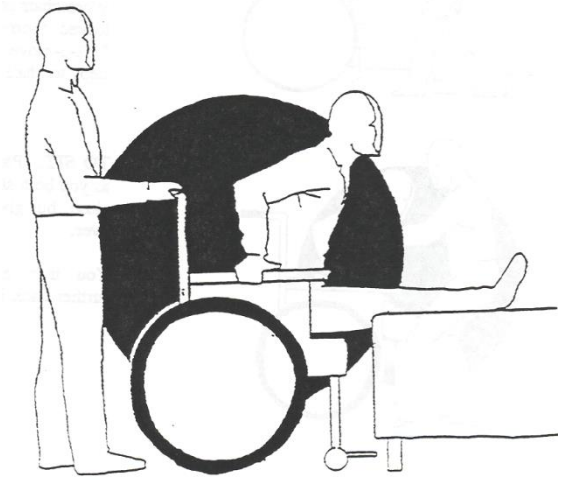
To Sit:

Patient grasps chair arms as you both slowly squat legs. Stand close, but give patient room to lean over.

You then assist patient to slide further back in chair.

Bed to Chair/Sliding

Chair against bed, arm off. Sliding board tucked in place. On chair side, support patient's legs against your knees and patient's trunk belt to slide patient across board. (If needed, another helper steadies board or chair.)



Bed to Chair

(From long-sitting position) You steady chair as patient pushes back with arms. Also have a second person assisting with the legs to avoid hyperextension of knees.

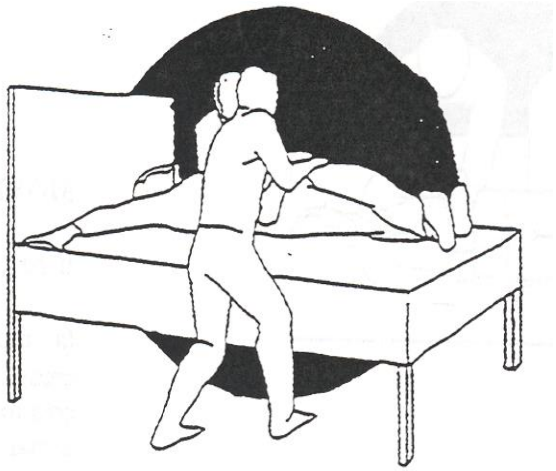
Moving to One Side of Bed

If heavy, use 3 persons:

1. Move patient's legs to side and cross arms over stomach
2. Position your hands as shown
3. On signal "1-2-3-pull", pull back as your weight shifts to rear leg (avoid twisting). It is best to use a lift sheet, which is placed under the patient to prevent any shearing action on the patients skin. Roll lift sheet close to patient's side (same position of people and use same pulling technique.

To Head or Foot

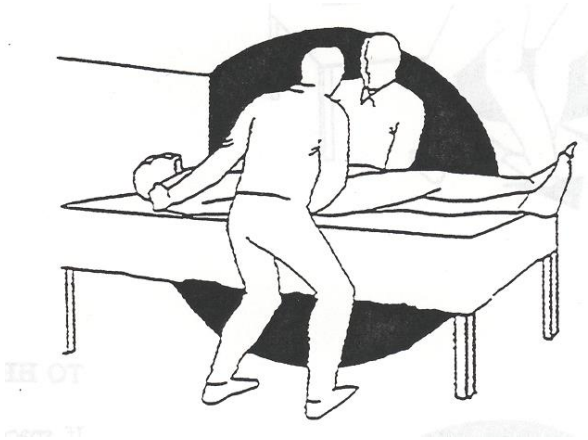
If space allows, one person should be on each side of patient. If space does not allow, stand on same side of patient. Use lift sheet again, grasp sheet near shoulders and hips. Front foot points in direction of movement. Have patient assist (if possible) by bending one leg and pushing. “1-2-3-pull.” Shift weight to forward foot.



Roll to Side

Position patient to have space when turned; then

1. Move right arm as shown; put left arm across stomach; left leg crossed over right.
2. Helpers alternately grasp shoulders and buttocks
3. “1-2-3-turn.” Protect the patient from falling.



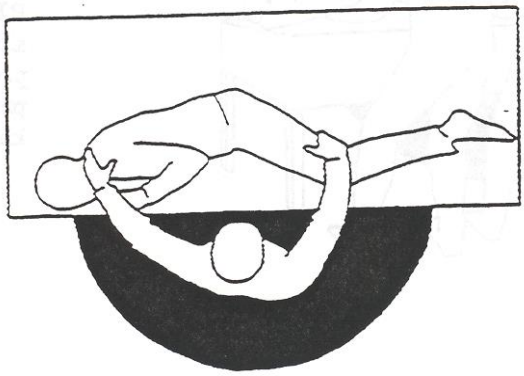
Roll to Stomach

1. Move patient to right side of bed
2. Lay patients right arm and leg to the left
3. Helpers alternately grasp right shoulder and hip
4. “1-2-3-roll.”
5. Prevent rolling onto patient’s arm, then slide to center.

Bed to Bed

1. Make sure both beds are locked and adjust heights of bed so they are the same.
2. Have two or three person pulling depending on the size of the patient
3. Move patient to the right and grasp the sheet as shown.
4. Move patient in two steps.
5. Those pulling should place one or two knees on the bed you are transferring to, and move patient to edge of bed.
6. Move one foot back and “1-2-3-pull” and shift weight to back leg.

Supine to Sitting/Passive



1. Turn patient on side. Flex knees as shown.
2. One arm reaches over to grasp bottom nee
3. Other arm supports head and shoulders (with your hip against bed)
4. Then “1-2-3-move” in one motion as you shift your weight to rear leg, swing patient’s legs over edge whole you pull shoulders to sitting position.

Wheelchair Transporting

Use safety straps as needed. Be sure arms are on lap. Open door, then back chair through. Pull on or off elevators to avoid upset.

Use caution when approaching corners and doorways.

Ambulation

Training is done per physical plan-physical therapy. If helping lesser-disabled patient, know the basic assisting position.

Patient “walks tall” picks up feet. As needed, you support at back close and slightly too weak side. Grasp safety belt; other hand stabilizes shoulder.

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ORIENTATION HANDBOOK POST-TEST

1. All of the following are patient rights, *except*:
   a. Right to get treatment regardless of age, race, sex, handicap, marital status, national origin, or source of payment for care.
   b. Right to refuse medical treatment to the extent permitted by law and to be informed of the consequences of refusing treatment
   c. Right to privacy during examination, treatment, and when discussing his case. This means out of the sight and hearing of people not involved in his care.
   d. Right to have all care provided without cost to the patient.

2. Who is responsible for protecting patients' individually identifiable health information?
   a. Chief Nursing Officer
   b. Ethics and Compliance Officer
   c. Physician
   d. All staff

3. If an employee has medical testing at an HCA facility, the appropriate way for him or her to access the test results is:
   a. Complete the release of information form in HIM and receive a copy of the results
   b. Check the Meditech computer system for his or her own results
   c. Get a fellow employee to access the results while looking over his or her shoulder
   d. Call a friend in the department where the test was done to get the results for the employee

4. While working in your area, you hear over the loudspeaker a **"Code Green**" Level 3." This would mean that there has been a disaster with:
   a. 0-15 casualties
   b. 16-30 casualties
   c. More than 30 casualties
   d. None of the above

5. While eating lunch in the cafeteria, you hear a **"Code Red"** called for your unit/department. Your correct action would be to:
   a. Remain in the cafeteria until the Code Red is cleared.
   b. Take the nearest elevator to your unit/department as quickly as possible.
   c. Call your unit/department to see if your help is needed.
   d. Proceed to your unit/department via the stairs and await emergency assignment as needed.

6. Which of the following statements about handwashing is **not** true?
   a. Handwashing is the single most important technique in preventing the spread of infections to patients and employees.
   b. Handwashing is not necessary if gloves are worn.
   c. Limiting jewelry worn will make handwashing more effective.
   d. While handwashing, you need to rub your hands for at least 10-15 seconds.

7. A Living Will is the same thing as a "Do Not Resuscitate" order:
   a. True b. False

8. Any injury should be reported immediately and an occurrence screen should be done as soon as possible and prior to the end of the shift.
   a. True B. False

9. To reduce the stress on your back, you should:
   a. Hold loads away from your body
   b. Hold loads close to your body
   c. Carry loads with one arm
   d. Any of the above methods, as long as you are careful

10. What is an "MSDS"?
    a. Material Safety Data Sheet
    b. Mandatory System of Dilution of Substances
    c. Multiple Substance Disposal system
    d. Morbidity of Substance Disclosure Sheet

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