



MemorialCare™
Orange Coast Medical Center

Contract Service and Student Orientation

Welcome to MemorialCare Orange Coast Medical Center

We are pleased that you are partnering with us to bring excellent patient care to our patients. This packet will inform and equip you with information needed during your stay. Please review this packet and complete attachments. Return the completed paperwork to your agency.

Thank you and again...**welcome!**

OUR HISTORY

Our campus was built in January 1986 as FHP Hospital. In January 1996, our hospital was sold to Memorial Health Services (MHS). The hospital was then renamed to Orange Coast Memorial Medical Center as a community based hospital. In 2017, the system went through a rebranding and introduced a new look to transform the system of hospitals to a fully integrated health system. The hospital was then renamed to MemorialCare Orange Coast Medical Center.

The MemorialCare family includes:

- MemorialCare Orange Coast Medical Center
- MemorialCare Long Beach Medical Center
- MemorialCare Saddleback Medical Center
- MemorialCare Miller Children's & Women's Hospital Long Beach
- MemorialCare Medical Groups

WHO'S WHO AT OCMC

Administration Team

Marcia Manker ~ Chief Executive Officer

Aaron Coley ~ Chief Financial Officer

Emily Randle ~ Chief Operating Office

Shela Kaneshiro ~ Vice President of Nursing/Chief Nursing Officer

Erin Hotra-Shinn ~ Vice President Strategy and Business Development

HUMAN RESOURCES

Michelle Gutierrez ~ Executive Director, Human Resources

Lauren Castagna ~ Manager, Human Resources

Denise Bello ~ Human Resources Generalist

April Adams ~ Human Resources Representative

Jessica Ayala ~ Human Resources Assistant

Maria Lopez ~ LOA/WC Specialist

Gabriela Hernandez ~ HRIS Analyst

Eileen Arbogast ~ Employee Health Nurse

OUR MISSION

To improve the health and well-being of individuals, families and our communities.

CUSTOMER SERVICE

A.I.D.E.T is a simple acronym that represents a very powerful way to communicate with people that are often nervous, anxious and feeling vulnerable.

➤ Acknowledge

- Acknowledge the patient by their name. Make eye contact. Smile.

➤ Introduce

- Introduce Yourself.

➤ Duration

- Clarify how long the visit, procedure or process will take.

➤ Explanation

- Explain and communicate clear expectations of what will be occurring and when.

➤ Thank You

- Say “Thank you...”
- Ask, “Is there anything else I can do for you?”
- If thanked, respond with ***“It’s my pleasure!”***

PERFORMANCE IMPROVEMENT

PERFORMANCE IMPROVEMENT ACTIVITIES

What is Performance Improvement (PI)?

Continuous assessment and improvement of key processes

Focus on systems NOT individuals.

Quality monitoring

Measurement of processes and outcomes

Comparison of performance with regulatory requirements and outside benchmarks

Identification of opportunities for improvement

Performance improvement activities occur at the department and hospital-wide levels.

Ask your manager about the performance improvement projects in your department.

Participate in activities that interest you.

PERFORMANCE MEASUREMENT

Joint Commission on Accreditation of Health Care Organizations Core Measures

Acute MI, CHF, Pneumonia, Pregnancy-related

Operative/Invasive Procedures

Medication Use

Restraint Use

Medical Record Documentation

Customer Satisfaction

Medical Record Documentation

Unusual Occurrences

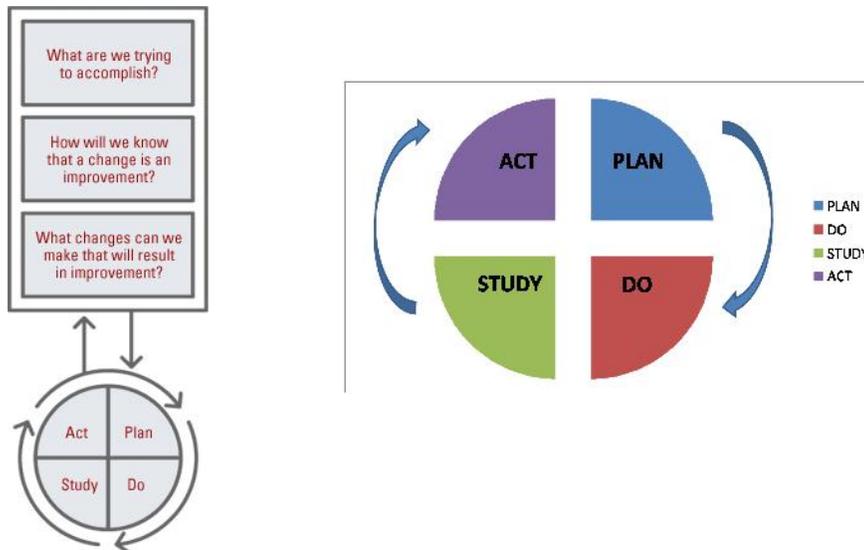
OPPORTUNITIES FOR PERFORMANCE IMPROVEMENT

Can be identified by any staff personnel including contract services and students

Can be clinical or non-clinical

Scope can be small or large

PERFORMANCE IMPROVEMENT MODEL



- Step 1: **Plan**
 - Plan the test or observation, including a plan for collecting data.
 - State the objective of the test.
 - Make predictions about what will happen and why.
 - Develop a plan to test the change. (Who? What? When? Where? What data need to be collected?)
- Step 2: **Do**
 - Try out the test on a small scale.
 - Carry out the test.
 - Document problems and unexpected observations.
 - Begin analysis of the data.
- Step 3: **Study**
 - Set aside time to analyze the data and study the results.
 - Complete the analysis of the data.
 - Compare the data to your predictions.
 - Summarize and reflect on what was learned.
- Step 4: **Act**
 - Refine the change, based on what was learned from the test.
 - Determine what modifications should be made.
 - Prepare a plan for the next test.

RISK MANAGEMENT

A System-wide Program to:

- ♦ Identify, analyze, evaluate and respond to risks
- ♦ Reduce preventable injuries and accidents
- ♦ Minimize the financial severity of claims
- ♦ Reduce or control financial loss

Our Clinical Risk Manager is Tanya Leach at extension 7651 or (714)378-7651

It is the responsibility of every contract/student to help reduce risk

Complete an electronic Unusual Occurrence Report (UOR) when you become aware of an event that has or could have contributed to patient injury.

UNUSUAL OCCURRENCES

- ◆ Patient claims they will take legal action
- ◆ Patient complaint
- ◆ Adverse reaction or complication
- ◆ Medication error
- ◆ Slips, falls, or other injuries
- ◆ Utility failure
- ◆ Security is called to intervene in a situation
- ◆ Return to the operating room
- ◆ Any event outside of normal procedure

UNUSUAL OCCURRENCE REPORT

- ◆ Confidential!!
- ◆ Not intended for disciplinary action
- ◆ NEVER print!
- ◆ Complete location and demographic information
- ◆ Attach additional documentation as needed
- ◆ Include information on patient outcome
- ◆ Notify supervisor to assist with UOR and documentation
- ◆ Contact your supervisor immediately if serious event or adverse outcome!

All Unusual Occurrences are reported online
through MemSafe. A report can be made anonymously.

DOCUMENTATION IN MEDICAL RECORD

Duty and responsibility of contract staff involved in the care of the patient to document unusual occurrence in the Electronic Medical Record (EMR)

- Describe the event, patient status and interventions
- Document event even if there is no injury
- Disclosure to patient
- Never refer to the UOR in the medical record

SENTINEL EVENT

“An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or limb function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome” – *Joint Commission on Accreditation of Healthcare Organizations*

INTENSIVE ASSESSMENT COMMITTEE

- Forum to complete a root cause analysis (RCA) on all sentinel events and near misses
- Team is comprised of:
 - Physician and administrative leaders

- Quality Improvement & Risk Management
- Nursing, Ancillary & Education
- Additional members as defined by event

FAILURE MODE EFFECTS ANALYSIS (FMEA)

- An assessment that examines a process in detail including sequencing of events
- Assesses risk and failure points in process steps
- Prioritizes areas for improvement based on impact on patient care

OCMC PATIENT SAFETY PLAN

- Promote a culture of quality, safety and accountability
- Promote “moving away from blame” reporting environment
- Reinforce communication amongst the healthcare team, patients and families
- Engage patients in the safety of their care
- Building an infrastructure that supports safe delivery of care
- Monitoring our compliance with recognized patient safety goals and standards

➤ Harvard study estimates suggest the rate of injury from medical error is about 1%
Pretty good?

1% error rate equals:

- 200,000 wrong prescriptions/year
- 5,000 incorrect surgical procedures per week!



Patient Safety Hotline
(714) 378-7888 or ext 7888

REPORTING SAFETY OR QUALITY CONCERNS



Memorial Medical Centers take patient and employee safety very seriously and are participating in several national initiatives to reduce risk to our patients.

We also encourage staff and physicians to report any unusual occurrence by completing a UOR and reporting these to their supervisor or Clinical Risk Manager at ext. 7651.

Staff may also report issues via the Patient Safety Hot Line at (714) 378-7888 or the MHS Ethics hotline at (888) 933-9044.

If you have exhausted these venues and still feel an issue remains, you may notify: Joint Commission (630) 792-5000, to report your concern for safety or quality of care without repercussion or disciplinary action from the hospital.

2021 Hospital National Patient Safety Goals

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

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01

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

Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

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

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01

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

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Identify patient safety risks

NPSG.15.01.01

Reduce the risk for suicide.

Prevent mistakes in surgery

UP.01.01.01

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

UP.01.02.01

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

UP.01.03.01

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

REGULATORY COMPLIANCE

- Major regulatory agencies include:
 - California Department of Public Health (CDPH) – state agency
 - Occupational Health & Safety (OSHA) – federal agency
 - Joint Commission on Accreditation of Healthcare Organizations – independent, not-for-profit organization
- If you see a surveyor enter the hospital
 - Welcome the surveyor(s), verify their identity by examining their identification badges, and contact Administration (x7409 or x5522)
- Many surveyors ask contract/students questions
 - Remain calm and friendly - be professional
 - Ask for clarification if you don't understand the question
 - Answer only what they've asked - don't offer extra info

PALLIATIVE CARE

The World Health Organization defines Palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.

OCMC is dedicated to providing effective end-of life care that is comprehensive, compassionate, and patient/family centered. The Plan of Care is determined by the goals and preferences of the patient and family with support and guidance in decision-making from the Interdisciplinary healthcare team. Included in the plan is aspects of symptom management, education and support of the patient and family. Education about the dying process provides essential information and decreases fears. Patients and families need information regarding the management of physical care, medications, spiritual and emotional needs, what to anticipate and coping strategies.

FALLS/SAFE

Patient safety is a major priority, included in this is the assessment for fall risk. Assessment is done on Admission, every shift; on transfer from another unit; and whenever there is a change in condition. Factors that may contribute to patient falls include: unsteady gait, dizziness, confusion, medication, and bathroom urgency. If a patient is determined to be “at risk” for falls, the patient is placed on the “Falling Star” program. Patients on the “Falling Star” program have a Yellow “Falling Star” magnet located on their door; and a Yellow armband applied; Yellow Chart Sticker and Yellow slip resistant booties. If the patient has been placed on the “Falling Star” program, the Nursing Diagnosis “Potential for Injury due to fall” is populated on the EMR Care Plan. Fall prevention modalities need to be implemented and documented (i.e. call light with –in reach, bathroom rounds, bed alarm, etc.)

Go Online to YouLearn and take the course OCM-Fall Prevention and the Falling Star Program, Application for Nursing. The Falling Star course is assigned to all Nursing Contract nurses.

RESTRAINTS

It is the philosophy of OCMC that each patient has the right to be free of restraints. If your patient assessment indicates the patient is at risk for injury or fall, please alert the Clinical supervisor or Charge RN. Before restraints are utilized, alternative methods must be considered. For example: aroma therapy, playing cards, music, etc. If it becomes necessary to use a restraint (such as Posey vest, mittens, wrist or leg device, or four side-rails, the patient's physician must be contacted and the Restraint order form completed. Only a clinical supervisor,

manager or Administrative House Officer (AHO) may obtain restraints for you.

AGE SPECIFIC POPULATIONS

Knowledge and skills to provide care appropriate to the age of the patient serviced and demonstrate ability to assess patients requirements relative to their age.



- Neonates ~ Birth to 1 year of age
- Children/Pediatrics ~ 1 year to 12 years of age
- Adolescents ~ 13 years to 17 years of age
- Adults ~ 18 to 64 years of age
- Geriatrics ~ 65 + years of age



IDENTIFICATION BADGES

REMINDER: Identification Badges must be worn at all times



POLICY AGAINST HARASSMENT

- OCMC is committed to providing a work environment that is free of all forms of discrimination
- We have a strict policy prohibiting unlawful harassment, including:
 - ⇒ sexual harassment and harassment based on race, color, religion, age, disability, marital status, pregnancy, ancestry or sexual orientation
 - ⇒ Contract/students who violate this policy are subject to discipline, including possible termination
 - ⇒ Any contract/student who believes he/she has been harassed by a co-worker, supervisor, or agent of OCMC should immediately report the incident to their supervisor or to the Human Resources Department.

Sexual Harassment Hurts Everyone

Sexual harassment or retaliation should be reported in writing or verbally. Please provide any relevant details, names of people involved and names of witnesses. You may report such activities even though you were not the subject of the harassment.

You do not need to complain directly to your immediate supervisor. You can bring your complaint to the designated company representative or an appropriate member of management.

Employees should never pressure other employees not to complain of harassment.

If you are a supervisor, you must report all complaints of harassment or retaliation.

If you have any questions, contact your personnel administrator.

An investigation will be conducted.

The investigation will be:

- Conducted by qualified personnel;
- Documented and tracked for reasonable progress; and
- Closed in a timely manner.

The company will reach reasonable conclusions based on the evidence collected.

Appropriate action will be taken.

Where evidence of sexual harassment or retaliation is found, prompt action will be taken to stop the harassment and ensure that it does not continue. Disciplinary action, up to and including termination, may result.

There will be no retaliation against you for filing a complaint.

Additional Complaint Information

Employees or job applicants who believe they have been sexually harassed or retaliated against may also file a complaint of discrimination with the Department of Fair Employment and Housing (DFEH) within **three years*** of the last act of harassment or retaliation.

The DFEH is the state agency that resolves complaints of unlawful discrimination, including sexual harassment. DFEH serves as a neutral fact-finder and attempts to help the parties voluntarily resolve the disputes. If they find a complaint is justified, the DFEH is authorized to file harassment cases directly in civil court. Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with the DFEH and a right to sue notice has been obtained.

Civil remedies include: damages for emotional distress from each employer or person in violation of the law; punitive damages; hiring, reinstatement, or promotion; back pay; and changes in the policies or practices of the employer.

The Equal Employment Opportunity Commission (EEOC) is the federal agency that resolves sexual harassment claims and has similar powers to investigate and resolve claims.

There are strict time limits for filing charges of employment discrimination and harassment. You should contact DFEH or EEOC promptly when harassment is suspected.

Contact DFEH at (800) 884-1684 or (800) 700-2320 (toll-free TTY number for individuals with hearing impairments). Email at contact.center@dfeh.ca.gov, or visit the DFEH Web site at www.dfeh.ca.gov.

If you have a disability that requires a reasonable accommodation, the DFEH can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711).

To schedule an appointment with DFEH, contact the Communication Center at (800) 884-1684 (voice or via relay operator 711) or (800) 700-2320 (TTY) or by email at contact.center@dfeh.ca.gov.

Contact EEOC at (800) 669-4000 or (800) 669-6820 (toll-free for individuals with hearing impairments). Additional information about EEOC is available at www.eeoc.gov.

*Effective 1/1/2020

ISBN 1-64956-050-8



9 781649 560508

© 2021 California Chamber of Commerce

Sexual Harassment Hurts Everyone



 **CalChamber.**
HR Expert & Business Advocate™

Notice to All Staff

Sexual harassment is prohibited by this company and is against the law.

You should be aware of:

- What sexual harassment is;
- What steps to take if harassment occurs; and
- Prohibition against retaliation for reporting sexual harassment.

Please read this information sheet. If you have any questions or concerns about it, contact your supervisor, personnel department representative or your investigative officer for further information.

What Is Sexual Harassment?

Both California and federal law prohibit sexual harassment.

Sexual harassment is a form of discrimination based on sex/gender (including pregnancy, childbirth, or related medical conditions), gender identity, gender expression, transgender, or sexual orientation. Although many people think of sexual harassment as involving a male boss and a female employee, this is not always the case. Individuals of any gender can be the target of sexual harassment. Sexual harassment may also involve harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity.

Sexually harassing conduct need not be motivated by sexual desire to be unlawful.

Sexual harassment often involves co-workers, other employees of the company or other persons doing business with or for the company.

Job applicants, independent contractors, unpaid interns and volunteers are also protected by the laws against sexual harassment.

Types of Sexual Harassment

In general, there are two types of sexual harassment:

"Quid Pro Quo" (Latin for "this for that") sexual harassment is when someone conditions a job, promotion or other work benefit by your submission to sexual advances or other conduct based on sex.

"Hostile work environment" sexual harassment occurs when unwelcome comments or conduct based on sex, unreasonably interfere with your work performance or create an intimidating, hostile, or offensive work environment, even if the offensive conduct was not aimed directly at you.

Even single incidents of harassment violate our policy and may be unlawful.

Behaviors that May Be Sexual Harassment

The definition of sexual harassment includes many forms of offensive behavior, including same-gender harassment.

1. Verbal harassment

Examples: *Sexual comments, derogatory comments or slurs, epithets, name-calling, belittling, sexually explicit or degrading words to describe an individual, sexually explicit jokes, comments about an employee's anatomy and/or dress, sexually oriented noises or remarks, questions about a person's sexual practices, use of patronizing terms or remarks, verbal abuse, graphic verbal commentaries about the body, suggestive or obscene messages or invitations.*

2. Physical harassment

Examples: *Physical touching, assault, impeding or blocking movement, pinching, patting, grabbing, brushing against or poking another employee's body, hazing or initiation that involves a sexual component, requiring an employee to wear sexually suggestive clothing, any physical interference with normal work or movement, sexually oriented gestures.*

3. Visual harassment

Examples: *Displaying sexual pictures or objects, derogatory posters, cartoons or drawings, displaying sexual media or electronic information, such as computer images, text messages, emails, web pages, or multimedia content, displaying sexual writings or objects, obscene letters or invitations, staring at an employee's anatomy, notes, leering, mooning, unwanted love letters or notes.*

4. Sexual favors

Examples: *Unwanted sexual advances or acts which condition an employment benefit upon an exchange of sexual favors. Continued requests for dates, any threat of demotion, termination, etc. if requested sexual favors are not given, making or threatening reprisals after a negative response to sexual advances, propositioning an individual.*

It is impossible to define every action or all words that could be interpreted as sexual harassment. The examples listed above, along with the definition of sexual harassment, are not meant to be a complete list of objectionable behavior nor do they always constitute sexual harassment.

Training Requirements

Employers who do business in California and employ 5 or more part-time or full-time employees must provide at least one hour of training regarding the prevention of sexual harassment, including harassment based on gender identity, gender expression, and sexual orientation, to each non-supervisory employee; and two hours of such training to each supervisory employee. Training must be provided within six months of assumption of employment.

Employees must be trained during calendar year 2020, and, after January 1, 2021, training must be provided again every two years. Please see Gov. Code 12950.1 and 2 CCR 11024 for further information.

Harassers Are Personally Liable

If you, as an employee, are found to have engaged in sexual harassment, or if you as a manager know about the harassing conduct of an employee or non-employee (e.g., client or customer) doing business with the company and condone or ratify it, you may be personally liable for monetary damages. This company will not pay damages assessed against you personally.

This company takes seriously its duty to take all reasonable steps to prevent discrimination and harassment from occurring and to create a workplace free of harassment. This company recognizes its own responsibility and potential liability for harassment in the workplace.

If harassment does occur, this company will take effective action to stop any further harassment and to promptly correct any harassing conduct. This company will take appropriate disciplinary measures — termination is one possible action — against any employee who engages in sexual harassment.

Protection Against Retaliation

Company policy and state and federal law forbid retaliation, and threats of retaliation, against any employee who rejects advances, complains about harassment, or participates in an investigation.

Prohibited retaliation includes but is not limited to:

- Demotion;
- Suspension;
- Failure to hire or consider for hire;
- Failure to give equal consideration in making employment decisions; and
- Failure to make impartial employment recommendations.

TERMINATION OF ASSIGNMENT

Some examples of inappropriate conduct that may lead to termination of assignment:

- False or misleading information
- Destruction or damage to OCMC property
- Theft
- Possession of firearms, weapons or hazardous, dangerous items
- Failure to report to work on any day without prior notification
- Release or misuse of company property and/or confidential information
- Altering or falsifying time keeping records
- Fighting, provoking a fight, or the use of offensive language
- Insubordination, refusal to do assigned work without legal justification
- Possession, and/or consumption of alcohol or drugs while on duty or reporting to work under the influence
- Possession, transfer, distribution of unlawful or non-prescribed drugs while at work or on medical center premises
- Noncompliance or disregard of any safety rule
- Sleeping during scheduled work hours
- Utilizing occupied or unoccupied patient rooms for personal use
- Leaving your job during scheduled working hours without notifying the supervisor
- Horseplay, or any other action that endangers others or medical center property or disrupts work
- Unlawful harassing, threatening, intimidating, or coercing any contract/student or OCMC employee
- Excessive tardiness or absence from work
- Failure to use appropriate call-in procedures for absence
- Smoking in any undesignated area of the hospital
- Failure to abide by the standards for meal and break periods
- Misuse of telephones
- Failure to comply with departmental dress and grooming standards
- Failure to work overtime in accordance with operational requirements
- Abuse or misuse of electronic media
- Possession or use of another contract/student's or OCMC employee's identification badge
- Unsatisfactory job performance
- Misconduct
- Unprofessional conduct
- Gambling on company property
- Returning to or remaining in work area when not on official business
- Misuse of company time
- Failure to report an on-the-job accident

SUBSTANCE ABUSE

OCMC is committed to providing an environment that is free of drug and alcohol abuse.

Contracts/Students/Employees are prohibited from reporting to work under the influence of any drug, alcohol or other substance that may in any way affect work performance and/or the safety of others.

NO SOLICITATION RULE

Contracts/Students may not solicit during working time for any purpose.

PATIENT'S RIGHTS AND RESPONSIBILITIES

A PATIENT ADMITTED TO OCMC HAS THE RIGHT TO:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure, who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and non-physicians who will see you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extent permitted by law.
7. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.
17. Know which hospital rules and policies apply to your conduct while a patient.
18. Designate a support person as well as visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood, marriage, or registered domestic partner status, unless:
 - No visitors are allowed.
 - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
 - You have told the health facility staff that you no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform you (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.
20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.
21. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, registered domestic partner status, or the source of payment for care.
22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or by calling MemorialCare Orange Coast Medical Center, 9920 Talbert Ave, Fountain Valley, CA 92708-9920, (714-378-7524): The grievance committee will review each grievance and provide you with a written response within days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).
23. File a complaint with the California Department of Public Health regardless of whether you use the hospital's grievance process. The California Department of Public Health's phone number and address is: (local address and phone number of CDPH)

California Department of Health Services	The Joint Commission
Medical Care Services	Hospital Accreditation
MS 400	One Renaissance Blvd.
PO Box 997413	Oakbrook Terrace, IL 60181
Sacramento, CA 95899-7413	800-994-6610

A PATIENT ADMITTED TO OCMC HAS THE RESPONSIBILITY TO:

1. Be considerate, respectful and cooperative when you are interacting with staff, physicians, and other patients.
2. Provide accurate information about your health, including your previous medical history, and all the medications you are taking.
3. Inform us quickly of changes in your condition or symptoms, including pain.
4. Let us know if you don't understand the information, we give you about your condition or treatment. Please ask questions.
5. Please speak up. Communicate your concerns to any employee as soon as possible, including any member of your patient care team, the manager, administrator, or patient relations representative.
6. Follow the plan of care and understand that you must accept the consequences if you refuse. Before you refuse, ask us for information to help you make the best decision possible.
7. Follow hospital rules, policies and regulations to ensure your safety and the safety of others.
8. Leave your personal belongings at home or have a family member take all valuables and articles of clothing home while you are hospitalized.
9. Respect the rights and property of others.
10. Respect the privacy of staff, physicians, and other patients. Photos, audio recordings and/or videos of patients, employees, volunteers, medical staff members, and other visitors are only permitted if written consent has been given. It cannot interfere with patient care, and not impede medical treatment. If you have questions, ask your health care team.
11. Understand and be responsible for instructions given to you when you are discharged. Please ask questions.
12. Pay your bills or make arrangements to meet the financial obligations of your care.
13. Provide the hospital with a copy of their Advanced Directives.

PAIN MANAGEMENT

- The goal of pain assessment and management is for the patient to be comfortable, functional and managing pain.
- The patient's pain level should be controlled so that he/she can participate in therapies.
- Prior to performing therapy, the patient should be asked if they are having pain.
- Patients having pain are asked to rate the pain's intensity using an "age/language appropriate" scale.

PAIN SCALES

- The 0-10 Visual Analogue Scale is used for non-cognitively impaired adults.
- The Wong-Baker Faces Scale is used for children and those with mild cognitive impairments.
- N-PASS (Neonatal Pain and Sedation Scale) is used for infants birth to 30 days.
- PAINAD – for advanced dementia and patients who are unable to communicate (e.g., comatose).

SMOKING

- OCMC is a smoke free campus
- "Smoke or smoking" means the carrying of a lighted pipe, lighted cigar, or lighted cigarette of any kind, including electronic cigarettes, or the lighting of a pipe, cigar, or cigarette of any kind, including, but not

limited to, tobacco, or any other weed or plant.

- Accordingly, it is the policy of Memorial to prohibit smoking in the buildings, parking lots or sidewalks surrounding the hospital, including the off-site areas.
- All Contracts/Students are expected to adhere to the policy

MULTICULTURAL ISSUES IN PATIENT CARE

- We have a diversity of cultures represented in our contract/student, employee and patient population.
- We must be sensitive and aware of the variations that factor into our communication.

Factors may include:

— **Conversational Style and Pacing**

👤 *ex: silence may show respect*

— **Personal Space**

👤 *ex: this can create inaccurate assumptions, as someone may be seen as aggressive for standing too close*

— **Eye Contact**

👤 *ex: avoiding eye contact could mean respect*

— **Touch**

👤 *ex: touching the head is very disrespectful*

— **Time Orientation**

👤 *ex: in some cultures, life paced according to the clock is not valued*

There are things that you may watch and be aware of in your communication between cultures:

- Watch for nonverbal signs like squinting, nodding and smiling
- Beware of a qualified “yes” in response to the question: “Do you understand?”
- Ask the listener to verbalize any instructions provided to confirm understanding
- Allow time for people to formulate questions
- Beware of the “yes” that means: “Yes, I hear your question.”
- Allow people to use writing wherever possible
- Invite the speaker to talk more slowly
- Allow the speaker to spell a difficult word

OUR BARIATRIC POPULATION

Orange Coast Medical Center provides specialized care to the bariatric population, also referred to as “patients of size.” It is very important that all staff and caregivers be sensitive to the needs of these patients, including: special large equipment, knowledge of the signs/symptoms and treatments of their common illnesses, and especially compassion. These patients are already sensitive about their size and the unfavorable reaction they commonly receive in public. It is important that Orange Coast Medical Center be a safe, healing environment. Our bariatric patients should never be subjected to any laughter, derogatory comments or inappropriate looks while at our hospital.

CAFETERIA

Located on the basement floor of the hospital

- Reasonably priced meals, snacks, and beverages
- Microwave ovens and vending machines also located in the same area
- ♦ ATM machine available



- ◆ A café is also available in the Patient Care Pavilion on the second floor during business hours.

ENVIRONMENT OF CARE

There are six components that comprise the “Environment of Care” (EOC) Joint Commission standards. The programs that make up the EOC are Safety, Security, Hazardous Materials, Fire Life Safety, Utilities Management, and Medical Equipment. Together these programs afford a standardized approach to the management of the EOC. Separately these components support, from an accreditation standpoint the necessary policies, procedures, and written documentation required to meet or exceed all Joint Commission EOC standards.

The group that implements, monitors, and evaluates all EOC performance standards is the Environment of Care committee (EOCC). The mission of this group is to assure a functional and safe environment for patients, visitors, staff, and other individuals served by or providing services within the Hospital. The EOCC has policies and procedures in place that allow for the goals and objectives set annually to be met. Included in these are guidelines for employees to use to resolve issues that impact the environment of care.

The following information will give a brief description of the six programs that comprise the EOC. Following the descriptions will be general information regarding hospital policies and procedures, for specific information regarding each program please refer to the associated program manual. Should you have any questions or concerns to bring to the EOCC, please contact your key manager or the Hospital safety officer.

SAFETY MANAGEMENT

The purpose of the plan is to establish, support and maintain a documented plan for Safety Management that provides for the annual evaluation of the objectives, scope, performance, and effectiveness of the program. The information contained in the Safety Manual provides information that will be a guide on Safety related issues that affect the environment of care. The Safety Manual will also provide information that is both department specific as well as Hospital wide policies, procedures and programs.

FIRE LIFE SAFETY MANAGEMENT

The purpose of the plan is to establish, support and maintain a documented plan for Life Safety Manual that provides for the annual evaluation of the objectives, scope, performance, and effectiveness of the program. The information that is contained in the Life Safety Program manual consists of information pertaining to fire emergencies and the prevention of them. Also integration with infection control, Construction and Patient Safety. This also contains information on the Emergency Kardex that will provide response guidelines in the event of emergency.

SECURITY MANAGEMENT

The purpose of the plan is to establish, support and maintain a documented plan for Security Manual that provides for the annual evaluation of the objectives, scope, performance, and effectiveness of the program. The information that is contained in the Security Manual will provide policies and procedures for Security related issues.

UTILITIES MANAGEMENT

The purpose of the plan is to establish, support and maintain a documented plan for Utilities Management that provides for the annual evaluation of the objectives, scope, performance, and effectiveness of the program. The information contained in the Utilities Management Program manual consists of information pertaining to the

management of the Utilities that serve the facility (Electricity, Water, Medical Gases, Air Conditioning, and Pneumatic Tube System).

MEDICAL EQUIPMENT MANAGEMENT

The goals of the hospital's Equipment Management program are to emphasize the management of clinical equipment on multiple levels, including complying with federal, state and local laws. The Equipment Management Program is designed to continuously test and maintain clinical equipment in optimal operating condition.

HAZARDOUS WASTE MANAGEMENT

The Hazardous Materials and Waste Program is established to ensure the health and safety of employees patients and visitors. Through the program, information about chemical labeling and Hazards will be made available. The use of Safety Data Sheets (SDS) is also explained in this program.

GENERAL SAFETY

By learning a few simple rules, you will be able to respond to emergency situations in the work place calmly and quickly. Safety is everyone's responsibility. There are various hospital committees that meet regularly to review events as well as address safety issues.

EMERGENCY KARDEX

An Emergency Kardex is available on each unit for quick reference should a problem arise. This Kardex is a clipboard with brightly colored cards, each containing brief clips of vital information. Should you encounter an emergency situation related to one of the topics, use the Kardex to quickly ascertain the correct way to deal with the problem. To report any Code, dial 1111. The topics listed on the Emergency Kardex are as follows:

- A. Code Red (Point of Origin – Fire or Smoke within your area)
- B. Code Red (Away from Point of Origin – outside your area)
- C. Code Pink - Infant Abduction
- D. Code Purple – Child Abduction
- E. Code Gray – Combative Person/Violence
- F. Code Silver – Weapon/Violence
- G. Code Triage - Internal or External Disaster
- H. Code Blue – Medical Emergency
- I. Code White – Pediatric Medical Emergency
- J. Code Orange – Spills Procedure
- K. Code Yellow - Bomb Threat
- L. S.D.S. – Safety Data Sheets
- M. Medical Equipment Failure Guide
- N. Injury / Illness / Blood Exposure
- O. OSHA - Hazardous Waste Management/Infection Control.
- P. Unusual Occurrence Reporting

- Q. Utilities System Failure Guide.
- R. EOCC Guidelines

Emergency Paging Codes

How To Call An Emergency:

Some departments have medical emergency code buttons. Please be familiar with their use if you are working at one of those stations.

If your department does not have a code button system or the emergency is other than medical:

THE TELEPHONE NUMBER FOR ALL EMERGENCIES IS 1111.

To Notify the Operator of an Emergency:

1. Dial 1111.
2. Tell the Operator WHAT AND WHERE your emergency is.

FIRE SAFETY

Fire/Smoke Alarm:

- 1) Locate the Fire Alarm Pull stations in your work area and learn how it operates.
- 2) Learn the evacuation routes and “Area of Refuge” from your area.
- 3) If you discover a fire and sound the alarm, also dial 1111 to page a “Code Red.”
- 4) Give the operator the specific location of the fire.

Response to a Smoke Alarm in your area:

1. If a smoke alarm is activated in your area, you will hear an alarm. The activated smoke alarm will have a red dot in the center of the smoke detector.
2. Dial the Emergency number 1111 to the switchboard and tell the operator where the fire or activated alarm is specifically located.
3. When a smoke detector goes into alarm, a Fire Alarm control panel at the switchboard will give the operator the area of the alarm.
4. Some areas are large so the information that you provide to the operator will allow for the operator to pinpoint the location.

Other Fire Safety Rules:

If a fire occurs:

1. Implement the R-A-C-E procedure:
 - R - Remove** anyone in immediate danger
 - A - sound the Alarm** (fire alarm and dial 1111)
 - C - Confine** the fire
 - E - prepare to Evacuate**
2. Evaluate your assigned responsibility and report the status to your supervisor and await instructions.
3. Do not use phones or elevators.
4. Turn off and unplug equipment.
5. If you're off of your unit when a Code Red is sounded, return immediately.

6. After the emergency is over, the person discovering the fire fills out an Unusual Occurrence Report. **THIS IS A REQUIREMENT.**

Operation of a Fire Extinguisher

All fire extinguishers at the Hospital are ABC. The ABC extinguishers are used on any type of fire.

1. Know the location of fire extinguishers on your unit.
2. Implement the **P-A-S-S** procedure:
 - P - Pull** the pin.
 - A - Aim**
 - S - Squeeze**
 - S - Spray**
3. Pull pin when you are ready to use.
4. After using, lay extinguisher on its side.
5. DO NOT ATTEMPT to use the extinguisher if it will place you in significant danger.
6. Always have an escape route behind you if you use the extinguisher - avoid getting trapped.

ELECTRICAL SAFETY

Electrical accidents are responsible for 1% of all accidental deaths in this country. Yet with just a little knowledge of electrical safety, almost all of these accidents can be prevented. Electricity is also responsible for approximately 20% of hospital fires, mainly due to overloads and short circuits.

What can we do to safeguard our use of electrical equipment?

1. All electrical equipment brought into the hospital must be electrically checked by Plant Operations before being put into use.
2. All electrical equipment must be grounded with a 3-prong "ground" plug.
3. It is the responsibility of ALL contracts/students to inspect electrical equipment for damaged, frayed cords, unsafe receptacles and other obvious defects.
4. When moving equipment, take care not to damage the cord.
5. Learn how to operate equipment prior to use - DON'T GUESS.
6. Report electrical issues immediately. A 'small shock,' over heating, sparking or noise are urgent warnings.
7. Remove unsafe equipment from use. Prepare a Work Order Request and send to Plant Operations.
8. Tag the equipment with a sign stating what is wrong. Equipment you feel may be a source of harm to the patient, the staff or the hospital must be taken out of service.
9. Water and electricity do not mix. Keep hands dry. Prevent dampness near switches and wiring of electrical devices.
10. Intact skin is a protective barrier from electrical shock. Patients in certain situations are more susceptible to shock; they include: open wounds, pacemakers, Swan-Ganz catheters and other like conditions.
11. Use of extension cords is prohibited, with the exception of these three; life-threatening emergency; demonstration or audio/visual equipment use; connecting personal computers.
12. Patients are notified before admission that they may not bring personal electrical equipment from home. In special circumstances that are deemed medically necessary, Plant Operations will inspect and tag any personal medical equipment needed while the patient is admitted.

DISASTER PLAN

In The Hospital

In the event of a disaster, the following announcements will be made over the public address system in the hospital:

“May I have your attention please!”

1. ***Triage Code Internal*** - Internal Disaster
2. ***Triage Code External*** - External Disaster

*ALERT, PLEASE STAND BY:

*Note: If a DRILL is in progress, this will be announced.

Your role:

1. Assess your area of responsibility for current status.
2. You must check with your supervisor to see if you can be released.
3. If released, proceed to the Personnel Pool (in the Doctor’s Dining Room) for assignment.

If there has been an actual disaster:

1. Note the time you received the call, and call the next person on your phone chain, relaying as exactly as possible the information you received.
2. Ensure your family and homes are secure. If not, stay home.
3. In the event of an area wide disaster (e.g., earthquake) you need to ascertain if you can get to the facility. You may wish to tune your radio to 640 AM or 710 AM.
4. If your family and home are secure, please report to the hospital for assignment to the Personnel Pool (Doctor’s Dining Room). You must present your ID badge.

If a drill:

Note the time the call was received and report to the caller how long it would take you to report to the facility. You are required to participate in a drill in the same manner as described for an actual fire/disaster. It is essential for staff to know the procedures and to have an opportunity to test the procedures on an episodic basis. Your participation and cooperation is expected.

EMERGENCY PREPAREDNESS AND H.I.C.S.

TYPES of DISASTERS: There are two types of disasters: In an external-type disaster, victims come to the hospital because they have been injured, such as from a mass casualty incident, (as in an airline crash, refinery explosion, or multiple auto injuries). An internal incident involves damage or threat to the hospital, as in a bomb threat, civil unrest, or an earthquake that not only brings victims to us, but equally causes damages to us. Both types will initiate a **CODE Triage** at the medical center.

RESOURCES: Be familiar with your Disaster Manual and *Emergency Kardex*.

YOUR ROLES AND RESPONSIBILITIES COULD INCLUDE:

Non patient care (Includes Volunteers)

As a contract staff/volunteer who is not directly involved with patient-care delivery, your role will vary depending on what type of disaster, and may include some of the following

Victims Coming to hospital: **Damage to hospital:**

- | | |
|---|--|
| <ul style="list-style-type: none"> •Remain on alert for activation of the Labor Pool. •Report to the Labor Pool if activated (you could become involved with transporting patients, providing clerical support, tracking costs, handling phones, comforting families, assisting with patient-care as directed). | <ul style="list-style-type: none"> •Assessing physical damages •Assessing supplies/ equipment •Assessing staff/visitor count •Documenting activities •Tracking disaster-related costs •Reporting to the Labor Pool if activated. |
|---|--|

Patient Care

As a contract staff/volunteer involved with patient-care delivery, your role is primarily focused on the care of the patient during a disaster situation, and may include the following actions.

Depending Upon Disaster Severity:

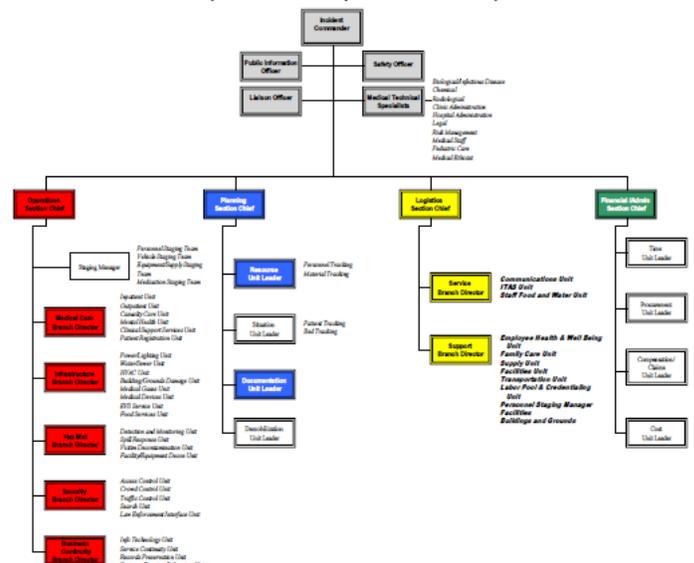
- | | |
|---|--|
| <ul style="list-style-type: none"> •Patient Triage •Determine bed count. •Assist in transporting patients to another unit •Prepare meds, equipment for patients who might be transported. •Remain on alert for the activation of the Labor Pool. •Report, if able, to the Labor Pool. | <ul style="list-style-type: none"> •Attend to patients—determine if injuries were sustained. •Determine if injuries to staff, visitors were sustained. •Assess physical damages •Assess supplies, equipment. •Document activities, costs. •Implement back-up plans if systems failure occur (eg., power outage, water failure, medical gas failure). |
|---|--|

HICS is the management-driven system at the hospital used to oversee the process of disaster management. It involves pre-defined personnel and roles, in an organizational format for the purpose of managing the disaster, using resources, coordinating efforts, treating and transporting patients and tracking information and decision-making. Your unique role supports this overall chain-of-command, which ultimately results in plans and or actions. Picture the **HICS** system like this:

H.I.C.S.: Managers assume their positions, and decisions and actions are made related to disaster. HICS participants report to superior officers, based upon the organizational chart at the right. HICS can be used to manage multiple types of disasters, and can staff can be appointed to assume roles on the PM or NOC shifts. HICS is not the hospital's disaster plan, but a *process* used by pre-selected staff to manage a disaster.

CODE TRIAGE: This is the code that is used for an internal or external type of disaster: Code Triage Internal, or Code Triage External will be used. The PBX operator will identify the type after the Code is announced, eg., the announcement will state: **"Code Triage" [External or Internal]**

Hospital Incident Command System – HICS – for Small Hospitals



COMMUNICATIONS: Back-up communications involve the following: PBX (overhead page) Ham Radio, HEAR, Reddinet, walkie-talkies, cellulars, intranet, emails and runners--employees designated to "run" from one department to the next to deliver messages if other communications are not working. If computers are not working, manual operations will go into place (eg., "downtime operations").

EARTHQUAKE PREPAREDNESS

You are required to participate in a drill in the same manner as described for an actual fire/disaster. It is essential for staff to know the procedures and to have an opportunity to test the procedures on an episodic basis. Your participation and cooperation is expected.

Earthquakes are a fact of life in California. Preparation is a major factor in reducing the possibility of injury during and after a quake. Participate in disaster drills and complete familiarity with your work area is essential. Be familiar with the location of fire extinguishers, valves, and shut-offs in your work area and at home. In the event of wide spread damage, support from outside services (such as the fire department) would be limited. It becomes our responsibility to be able to react appropriately during this type of disaster. Give serious thought as to what you would do if an earthquake struck when you were at home, in a car, at work, in a store, etc. Your prior planning will help you to act calmly, safely, and constructively in an emergency and enable you to help others.

To prepare for an earthquake:

1. Make sure tall cabinets and shelves are firmly secured to walls or other stable structures.
2. Store large or heavy items close to the floor or below waist level so they cannot fall on you.
3. Keep the work area and pathways clear to reduce the possibility of obstructions that could hinder evacuation.
4. Know the location of extinguisher, oxygen cylinders, flashlights, and other emergency equipment.
5. Review the fire and disaster procedures on a regular basis.
6. Prepare a personal fire and disaster procedure for your home.

When an earthquake strikes, REMAIN CALM. Slow down and consider the consequences of any actions that you may take:

1. If you're in a building, get under a desk, table, bed, etc.
2. Protect yourself from injury from falling objects; this causes most earthquake injuries.
3. Do not attempt to evacuate during the quake. You may be hit with debris falling from outside the building.
4. If outside, stay outside and avoid tall structures, walls, power lines; get to an open area and protect yourself as much as possible.
5. If you are in your motor vehicle, get off of or out from under overpasses, pull off the roadway and stop. Stay in the vehicle.

After the quake:

1. Survey your immediate area of responsibility for effects of the quake.
2. Be prepared to attend to issues requiring immediate action and establish priorities for your area.
3. Shut off electricity, valves, etc., as indicated by the situation.
4. Check for fire hazards and injuries.
5. Seek assistance as necessary.
6. Do not use elevators or heavily damaged stairs.
7. Be prepared for after shocks.
8. Prepare for the disaster procedure to be initiated.
9. The inside cover of your phone book has a list of items to have at home in a earthquake kit. It is also a great source of information for other aspects of dealing with a disaster.

HAZARD COMMUNICATION STANDARD

The Occupational Safety and Health Administration (OSHA) issued a law, the Hazard Communication Standard, which will help us keep you safe and healthy. It says you have a 'RIGHT TO KNOW' what hazards you face on the job and how to protect yourself against them.

In the past there was no guarantee that workers would be told about the chemical hazards they might face on the job. Chemical manufacturers have to determine the physical and health hazards of each product they make. They then have to let users know about those hazards by using container labels and Safety Data Sheets (SDS).

Employers must develop a written hazard communication program. They must: 1) tell employees about the Hazard Communication Standard; 2) explain how it's being put into effect in their workplace; 3) provide information and training on hazardous chemicals in their workplace. This includes how to recognize, understand and use labels and Safety Data Sheets (SDS) and use safe procedures when working with hazardous substances.

Contracts/students have to protect themselves, too. Contracts/students must read labels and Safety Data Sheets, and naturally, follow these instructions and warnings.

Safety Data Sheets (SDS)

The Safety Data Sheets (SDS) is your guide to hazardous material safety in your workplace. All of the hazardous materials used in your work area have a SDS.

To obtain a SDS on a particular product, contact 3E Company 24 hours a day, 7 days a week at (800) 451-8346. This number is located on each department phone for a quick reference.

The information you should have when calling are:

1. Product Name and Number
2. Manufacturer Name
3. UPC Code (if available)

The SDS is then faxed to you immediately.

If a container you are handling has no label, notify supervisor and ask for instructions.

Forms of Toxic Materials

- Solids - e.g., decomposing plastics, fumes and gases.
- Dusts - tiny particles of solids that may be breathed from mixing, etc.
- Fumes - usually from a solid that is melted and starts to vaporize.
- Liquids - e.g., acids and solvents that may give off vapors.
- Vapors - the evaporated phase of a liquid.
- Mist - from sprays, foams, or splashing.
- Gases - a formless fluid detectable by color or smells.

Routes of Entry

- Lungs (most common entry)
- Skin
- Digestive System (less common and often overlooked)

Body's Reaction

Acute -immediate response to exposure

visible and usually traceable

reactions usually short lived - may recover or have permanent damage

Chronic - may not be obvious

gradual onset

harder to trace cause

Signs and Symptoms of Occupational Hazards

Eye irritation

Odors

Visible direct clouds of fumes

Chemical spills

Sight - warning signals

Sounds - sirens, whistles

But remember, hazard communication can protect you only if **YOU**:

- ✓ Read labels and Safety Data Sheets
- ✓ Know where to find information about your chemicals
- ✓ Follow warnings and instructions
- ✓ Use the correct protective clothing and equipment when handling hazardous substances
- ✓ Learn emergency procedures
- ✓ Practice sensible, safe work habits

RADIATION SAFETY

Patients at the facility may have exposure to radiation in several ways. There several types of radioactive substances for therapeutic or diagnostic purposes. Nuclear Medicine and PETCT scans require the injection of radioisotopes for accurate imaging. Patients may also be receiving beam radiation for diagnostics or as therapy for various types of cancer as well as oral dosing of I-131 ("Iodine-131") for the treatment of thyroid cancer. Patients may also receive X-rays or Fluoroscopy during a procedure or examination.

Patients who have undergone beam radiation, x-ray or fluoroscopy do not require special care post-procedure. However, patients who have received nuclear imaging, I-131 or PETCT are considered radioactive until the substance has been adequately excreted.

In Radiology, or during portable radiography or fluoroscopy The X-rays are a potential source of exposure to radiation. For personal safety, care must be taken to minimize exposure to the nurse, when accompanying a patient undergoing a procedure in the radiology department or when attending with portable equipment present. Care must also be taken to minimize exposure to other staff members. This will involve remaining behind either a lead wall or shield while the imaging is in process. Only essential personnel are permitted in a room with X-ray being generated and are to be donned with appropriate PPE; if the patient requires constant attendance, a lead apron or additional lead apparel may be necessary. Pregnant staff members should avoid exposure whenever possible. Once these tests are concluded (i.e. the beam is "off"), there is no residual radiation in the patient about which the staff should be concerned.

Patients who are undergoing a Nuclear Medicine or PETCT exams, patients have been injected with a radioisotopes which may be present in: urine, blood, vomitus, and perspiration, use of universal precautions is mandatory. The amount of radiation poses no danger to the public and is allowed by NRC medical use regulations.

For patients undergoing PETCT exams, the following precautions must be followed for the 6-12 hours after the patient was administered a radioactive dose. Hospital personnel, patient's family members, neighboring patients, children/infants, and pregnant females must avoid long periods of close contact time with the patient. Maintain distance of at least 6 feet from others that need to be in patient's room for extended durations. Staff is to follow universal precautions when caring for patients. Flush toilets several times when disposing of urine. The radioisotope is a small amount and short lived. Hydrating patients will hasten the elimination of residual radioactivity from the system.

Patients undergoing I-131 therapy, are not normally treated here at OCMC as they are permitted to go home with doses under 30 mCi ("microCuries"). For those patients with greater than 30 mCi therapy your Nuclear Medicine Department will notify Nursing Administration and assist with following the guidelines for patients instituted for I-131 therapy as outlined in detail in policy #MS-0122.2: "Radiopharmaceuticals, Care of Patient Recovery."

- a. The patient is admitted to room 304 on the Medical Unit. This room has been specially adapted for the care of the I-131 therapy patient.
- b. All staff entering the room wears a dosimeter to count their radiation exposure. The dosimeter readings are recorded on a form outside of the room
- c. Post a Radioactive Materials caution symbol sign on the door of the room.
- d. Post a copy of the protocol for care of the patient on I-131 therapy on the door.

There are precautions with patients undergoing I 131therapy; the 24 - 48 hour period following initiation of treatment is the most significant. Radiation may be present in: urine, blood, vomitus, and perspiration. In case of a spill - ACT QUICKLY! Cover the spill with linen and or several layers of absorbent waterproof pads. The Radiation Safety Officer must be called at extension 7191. After hours, contact is through the Administrative House Officer (AHO). This procedure is outlined in detail in policy #MS-0122.2: "Radiopharmaceuticals, Care of Patient Recovery." The policy may be referred to for guidelines in properly preparing the room and caring for these patients, the Nuclear Medicine staff will assist with this process.

Finally, be alert to any yellow and magenta radiation signs e.g. Caution Radioactive Material, Caution X-ray etc. as they indicate that a radiation source is nearby and precautions must be taken to avoid exposure. For questions regarding these signs or other procedures please contact the Nuclear Medicine Department or the Radiology Manager for assistance.

BODY MECHANICS

CORRECT LIFTING TECHNIQUE

1. Assess the object to be lifted. If it is too heavy or clumsy, obtain help.
2. Stand close to the object to be lifted, with your feet apart for balance. The closer the load to your body, the less pressure it exerts on your back.

3. Bend your knees and hips, but keep your back as straight as possible in relation to your pelvis as you descend to the object that you intend to lift.
4. Get a grip or handle on the object.
5. Lift the object gradually as you straighten your knees and hips, then stand, using your leg and hip muscles.

AVOID QUICK, JERKY MOVEMENTS, AND AVOID TWISTING. IF YOU HAVE TO TURN, BE SURE YOU MOVE YOUR BODY AS A WHOLE UNIT.

For further information or direction regarding any safety issue, please call the Facilities Department.

Contract/student personnel Injuries:

Injury – Contracts/students are to report to their OCMC supervisor and report their work related injury to their agency. If you have an injury, it is your responsibility to be seen by a treatment facility approved by your company. Please be familiar with your company's workman's compensation policies.

INFECTION CONTROL

Standard Precautions:

Standard precautions are designed to reduce the risk of transmission of pathogens and applies to all patients regardless of their diagnosis or infection status. Standard Precautions apply to 1) blood; 2) all body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood; 3) nonintact skin; and 4) mucous membranes. Wear appropriate personal protective equipment (PPE) and practice hand antisepsis.

Hand Antisepsis:

Single most effective means for preventing the spread of infection.

Wash hands with soap and water for 30 seconds.

Gloves are not a substitute for hand washing. Gloves leak.

Waterless gel may be used repeatedly as long as your hands feel and look clean.

Soap and water must be used for patients with C Difficile diarrhea.

Personal Protective Equipment (Gloves, gowns, masks, goggles):

- OSHA requires that employees have PPE that are readily available.
- Check with your manager/supervisor to find out where they are stored.
- When a patient is in isolation, an isolation cart is placed outside the room.
- Notify your manager if you are unable to use what's available or if you do not have what you need.

Appropriate Types of Isolation:

See "Simplifying Isolation" table located in isolation carts and on Infection Prevention Homepage on M-Connect

Airborne Isolation:

Put the patient into a negative pressure room ASAP

Healthcare workers must use an N-95 respirator or a PAPR (personal air purifying respirator) and visitors are to use a surgical mask.

The most common reason for Airborne Isolation is to rule-out Tuberculosis (TB)

Signs and symptoms of Tuberculosis:

- A history of more than 3 weeks of a frequent productive cough
- Blood in the sputum (hemoptysis)
- Night sweats
- Weight loss
- Fever

Tuberculosis patients CANNOT be discharged unless clearance from Orange County Department of Public Health has been granted.

To protect yourself from a coughing patient who does not contain their cough, use a surgical mask!

Contact Precautions:

Wear the appropriate PPE for the following organisms:

MRSA: gown and gloves

Vancomycin Resistant Enterococci (VRE): gown and glove

Clostridium difficile: gloves only. Use soap and water for hand washing.

Scabies: gown and glove

Droplet:

Utilize a surgical mask within 3 feet of the patient. Use for all Influenza patients.

Medical Waste:

Medical waste is defined as fluid blood waste or body fluids which main contain blood.

Dispose of medical waste into red bags.

Do not carry red bags, they must be transported into solid rigid containers. Please secure a 5-gallon biohazardous bucket from the utility room to transport the red bag.

HIPAA ~ SECURITY COMPLIANCE

Health Insurance Portability and Accountability Act (HIPAA)

Introduction

By now, you know the HIPAA Privacy Rule- federal standards that protect our fundamental right to privacy and confidentiality. The Department of Health and Human Services (HHS) issued a second set of federal standards to protect health information in electronic form. It's called the HIPAA Security Rule.

This handout outlines the basics of the Rule and some of the security safeguards that may affect the way you do your job.

Security Basics

Covered entities had to comply with the Security Rule by April 2005. Why do you need to learn the basics of the Rule?

- Breaches in security can lead to breaches in the HIPAA Privacy Rule
- Experts point out that 164.530 of the Privacy Rule requires covered entities to take reasonable measures to secure all protected health information-including PHI in electronic form.

Let's look at who and what is protected by the Security Rule, so you're not opening the door to privacy concerns now.

The Security Rule protects:

- Confidentiality of electronic PHI, termed ePHI
- Integrity of ePHI- meaning once ePHI is created, it can't be tampered with
- Availability of ePHI, so it can only be accessed by people with the authority to do so whenever its needed.

Like the Privacy Rule, health information is protected when it contains personal information that connects the patient to the information, such as:

- Patient's name and address
- Social security number
- Billing information
- Physician's note

The Security Rule is divided into three parts. Together, they cover the policies, procedures, processes and systems you need to protect ePHI from the time it's created to its disposal, and all parts in between.

Administrative Safeguards

Administrative safeguards are carried out by executive teams and managers and the designated HIPPA Security Official who has ultimate responsibility for your facility's security program. They work as a team to conduct on-going risk analyses, called security audits, and create formal policies and procedures to safeguard all ePHI.

Administrative safeguards include:

- Rules on workplace security such as who can access ePHI and who cannot, and who has limited access, such as contractors or vendors
- Detection systems to detect, correct and prevent security breaches
- Security incident policies on how to handle violations and security breaches, for example, your facility's

internal processes for reporting security concerns and infractions

- Contingency plans that outline how to respond in emergencies or natural disasters that damage ePHI
- Back-up systems off-site that can be retrieved quickly in the event of an emergency or disaster
- On-going evaluations and audits to make sure your facility is in compliance with the Security Rule, and stays that way.

In some cases, new policies may not be necessary. You may just need to document what you've been doing all along, and how it meets the security requirements

A word about computer passwords

- Never share your password with anyone or they could breach security in your name
- When you share a password, you allow another person to use your access
- Some facilities discipline or terminate for this lack of responsibility

If someone is terminated

- A employee with access to your facility network could potentially sabotage or leave behind code to destroy or disrupt ePHI security
- When someone is terminated, steps are taken to lock that person out of the system before damage occurs.

Physical Safeguards

Physical safeguards cover protection of physical things such as computer systems and high tech equipment as well as the facility where ePHI is stored. They include:

- Physical access controls to limit access of ePHI and make sure authorized persons can access data when they need it
- For example, passwords to log on to your computer and access ePHI- that are changed regularly, so they do not fall into the wrong hands
- PIN numbers and telephone call back procedures for dial-up modems, to validate who is accessing ePHI
- Unique user Ids, like fingerprints, to verify that the person trying to log on to the computer is who he or she claims to be
- Facility access controls to protect areas where ePHI is housed
- Parking restrictions to control access to certain areas of the facility
- Security guards and personnel identification verification, such as ID badges and nametags
- Sign-in sheets for visitors and escorts when necessary
- Device and media controls to ensure the security of ePHI is accessed and guard against unauthorized access, including laptops and PDAs on and off-site
- Automatic log-off, so terminals log-off when you leave your desk
- Workstations located away form public areas

Wireless technology poses a risk to ePHI.

- Anyone with the right network scanner can obtain wireless ePHI
- Follow facility rules about access to wireless technology

Technical Safeguards

Technical safeguards include all the technology that makes physical safeguards possible. In most cases, your IT department will put these systems n place, but you may be using the software. They include:

- Access controls for electronic systems that hold ePHI to make sure people with access rights can access data when they need it
- Integrity controls to protect ePHI from alteration or destruction, like virus-checking software to protect

equipment from malicious software

- Transmission safeguards to protect ePHI transmitted over open networks from intruders.
- Encryption, for instance, to convert ePHI into a secret code for transmission over public networks:
 - Used for email documents containing ePHI and for highly confidential web browser sessions between patients and physicians
 - When received, data is decoded and turned back into plain text
- Authentication policies to verify if the people logging on to the system are who they claim to be
- Digital signatures or message authentication codes to make sure stored ePHI is not tampered with or destroyed
- Monitoring systems to track who's logging into the system successfully, and who's trying to log in unsuccessfully
- Internal system audits and controls to track and record daily activity in information systems to look for abnormal or suspicious behavior
- Instant reporting systems, such as alarms, to alert administration of possible intruders

Security Walkthrough

Security compliance requires a change in the culture of your organization. We will all have to think differently – think security first, just like we now think safety first. No matter how many policies you have in place to protect ePHI, none will work without you. So, let's look at some of the simple things you can do right now:

- If you see someone in the parking lot who looks lost or suspicious, notify security or your supervisor.
- Report visitors without badges or temporary ID cards, and don't assume someone walking into a sensitive area should be there.
- When you enter the facility, make sure you have your ID or nametag handy. It saves time for everyone.
- Never leave laptops or PDAs in your car. Both can be a target for would-be intruders
- Log off when you walk away from your workstation
- Become familiar with your facility's policies on changing passwords, and never give anyone your password- including someone who says they are from IT. No one ever needs your password to fix a computer.
- Never open an email attachment unless you know who sent it. Email attachments are the most common way for viruses to infect an entire network.
- Never download or use software given to you, even if you know who it came from. All software must be approved by IT.
- Become familiar with your computer anti-virus system, so you can inform IT to a virus alert.
- Safeguard computer-generated faxes just like you safeguard ePHI
- Report any security incidents or violations where a business associate is not following appropriate procedures, or you or your facility will be held responsible.

Summary

The HIPAA Privacy Rule got us started. The HIPAA Security Rule fills in any security gaps:

- Don't wait to make security a part of your daily routine
- Be vigilant and use your professional judgment to protect ePHI