MemorialCare™
Orange Coast Medical Center

Contract Staff and Student Hospital Orientation

Welcome to MemorialCare Orange Coast Medical Center
We are pleased you are partnering with us to bring excellent patient care to our patients. This packet equips 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!**

Revised 3/20/2023

OUR HISTORY

MemorialCare Orange Coast Medical Center (OCMC) was built in January 1986 as FHP Hospital, and in January 1996, was purchased by Memorial Health Services (MHS). The hospital was renamed Orange Coast Memorial Medical Center and established as a community-based, nonprofit hospital. In 2017, MemorialCare went through rebranding in order to reflect its status as a fully integrated health system, and the hospital was renamed MemorialCare Orange Coast Medical Center. Orange Coast Medical Center provides for its community's health care needs with innovation and a commitment to excellence, all delivered in a beautiful setting. We serve our community by providing personalized care delivered in a thoughtful, compassionate manner.

Orange Coast Medical Center is honored to be recognized for the following:

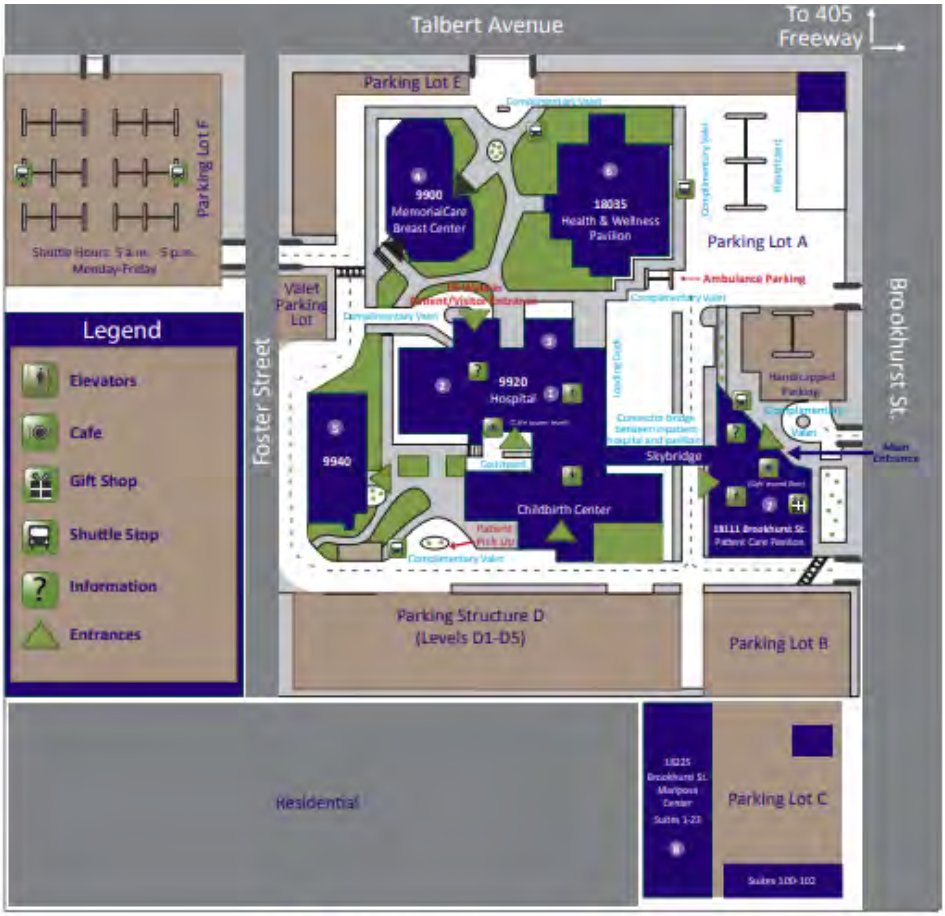
- Voted a "Top Workplace" for 12 years and the "#1 Best Hospital in Orange County" County by readers of The Orange County Register for a sixth year in a row — our ninth consecutive year of being named a Best Hospital
- Magnet ® recognized by the American Nurses Credentialing Center for nursing excellence
- First place as "Best of Fountain Valley" in the healthcare category of the Fountain Valley Chamber's "Best of" awards
- Received the 2022 Honor Roll Award for Maternity Care from the California Health and Human Services Agency
- Recognized as a Comprehensive Center for Bariatric Surgery by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program. (MBSAQIP)
- Recognized as a Center of Excellence for Bariatric Surgery by all major health plans
- Commission on Cancer (CoC) accredited cancer program by the American College of Surgeons Commission on Cancer and recognized as a Comprehensive Community Cancer Program (CCCP)
- Accredited by the American College of Radiology (ACR) as a Breast Imaging Center of Excellence and a Magnetic Resonance Imaging Accredited Facility
- Breast Centers are Accredited by the American College of Surgeons National Accreditation Program of Breast Centers
- Recognized as a Lung Cancer Center of Excellence by the Go2 Foundation
- Recognized as a "5-Star Recipient" for the Treatment of Heart Attack
- Recognized as a "5-Star Recipient" for Coronary Bypass Surgery
- Recognized as a "5-Star Recipient" for Treatment of Sepsis
- Recognized as a "5-Star Recipient" for Total Knee Replacement
- Recognized as a "5-Star Recipient" for Total Hip Replacement
- Recognized as a "5-Star Recipient" for Hip Fracture Treatment

In addition to **Orange Coast Medical Center**, MemorialCare hospitals include the following:

- MemorialCare Long Beach Medical Center (LBMC)
- MemorialCare Miller Children's & Women's Hospital Long Beach
- MemorialCare Saddleback Medical Center (SMC)

PARKING

PLEASE PARK IN THE PARKING STRUCTURE D, 3RD LEVEL OR ABOVE.



1 9920 Building

Ground Level
- Cafeteria
- South Conference Room
- Medical Records - New Location: Mariposa Building 18225 Brookhurst St., Mariposa, Suite 7

Monday - Friday: 8 a.m. - 4 p.m.

First Floor
- Childbirth Center
- Labor and Delivery
- NICU
- Emergency Department
- Surgical Waiting Area

Childbirth Center Entrance is open 24/7.

Second Floor
- Critical Care Unit
- Oncology Unit
- GI Lab

Third Floor
- Medical Unit
- Surgical Unit
- Telemetry Unit
- MemorialCare Joint Replacement Center

2 Cardiovascular Center
- Annie Capaldi Heart Revitalization Suite
- Cardiac Catheterization Suite

3 Emergency Services

4 9900 Building
- MemorialCare Breast Center
- Conference Room 1A
- Physician Offices

5 9940 Specialty Building
- Miller Children's Pediatric Specialty Clinic
- Physician Offices

6 18035 Building - Health and Wellness Pavilion

First Floor
- Outpatient Pharmacy
- Spine Health Center
- MemorialCare Heart & Vascular Institute
- The Coast Resource Center
- Community Conference Center
  South Coast Conference Room
  Pacific Coast Conference Room
  California Coast Conference Room
  West Coast Conference Room
  Huntington Coast Conference Room
- Physician Specialist Offices

Second Floor
- MemorialCare Medical Group – Physician Offices
- Newport Coast Conference Room

7 18111 Building - Patient Care Pavilion

Ground Level
- Radiation Oncology
- CyberKnife

First Floor
- Admitting/Registration
- MemorialCare Imaging Center
  - Ultrasound
  - MRI
  - CT
  - PET/CT
  - Diagnostic X-ray

Second Floor
- Outpatient Cardiology
  - Cardiology/Nuclear Medicine
  - Cardiac Rehabilitation
- Outpatient Rehabilitation Services
  - Physical Therapy
  - Speech Therapy
  - Cancer Rehabilitation
- Outpatient Lab
- PCP Café
- Physician Offices

Third Floor
- Orange Coast Center for Surgical Care
- Physician Offices

Fourth Floor
- Cancer Services
  - Infusion Therapy Center
  - American Cancer Society Information Center
- Orange Coast Foundation
- Administrative Offices
- Human Resources
- Patient Relations
- Physician Offices

Fifth Floor
- MemorialCare Surgical Weight Loss Center
- Physician Offices

Sixth Floor
- Doheny Eye Institute UCLA
- Physician Offices

8 18225 Building - Mariposa Center
- The Good Life Fitness Classroom, Suite 12
- Medical Records, Suite 7
  Monday - Friday: 8 a.m. - 4 p.m.
- Physician Offices

WHO'S WHO AT OCMC

Administration Team
Marcia Manker ~ Chief Executive Officer
Aaron Coley ~ Chief Financial Officer
Emily Randle ~ Chief Operating Officer
Shela Kaneshiro ~ Vice President of Nursing/Chief Nursing Officer
Erin Hotra-Shinn ~ Vice President Strategy and Business Development

HUMAN RESOURCES

Michelle Gutierrez ~ VP, Human Resources
Lauren Castagna ~ Manager, Human Resources
Denise Bello ~ Human Resources Generalist
Jazmine Simon – Human Resources Representative
Rafael Gallo Flores – Human Resources Assistant
Melissa Reyes ~ 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

What is Performance Improvement (PI)?

The Goal of the PI program is to continuously improve patient outcomes and processes that support patient care and life safety. PI activities are most effective when they are:

- Planned, using a systematic methodology (OCMC uses Rapid cycle improvement and Lean)
- Align with organization-wide strategic goals and objectives
- A team effort
- Driven by a measurable goal

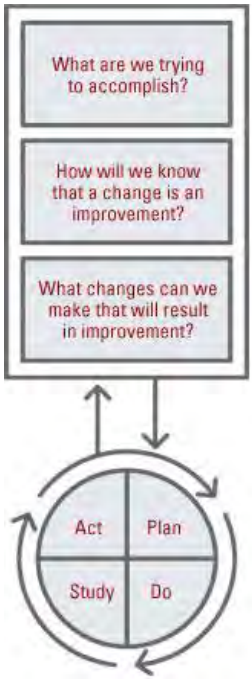
RAPID CYCLE IMPROVEMENT

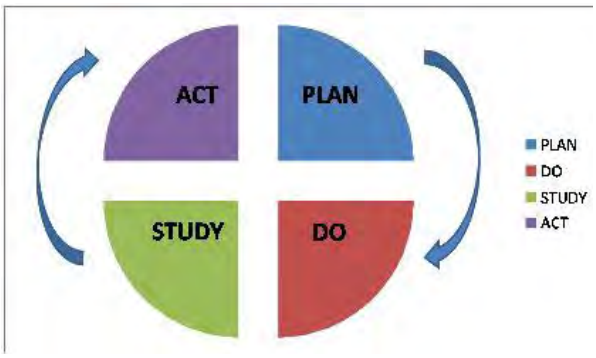
Rapid Cycle Improvement, also called AIM-PDSA (Plan, Do, Study, Act) is MemorialCare's model for improvement. This model uses a systematic methodology to plan, implement and measure "small tests of change". It is used to accelerate the change process and stay focused on targeted improvements. Rapid cycle plans are not just to do things faster, but to do things better. Using this methodology, small samples are used to test change ideas quickly, ideas can be tested while existing processes remain, many ideas can be tested quickly, "failures" of test ideas do not impact performance and it is easier to implement changes after they are successfully tested.

When utilizing the PDSA model, we ask:

- What are we trying to accomplish?
- How will we know a change is an improvement?
- What changes can we make that will result in an improvement?

PERFORMANCE IMPROVEMENT MODEL





How are performance improvement projects identified?

A project may be clinical or non-clinical. It may involve more than one department within the hospital or it may be small in scope, impacting only one department. It may involve physicians and other clinicians. The outcomes targeted for improvement may be patient outcomes, financial performance, throughput time, and/or customer satisfaction.

Anyone can identify an opportunity for improvement and bring it to their manager's attention, their Unit Based Council or the Performance Improvement and Patient Safety Department.

Examples of organization wide PI activities that have occurred or are currently in process at OCMC:

1. Always Ask Always Teach (Medication Side Effect Sheet)
2. Antimicrobial Stewardship Program
3. Decrease diversion hours
4. Early identification of Sepsis
5. Elimination of Early Elective Delivery
6. Hand Hygiene compliance
7. Improving the patient experience ("HCAHPS")
8. Preventing Patient Falls and Hospital Acquired Patient Injuries (HAPIs)
9. Promoting Exclusive Breastfeeding
10. Ready Bed
11. Reduction of Mortality from Sepsis

Core Measures

The Joint Commission and CMS have sharpened the focus of accreditation on patient quality and safety by requiring hospitals to collect and submit data on 'core' performance indicators. The data is reviewed by the Joint Commission who looks for trends and compares our performance against other hospitals' Core Measure

performance. The results are posted on the Joint Commission and CMS websites for public disclosure. Our goal is to provide "Perfect Care" (meeting all applicable indicators). In addition to focusing on mortality, readmission, patient satisfaction, we measure:

- Venous Thromboembolism (VTE)
- Early Elective Delivery
- Exclusive Breastfeeding
- Stroke Treatment
- Severe Sepsis and Septic Shock (SEP)
- Emergency Department Arrival and Department Times
- NTSV Rates
- Unexpected Newborn complications

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 MemSafe when you become aware of an event that has or could have contributed to patient injury.

SAFETY EVENTS

- 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

MEMSAFE REPORT

- Confidential!!
- Not intended for disciplinary action
- NEVER print!
- Complete required fields in the electronic form
- Notify supervisor to assist with MemSafe and documentation
- Contact your supervisor immediately if serious event or adverse outcome!

All safety events 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 safety event 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 MemSafe in the medical record

SENTINEL EVENT

"Is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."

ROOT CAUSE ANALYSIS (RCA)

- Forum to complete a debrief and 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. WE…

- 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
- Build an infrastructure that supports safe delivery of care
- Monitor our compliance with recognized patient safety goals and standard

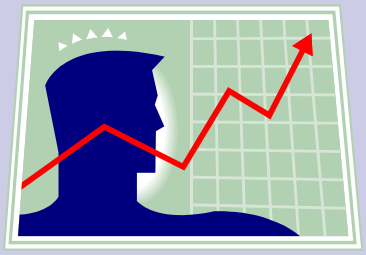
REPORTING SAFETY OR QUALITY CONCERNS:

MemorialCare take patient and employee safety very seriously and participate in several national initiatives to reduce risk to our patients.

We encourage employees and physicians to report any safety event by completing a MemSafe, report to their supervisor, or Clinical Risk Manager at ext. 7651

Employees and Physicians may also report concerns via the Patient Safety Hotline: (714)378-7888 or ext. 7888 or the Compliance & Ethics Hotline: (888) 933-9044

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.

2023 Hospital National Patient Safety Goals

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

Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
Improve staff communication	
NPSG.02.03.01	Get important test results to the right staff person on time.
Use medicines safely	
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
Use alarms safely	
NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
Prevent infection	
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
Identify patient safety risks	
NPSG.15.01.01	Reduce the risk for suicide.
Prevent mistakes in surgery	
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

REGULATORY COMPLIANCE

- Major regulatory agencies include:
  - California Department of Public Health (CDPH) – state agency
  - Occupational Health & Safety (OSHA) – federal agency
  - The Joint Commission – 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.

Patient Safety

FALLS

Patient safety is a major priority, including the assessment for fall risk. Assessment is done on Admission, every shift; on transfer from another unit; whenever there is a change in condition; after procedure/surgery and after a fall. Factors that may contribute to patient falls include: unsteady gait, dizziness, confusion, medication, and bathroom urgency. All patients will be considered a fall risk. Patients determined at high risk for falls will have HIGH RISK interventions implemented including a yellow armband and the FALL/Trauma/Injury risk EMR Care Plan. Fall prevention modalities need to be implemented and documented (i.e. call light with –in reach, bathroom rounds, bed alarm, etc.). At OCMC, we promote supervised toileting. We also support a "No Pass" culture which means that anyone can answer a call light or respond to a bed exit alarm and get assistance to promote patient safety. Refer to MemorialCare Policy Manager (MPM) for Fall Prevention policy at OCMC.

RESTRAINTS

It is the philosophy of OCMC that each patient has the right to be free of restraints. The only units where restraints are utilized is Critical Care and the Emergency Department. Before restraints are utilized, alternative methods must be considered. For example: aromatherapy, playing cards, music, etc. If it becomes necessary to use a restraint (such as, wrist or leg device, or four side-rails), the patient's physician must be contacted for an order to apply restraints. Only a Clinical Supervisor, Manager or Administrative House Officer (AHO) may obtain restraints for you.

Patient Identification:

Patient identification may seem like a simple process, but unfortunately Orange Coast has experienced errors. Patient misidentification can result in serious harm or distress to patients and their families. Orange Coast takes these situations very seriously, and as result conducted a Lean event to identify best practices and opportunities for improvement in how we identify our patients to ensure patient safety. The vision of the Patient Identification Lean event was to create a culture where these safe practices are hard-wired, patients are engaged, staff know exactly what is expected and they have the tools to make it easy to perform them for every patient every time.

As a result of our Lean event, all Orange Coast entities including inpatient, outpatient, and ambulatory areas, will use standard work to identify patients using two identifiers, every time, with every encounter. Effective February 6, 2023, all staff will be expected to use the two approved identifiers: first and last name, and date of birth. The goal is for the patient to verbalize his/her name versus the staff or physician stating his/her name and asking if it's the correct person. In addition, another goal is to standardize the nomenclature of how we refer to the ID band by using the same terminology, which is the "ID band."

Release of Medical Records:

Patients have a right to access their health information (medical record) through oral or written request. Under the Health Insurance Portability and Accountability Act (HIPAA), it is the hospital's responsibility to protect the privacy and security of patient's health information. To ensure all requests for health information are released following HIPAA requirements, the Health Information Management (aka Medical Records) Department processes all requests for record releases. By channeling all requests through the Medical Records Department, the hospital is ensuring that records are released following HIPAA requirements.

When a patient or family member requests copies of health information (i.e. lab results, imaging reports, provider notes, flowsheet data, etc.), staff provide the requester with the phone number for the Medical Records Department (714-378-7440). The Medical Records Department will process the request and ensure the records are provided to the patient safely and timely.

AGE SPECIFIC POPULATIONS

It is understood that various populations of patients may be under the care of OCMC. It is vital that staff have the knowledge and skills necessary to provide care that is appropriate to the age of the patients served. Staff must also have the knowledge of the growth and development over the lifespan and possess the ability to assess patient's requirements relative to their age and provide the care needed reflected by the following age categories:

- 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

DRESS CODE AND APPEARANCE EXPECTATIONS

Students or Contract Service Employees who are providing services or care to patients on MemorialCare properties are expected to follow all applicable dress and appearance rules; upholding the highest standards of professionalism and attention to personal hygiene. Applicable dress and appearance include presenting a clean,

neat, well-groomed appearance at all times while providing care or conducting campus-related business.

Dress and appearance play an important role in enhancing MemorialCare's reputation and image. Policy HR-318 (Dress and Appearance Policy) defines dress and appearance standards. A brief listing of requirement will be reflected below, for more detail, please refer to Policy HR-318.

- Uniforms will be worn when delivering patient care. Students are to wear uniforms assigned by school. Other Contract Service employees are to wear neat and clean clothing befitting the job being performed and appropriate for a professional work environment.
- Tattoos that depict offensive or inappropriate language or images or violate Company policies (including policies prohibiting discrimination and harassment based on a protected category) are not permitted.
- Earrings and other jewelry will be conservative in nature and may not be work where safety or health standards might be compromised.
- Perfumes and cologne should be minimally worn in consideration of others and may be prohibited entirely in certain areas/locations.

IDENTIFICATION BADGES

- Must be worn with name, picture and other identifying information facing out, at a level that can be readily seen.
- Students are to ward their badge from their school. Students in the following areas will obtain a MemorialCare Badge:
  - Rotations or Preceptorships in Maternal-Child Health Areas
  - Preceptorships in the Operating Room

REMINDER: Identification Badges must be worn at all times.

SUBSTANCE ABUSE AND DRUG DIVERSION

OCMC is committed to providing an environment that is free of drug and alcohol abuse.
Employees/Contract Services/Students 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.

Employees need to be aware of the warning signs of substance use disorders. Indications of substance impairment include severe mood swings, irritability, agitation, inappropriate verbal responses, elaborate excuses, gradual decline in work performance, withdrawal from peers, increase in errors/accidents/injuries, confusion, difficulty concentrating, inability to focus, unable to keep deadlines, deterioration in personal appearance, etc.

Substance abuse and addiction are the leading cause of drug diversion in healthcare. Drug diversion impacts an estimated 10-15 percent of all healthcare workers and can also affect work performance and cause the patient unnecessary pain. Drug diversion signs may include: failure to document waste, wasting of narcotics not witnessed, removing controlled substances for more than on patient at a time, frequently wasting drugs that never reach the patient (dropped meds/patient refusal), frequent volunteering to administer narcotics for others, repeatedly wasting with the same person as a witness, frequent breaks or trips to bathroom while on duty, placing controlled drugs in pockets, tampering with sharps containers, constantly has patients in uncontrolled pain, etc.

Promoting a culture of safety is key to diversion detection. It is important to note that co-workers play an important role by recognizing and reporting suspicion of substance abuse and drug diversion to supervisors. Reporting suspicious behavior is not betrayal, it is a critical tool for preventing drug diversion and saving a life. When healthcare workers buy into creating a safe culture, diversion can be detected earlier and those who divert have better outcomes.

NO SOLICITATION RULE

Contractors/Students may not solicit during working time or in work areas for any purpose.

SMOKING

- OCMC is a smoke free campus, and a drug and alcohol-free workplace.
- "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 MemorialCare to prohibit smoking in the buildings, parking lots or sidewalks surrounding the hospital, including the off-site areas.

All Contractors/Students are expected to adhere to the policy.

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
- NOTE: A cafe is located on the 2nd floor of the Patient Care Pavilion offering Starbucks and grab-n-go foods.

Workplace Violence/Management of Assaultive Behavior

Violence in the workplace has been on the rise in recent years and is now recognized as a critical issue across the United States. Current statistics reflect that approximately 2 million people become victims of workplace violence annually, with healthcare workers being the most often affected. Violence against healthcare workers is 12 times higher than the rest of the United States workforce. Another form of workplace violence is bullying. Bullying at work has impacted approximately 60.4 million Americans. In 2019 a survey found that approximately 94% of those surveyed had been bullied at work which was up from 75% in 2008 (Robinson, B., 2019). Overall, 75% of all workplace violence incidents that happen each year in the United States involve healthcare professionals.

As of 2018, hospitals are required to screen patients for risk of violence. The assessment of risk of violence begins at the patient's first point of entry (e.g. Emergency Dept., Inpatient Units, Pre-op, etc.). The Registered Nurse performs the assessment and documents findings in the electronic medical record. When a risk of violence is present, a flag is created in the chart to notify all healthcare team members. As well, a gray magnet and signage is place on the patient's door.

According to OSHA, workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, patients, physicians and visitors. MemorialCare campuses work to ensure that all employees work in a safe environment and have been actively tracking and managing any reported issues/events.

As an employee in a healthcare organization, it is important to recognize the first signs of frustration that can lead to aggression and violence. This could include verbal threats, physical signs such as a raised voice, clenching of fist, trembling, wide stance, pacing, anxiety, panic or even confusion. It is important to recognize that violence can come from patients, visitors and others regardless of gender, age or size. If you find a patient or other is becoming increasingly agitated, use these techniques to help de-escalate the situation.

Strategies to Avoid Physical Harm:

1. **Dress for Safety**: Well-fitting clothing, avoid wearing cords/chains/lanyards
2. **Situational Awareness:** know where your exits are, do not back yourself into a corner, keep 6-foot distance, know how to activate assistance
3. **Respond Professionally:** Keep calm, do not overreact, do not engage in verbal altercation, use non-threatening body language, treat person professionally
    a. **Apologize/Acknowledge**
    b. **Listen, empathize and ask open questions**
    c. **Offer explanation**
    d. **Fix issue when possible**
4. **Activate Assistance:** call for assistance as necessary, activate the code gray response, report incident to manager/supervisor

Debriefing: Clinical supervisor or charge nurse will conduct a timely discussion following any encounter of *assaultive behavior*. Establish facts of the incident, ask any questions, and identify lessons learned to improve response to *workplace violence*. Offer peer support resources, such as Social Services or Resilience in Stressful Events (RISE), especially in incident involving serious injury or traumatic events.

Document Situation: Notify unit supervisor, AHO, and manager. Initiate an Unusual Occurrence Report (UOR). If an injury is sustained, notify the Employee Health Office. Seek treatment in the Emergency Department if needed.

POLICY AGAINST HARASSMENT

- OCMC is committed to providing a work environment that is free of all forms of discrimination, harassment and retaliation
- We have a strict policy prohibiting unlawful harassment, including:

    ⇒ Sexual harassment and harassment based on age, ancestry, color, religious creed, denial of Family and Medical Care Leave, disability, marital status, medical condition, genetic information, military and veteran status, national origin, race, sex (including pregnancy, childbirth, breastfeeding or related medical conditions), gender, gender identity, gender expression, sexual orientation, or any other characteristic protected by state or federal law.

    ⇒ Contract staff/students who violate this policy are subject to discipline, including possible termination of assignment

    ⇒ Any contract staff/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, any other member of management, or to the Human Resources Department.

Sexual Harassment Hurts Everyone

Notice to all Staff

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

Every employee and independent contractor 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?

Although many people think of sexual harassment as involving a male boss and a female employee, this is not always the case. Sexual harassment often involves co-workers, other employees of the company or other persons doing business with or for the company. It's also against the law for females to sexually harass males or for an employee to sexually harass a person of the same gender.

California Law

California law defines sexual harassment as harassment based on sex or of a sexual nature; gender harassment (including harassment based on gender identity or gender expression); and harassment due to pregnancy, childbirth, breastfeeding or related medical conditions.

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.*

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, when directed at an individual.*

3. **Visual harassment**

   Examples: *Displaying sexual pictures, 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, leering, sexually oriented gestures, 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 state definition of sexual harassment, are not meant to be a complete list of objectionable behavior nor do they always constitute sexual harassment.

Federal Law

Under federal law, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
2. Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individuals; or
3. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

Verbal, physical and visual harassment, as discussed in the above list of examples, are also all prohibited under federal law.

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 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 obligation to take all reasonable steps to prevent discrimination and harassment from occurring and recognizes its own responsibility and potential liability for harassment by its supervisors or agents.

If harassment does occur, this company will take effective action to stop any further harassment and to correct any effects of the harassment. 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 against any employee who opposes sexual harassment, files a complaint, testifies, assists or participates in any manner in an investigation, proceeding or hearing conducted by the company, the Department of Fair Employment and Housing or the Equal Employment Opportunity Commission.

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;
- Failure to make impartial employment recommendations; and
- Adversely affecting working conditions or otherwise denying any employment benefit to an individual.

How to Stop Sexual Harassment

- **When possible, talk to the harasser and ask him/her to stop.**

  The harasser may not realize the advances or behavior are offensive. When it is appropriate and sensible, you may want to tell the harasser the behavior or advances are unwelcome and must stop. A simple discussion will sometimes end the situation.

- **You are strongly encouraged to report any sexual harassment. Contact your supervisor, personnel department representative or appropriate member of management.**

Sexual harassment or retaliation should be reported in writing or verbally. You may report such activities even though you were not the subject of the harassment. Employees should never pressure other employees not to complain of harassment.

- **An investigation will be conducted.**

The company will thoroughly investigate, in a discreet manner, all reported incidents of sexual harassment and retaliation.

- **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.

Additional Information

The Department of Fair Employment and Housing (DFEH) is the state agency that resolves complaints of unlawful discrimination, including sexual harassment. After a complaint is filed, the DFEH has one year to investigate the complaint.

Contact DFEH at (800) 884-1684 or (800) 700-2320 (toll-free TTY number for individuals with hearing impairments). Visit the DFEH Web site at **www.dfeh.ca.gov.**

The Equal Employment Opportunity Commission (EEOC) is the federal agency that resolves sexual harassment claims. 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**.

There are strict time limits for filing charges of employment discrimination and harassment. Employees who believe they have been sexually harassed may file a complaint of discrimination with DFEH within one year of the harassment. You should contact DFEH or EEOC promptly when harassment is suspected. If they find a complaint is justified, the DFEH is authorized to file harassment cases directly in civil court and a wronged party may be entitled to actual, compensatory and punitive damages, as well as other remedies. The EEOC also has the power to order, among other actions, that the wronged party be hired, given back pay, promoted, reinstated or granted damages for emotional distress. A company may also be ordered to prevent further unlawful activity and be required to change its policies or practices.

Sexual Harassment Complaint Procedure

This company has a policy against harassment due to sex, which includes sexual harassment, gender harassment (including gender identity and gender expression) and harassment due to pregnancy, childbirth, breastfeeding or related medical conditions. If you believe that you have been subjected to harassment, report your complaint immediately as follows:

File your complaint with your supervisor (or with another supervisor if the complaint is against your immediate supervisor), the personnel administrator or the president.

It would be best to communicate your complaint in writing, if possible, but this is not mandatory. Include any relevant details, names of the people involved and the names of any witnesses.

The company will investigate your complaint thoroughly.

The company will act upon your complaint promptly. A representative of the company will tell you the outcome of the investigation.

If the company finds that harassment has occurred, effective action will be taken to stop the harassment and ensure that it will not continue in the future. Any employee determined by the company to be responsible for harassment will be subject to appropriate disciplinary action, up to, and including termination.

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

If you have any questions, contact your personnel administrator.

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Sexual Harassment Hurts Everyone

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TERMINATION OF ASSIGNMENT

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

1. Dishonesty, poor judgement or unethical conduct, including falsifying, altering or omitting information on any MHS documents, timekeeping records, employment applications and customer records; giving false replies to inquiries from MHS representatives, etc.
2. Violent behavior, fighting, or threats of violence, including abusive, threatening, or intimidating language.
3. Possessing firearms, weapons, incendiary devices, alcohol, illegal drugs, chemicals or other dangerous materials (including materials that resemble previously mentioned items) on MHS property without authorization.
4. Insubordination, including but not limited to disruptive conduct, failure or refusal to obey the orders or instructions of a supervisor or member or management, or the use of abusive or threatening language toward a supervisor or ember of management.
5. Theft, unauthorized possession, removal or damage to another individual's or MHS's property.
6. Using MHS-owned or controlled material, time, equipment, resources or facilities of any unauthorized purpose.
7. Improper personal use of MHS's telephone or computer systems for non-business reasons.
8. Irregular attendance, unreported/unexcused absences; repeated or excessive absences, tardiness or early departures. Unplanned absences for (3) consecutive workdays without notice to your Supervisor, unless reasonable excuse is provided and accepted by MHS.
9. Failing to observe work schedules, including rest and meal periods.
10. Non-Compliance with any state or federal law.
11. Non-compliance with any MHS policy, rule or procedure.
12. Violating safety or health rules or practices or engaging in conduct that creates a safety or health hazard.
13. Failure to follow security protocols, rules related to facilities, access, restricted areas or parking.
14. Disclosing, improperly accessing, viewing or misusing Protected Health Information, Personally Identifiable Information (as defined in MHS's "Responsible Use of Technology and Information Resources" policy). MHS trade secrets or confidential proprietary information in violation of MHS policy.
15. Using, possessing, distributing, transferring, or being under the influence of alcohol or illegal or controlled substances or abusing prescribed medication while on duty.
16. Committing any act, or involvement in any act, of unlawful harassment, discrimination, bullying or any form of abusive conduct or another individual.
17. Violating dress standards.
18. Participating in horseplay or practical jokes while on working time or on MHS premises.
19. Engaging in reckless behavior that could cause harm to another.
20. Inefficient or carless performance of job responsibilities or inability to perform job duties satisfactorily.
21. Unauthorized use of communication and information systems, software, passwords, or access codes.
22. Misuse of company time.
23. Sleeping or the appearance of sleeping during working hours. Employees are responsible to remain awake, alert and ready to respond to patients and other work-related issues while on work time.

PATIENT'S RIGHTS AND RESPONSIBILITIES

A PATIENT ADMITTED HAS THE RIGHT TO:

1. Considerate and respectful care, and to be made comfortable. Patient has the right to respect for their cultural, psychosocial, spiritual and personal values, beliefs and preferences.

2. Have a family member (or other representative of their choosing) and their own physician notified promptly of their 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 their care, and the names and professional relationships of physicians and non-physicians who will see them.
4. Receive information about their health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms they can understand. They have the right to effective communication and to participate in the development and implementation of their plan of care. They have the right to participate in ethical questions that arise in the course of their 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, they do not have the right to demand inappropriate or medically unnecessary treatment or services. They 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 their care or treatment. They 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 their pain, information about pain, pain relief measure**s** and to participate in pain management decisions. They 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 them 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 they become incapable of understanding a proposed treatment or become unable to communicate their 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 their behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. They have the right to be told the reason for the presence of any individual. They 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 their care and stay in the hospital. They will receive a separate "Notice of Privacy Practices" that explains their privacy rights in detail and how we may use and disclose their protected health information.
13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. They 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. They have the right to be involved in the development and implementation of their discharge plan. Upon their request, a friend or family member may be provided this information also.

17. Know which hospital rules and policies apply to their conduct while a patient.

18. Designate a support person as well as visitors of their choosing, if they have decision-making capacity, whether or not the visitor is related by blood, marriage, or registered domestic partner status, unless:

a. No visitors allowed
b. 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.
c. Patient has told the health facility staff that they no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation and number of visitors. The health facility must inform the patient (or their support person, where appropriate) of their visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

19. Have the patient wishes considered, if they 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 their 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 of 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 they want to file a grievance with this hospital, they may do so by writing or by calling. The grievance committee will review each grievance and provide the patient with a written response.

23. File a complaint with the California Department of Public Health regardless of whether the patient used 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
Medical Care Services
MS 400
PO Box 997413
Sacramento, CA 95899-7413
800-994-6610

The Joint Commission
Hospital Accreditation
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

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.

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.

Common Variations in Communication that may Impact Cultural Diversity:

—Conversational Style and Pacing

- *ex: in some cultures, silence may show respect*

—Personal Space

- ex: *in some cultures, this can create inaccurate assumptions, as someone may be seen as aggressive for standing too close*

—Eye Contact

- ex: *in some cultures, avoiding eye contact could mean respect*

—Touch

- ex*: in some cultures, 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

- As stated in the patient rights, OCMC must provide patients with "current information concerning their diagnosis, treatment and progress in terms that they can understand."
- Each nursing unit has a video interpreter iPad that is used for communicating with patients who do not speak or understand English.

BARIATRIC POPULATION

OCMC 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 use of right sized equipment, knowledge of the signs/symptoms and treatments of their common illnesses and surgeries, and especially compassion. These patients are already sensitive about their size and the unfavorable reaction they commonly receive in public. It is important that OCMC is a safe, healing environment. Patients should never be subjected to any laughter, derogatory comments or inappropriate looks while at our hospital.

PAIN MANAGEMENT

Pain is the most common reason individuals seek medical attention. Pain has been historically undertreated and undermanaged, however, due to a heightened focus on pain management and use of opioids to treat pain, our healthcare systems have seen the effects of opioid abuse across our diverse patient populations. Pain management and treatment is complex and can lead to harmful effects if not properly monitored. It requires interdisciplinary effort to provide successful management and treatment.

Pain management and stewardship continues to be a critical objective for our healthcare providers. **The goal of pain assessment and management is for our patients to be comfortable and get to a functional or acceptable quality of life.**

Pain management is an element of patient care that must be assessed, addressed and treated by all licensed healthcare providers. A patient's self-report of pain is highly personal and subjective and is considered the most reliable indicator of pain.

Licensed healthcare providers at OCMC have the responsibility to acknowledge and act on a patient's expression of pain, provide strategies to manage pain, and assess outcomes of therapeutic interventions.

<u>Pain Assessment and Pain Intensity Rating Scales</u>

- ❑ Assess patient for presence of pain
    - Pain level at rest and with activity may differ
- ❑ Use appropriate intensity rating scale based on patient's age, mentation, and preferred language
- ❑ Ask patient for level of pain that is tolerable
- ❑ Assess how patient manages their pain at home
    - Patients may use complementary and alternative modalities (CAM) such as aromatherapy, pet therapy, music, guided imagery, to manage their pain.
    - OCMC offers a variety of CAM products for our patients.
- ❑ Reassess patient after any intervention for pain and document response in the electronic medical record.
- ❑ Administer scheduled pain medication as ordered, following medication administration rights.
- ❑ For additional PRN or as needed medications, administer based on parameter(s) and patient's level of pain.
    - For a patient's pain of moderate pain, only give pain for moderate or moderate-severe pain as ordered. Do not give med for severe or mild.
    - If the patient prefers to receive the medication for a different intensity/parameter, call provider to update the order.
- If an oral and IV dose are both ordered for the same severity, provide the oral dose unless patient is unable to tolerate oral intake.
    - ❑ Document patient's oral intake status when using alternate route.

- ❑ If patient's pain does not match the order parameters or the medication, call the provider to clarify and update the orders.

Patient Education

During hospitalization, educate patients on:

- ❑ Risk for and/or cause of pain
- ❑ Importance of effective pain management, including action of pain medications and medication side effects
- ❑ Pain assessment process
- ❑ Options for pain management when identified as part of the treatment
    - ❑ GetWell has educational videos on pain, safe use of opioids, etc.

Prior to discharge, educate patients on:

- ❑ Safely managing pain at home
- ❑ Side effects of any prescribed opioid/narcotic medications
- ❑ Storage and disposal of medications

PAIN SCALES

Patient Able to Self-Report	Patient Unable to Self-Report
0-10 Visual Analogue Scale - used for those who can verbalize through numerical scale	Pain Assessment in Advanced Dementia (PAINAD) Scale – used for patients with dementia
Wong-Baker Faces Scale – used for adults or children who can verbalize or point to the depicted facial scale	Neonatal Pain, Agitation, and Sedation Scale (N-PASS) – used for neonates
Universal Pain Scale (Combined 0-10 Visual Analogue and Wong-baker Faces Scale)	Critical Care Pain Observation Tool (CPOT) – used for patients in intensive care unit

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 EQUIPMEMT 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.

CLINICAL ALARMS

All hospital staff and medical staff who use medical equipment must check alarm settings and/or parameters, to ensure they are appropriate and that audible alarms will be clearly discernable relative to ambient and competing noise. Alarm and alarm limits will be set based on clinical settings and the clinical condition of the patient when the equipment is placed in use. Parameters for critical alarms will be consistent with default settings established by hospital clinicians and the device manufacturer. Changes to the manufacturer default settings may only be made upon order of the patient's physician, or qualified designee, who is familiar with the patient's clinical condition. Critical alarms may not be disabled or placed permanently in the off position unless directly ordered by the patient's physician. Critical alarms may be suspended while the patient is off the equipment, or staff is working directly with the patient, but must be returned to the on position when the equipment is placed back on the patient or when care is completed. Staff is expected to verify that critical (life

threatening) alarms are in the on position.
Critical alarm volumes shall be set at a level so that staff can hear them. If there is competing noise in the area, or the patient is housed at some distance from staff, then the volume of alarms will be set high enough or augmented in a manner that allows staff to hear them. Staff shall monitor and respond to the activation of a critical alarm in a timely manner. Monitoring may be either direct or indirect depending on the patient's clinical condition, care setting, medical devices in use, and other pertinent factors. If alarms are continuously alarming, staff is recommended to conduct additional assessments by utilizing troubleshooting guides.

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. Code Crimson when patient is recognized to be at risk for excessive blood loss and a team is mobilized to respond
M. S.D.S. – Safety Data Sheets
N. Medical Equipment Failure Guide
O. Injury / Illness / Blood Exposure
P. OSHA - Hazardous Waste Management/Infection Control
Q. Unusual Occurrence Reporting
R. Utilities System Failure Guide

S. 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 locations.

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 away from 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 - **Sweep**
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," overheating, 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 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. 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:

- 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).

Damage to hospital:

- 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.

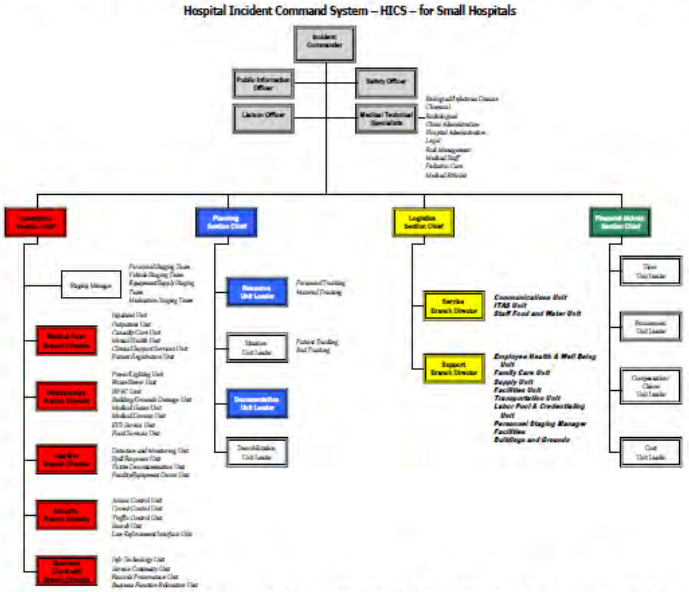
Depending Upon Disaster Severity:

- 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.
- 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]**



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 an 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 in 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 PET/CT 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 PET/CT 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, or outside of the room 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 PET/CT 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 PET/CT 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.

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

MRI SAFETY

Magnetic Resonance Imaging (MRI) is one of the most powerful medical diagnostic technologies, combining strong magnetic fields with powerful computer image processing to produce detailed three-dimensional pictures. The core of an MRI machine is a very high-strength magnet arranged to surround most of the patient's body. The magnetic field is present 24 hours a day; whether the MRI machine is being used or not. The main potential danger from MRI machines comes from the interaction of the magnetic field with metallic objects. Metallic objects in the vicinity of the MRI room can be attracted by the magnetic field, causing them to be sucked into the MRI machine at high speed, posing severe danger to patients or anyone in the vicinity of the MRI room.

Examples of problematic metallic objects are cell phone, keys, glasses, hair pins/barrettes, jewelry, safety pins, paper clips, coins, pens, pocketknife, nail clippers, steel-toed shoes, tools, clipboards, wheelchairs, IV poles, oxygen tanks, etc.

Magnetic Field Areas have been broken into four zones. Zone 1 & 2 allow for presence of unscreened patients/non-MRI employees, Zone 3 is approved for entry by screened MRI patients and personnel and Zone 4 is for screened MRI patients under constant supervision of Trained Staff. All non-MRI personnel entering the MRI scanner room must be screened for problematic metallic objects.

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 – Contract staff/students are to report to their OCMC supervisor and report their work-related injury to their agency, Manager of unit and/or Instructor/Preceptor. If you have an injury, it is your responsibility to be seen by a treatment facility approved by your agency/school. Please be familiar with your agency/school company's workman's compensation policies.

INFECTION CONTROL & EXPOSURE CONTROL PLANS

BLOODBORNE PATHOGENS

The facility has an exposure control pan for bloodborne pathogens to identify workers who are at risk for exposure to blood or other potentially infectious materials. Three (3) common bloodborne pathogens are HIV, hepatitis B and hepatitis C. a quick reference to the OSHA bloodborne pathogen standard can be found here: https://www.osha.gov/SLTC/bloodbornepathogens/bloodborne_quickref.html

Modes of transmission:

1) Blood
2) Body Fluids- semen, vaginal secretions, cerebrospinal fluid, amniotic fluid, pleural fluid, pericardial fluid, peritoneal fluid, and fluid visibly contaminated with blood
3) Broken skin, open sores abrasions, cuts
4) Contaminated sharps injuries

- **Use Universal (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; the wearing of PPE and the following of all isolation precautions and hand hygiene must occur regardless of whether the staff member, contract service employee or student has physical contact with the patient.

  Prior to leaving an isolation room, ensure that:

  1. All PPE is removed and disposed of in the patient room.
  2. Perform hand hygiene prior to leaving the patient room.

- **Use Personal Protective Equipment (Gloves, gowns, masks, goggles**):
  1. OSHA requires that employees have PPE that are readily available.
  2. Check with your manager/supervisor to find out where they are stored.
  3. When a patient is in isolation, an isolation cart is placed outside the room.
  4. Notify your manager if you are unable to use what's available or if you do not have what you need.
  5. PPE is not to be worn outside of work area (e.g., to cafeteria)

AEROSOLIZED TRANSMISSIBLE DISEASES

Staff provide care to patients with aerosol transmissible diseases (ATD's) in a manner that minimizes the risk of transmission to staff, patients and visitors. Early diagnosis, timely and effective treatment of individuals; effective use of administrative, work practice and engineering controls; the use of respiratory protection; and a comprehensive healthcare worker surveillance program are the key to this exposure control. Ways to control exposure of ADT's is by adhering to the use of appropriate PPE for specified isolation types:

Isolation Types:

Airborne Precautions:

Put the patient into a negative pressure room ASAP

Healthcare workers must use an N-95 respirator or a CAPR and visitors are instructed to use a surgical mask that we will provide for them.

Signs and symptoms of Tuberculosis:

- A history of a frequent productive cough
- Blood in the sputum (hemoptysis)
- Night sweats
- Weight loss/loss of appetite
- Fever

Tuberculosis patients ***CANNOT*** be discharged unless clearance from the Orange County Department of Public Health has been granted. Contact Infection Prevention or Case Management for assistance.

Droplet:

Utilize a surgical mask within 3 feet of the patient. (coughing, sneezing). Use for all influenza patients.

Contact Precautions:

Wear gown and gloves when in contact with patient or their environment

Sharps- any object that can reasonably anticipated to penetrate skin and result in exposure is placed in sharps container. Staff are to adhere to work practice controls and use needless systems and/or avoid re-capping of needles. A s*harps injury should be reported* for exposure determination, tracking and follow up.

Medical waste is defined as fluid blood waste or body fluids which main contain blood. Dispose of medical waste into red bags or red containers. 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. Use identified waste containers for disposal of hazardous drugs.

Infection Control specific to Covid -19

Transmission and PPE

COVID-19 spreads when an infected person breathes out droplets and very small particles that contain the virus. These droplets and particles can be breathed in by other people or land on their eyes, noses, or mouth. In some circumstances, they may contaminate surfaces they touch. People who are closer than 6 feet from the infected person are most likely to get infected. The exposure standard is 10 minutes of contact less than 6 feet from the person and without a mask.

COVID-19 is spread in three main ways:

- Breathing in air when close to an infected person who is exhaling small droplets and particles that contain the virus.
- Having these small droplets and particles that contain virus land on the eyes, nose, or mouth, especially through splashes and sprays like a cough or sneeze.
- Touching eyes, nose, or mouth with hands that have the virus on them.

It is suspected an infected person can spread the virus before they have symptoms. The incubation period or time between becoming infected and the onset of symptoms is estimated to be between 1 – 14 days, with 5 days being the average.
Different variants of COVID-19 may have different incubation periods and varying onset periods.

During the Coronavirus Disease 19 (Covid-19) pandemic, keeping hands clean and wearing a mask is especially important to help prevent the virus from spreading. Wearing an N95 mask or CAPR is required when caring for patients with acute cases of COVID-19. **Do not** remove your mask until you have left the patient room. Dispose of all other PPE inside the room.

Hand Hygiene

Handwashing is one of the best ways to protect yourself and your family from getting sick. Learn when and how you should wash your hands to stay healthy.

Health care team members should wash hands with soap and water in these situations:

1. When hands are visibly dirty
2. When hands are visibly soiled with blood or other bodily fluids
3. When hands are contaminated with proteinaceous material

4. After using the bathroom
5. After exposure or suspected exposure to spore-forming pathogens (e.g., *C. difficile*)[3]

If hands are not visibly soiled or do not meet any of the above criteria, health care team members may use an alcohol-based hand rub.

If an alcohol-based hand rub is not available, health care team members should wash hands with soap and water. Health care team members should avoid washing hands with soap and water in addition to using an alcohol-based hand rub because it is unnecessary and may lead to dermatitis.

Follow Five Steps to Wash Your Hands the Right Way

Follow these five steps every time.

1. **Wet** your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
2. **Lather** your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
3. **Scrub** your hands for at least 20 seconds. Need a timer?
4. **Rinse** your hands well under clean, running water and dry thoroughly with a disposable towel. Use towel to turn off the faucet
5. When using alcohol-based hand sanitizer:
   - Put product on hands and rub hands together. Cover all surfaces until hands feel dry
   - This must be done for 20 seconds.

Hand Hygiene surveillance

It is the responsibility of all staff, students, and volunteers to perform perfect hand hygiene. If someone is observed not performing perfect hand hygiene, please gently remind them to perform hand hygiene. Hand hygiene audits are performed by unit-based auditors, hand hygiene champions, as well as the Performance Improvement department. MemorialCare's goal for hand hygiene compliance is 100%!

Personal Protective Equipment

We have secured enough PPE to meet our needs and for our projected needs as we experience a surge in Covid-19 patients. However, it is important that all staff work to conserve our supplies.

It is unclear how long the virus can survive on surfaces. It is thought the virus can survive up to nine days.

Gloves

Wear gloves whenever caring for a confirmed or suspected Covid-19 patient. Gloves are not to be reused. DO NOT double glove.

Gowns

Wear an isolation gown whenever entering a room of a confirmed or suspected Covid-19 patient. Gowns are not reused.

Masks

Mucus membranes are an entry way for the virus. This means your mouth, nose and eyes can be a portal of entry for the virus.

Any staff member entering a clinical area is to wear a surgical or procedural mask.

Face Shield/ Goggles

Wear N-95 masks and face shield or eye protections/goggles when entering a room with a suspected Covid-19 Isolation room. Mask/face shields are discarded after leaving the room.

Goggle disinfection

1. Don gloves
2. Use an approved disinfectant wipe to prepare a surface upon which the goggles will be placed and remove goggles.
3. Wipe down the goggles with an approved disinfectant wipe observing the manufacturer's recommended wet/contact times.
4. Doff gloves and perform hand hygiene.
5. Store goggles for reuse in a brown bag that is issued to you with your name on it.

N95 Masks

N95 respirators are for use in suspected or confirmed Covid-19 patients or other in airborne isolation or with certain aerosolizing procedures.

Because N95 masks may be from various manufacturers, it is very important to perform a Fit (seal)-Check each time you don a mask.

How to perform a Fit (seal)-Check:

Apply N95 by molding the mask with BOTH hands to the face to create a seal, Do NOT pinch at the nose	
Perform the Fit Check: Cup both hands over the mask covering as much area as possible. Inhale and exhale sharply. If air leaks around the mask, readjust using the molding technique above and repeat this step until a seal is achieved	

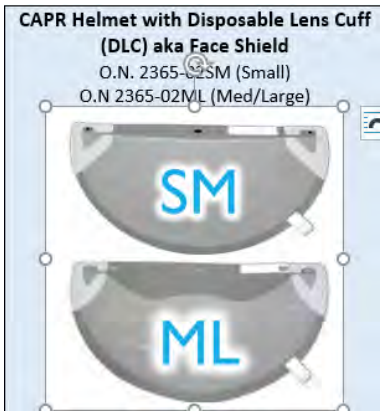
FOR STUDENTS: N95 fit checks are not required for students. Students do not care for patients requiring Airborne precautions (ex: r/o TB, Chicken pox or Covid-19).

Continuous Air-Purifying Respirator (CAPR)

CAPRs are used during procedures with high risk for aerosolization, such as intubation, nebulizer

treatments, suctioning, etc. Just in time training videos are accessed from MConnect-Professional Education webpage- Respiratory Care (Clinical Practice Training content)

After each use, the CAPR is wiped down with approved disinfectant wipes observing the manufacturer's recommended wet/contact time.



COMPLETE HELMET SET-UP	A. CAPR Helmet a. CAPR Disposable Lens Cuff (DLC) B. Battery	Clean CAPR Helmets and Battery after each use - Dispose cuff/DLC after shift (Clean between use by same provider)
DONNING CUFF SYSTEM – CHECKING INDICATOR LIGHTS  Connect helmet power cord to the battery and push until the secure connection audibly clicks  Upon initial connection all 5 indicator lights will illuminate  After 5-10 seconds the 3 green lights should illuminate, we recommend donning the helmet with no less than 2 green indicator lights illuminated **Indicator Light Meanings** **Yellow** – Low airflow: potential cause is a loaded filter. Doff system as soon as is safe and replace filter if necessary **3 Green** – Battery Charge: ~75%-100% **2 Green** – Battery Charge: ~50%-75% **1 Green** – Battery Charge: ~25%-50% **Red** – Battery Charge: 0%-25%, Doff system as soon as is safe, exchange discharged battery for charged battery.		Yellow light indicates: low battery, or fan slowing down. - For Orange Coast Medical Center, filters are replaced every 6 months. Contact RT or BioMed for assistance.
DONNING CUFF SYSTEM – HELMET AIRFLOW SWITCH The helmet airflow switch is located at the rear of the helmet, next to the helmet power cord receptacle. Select your desired airflow based on your exertion level for your application. The recommended position for typical activities is Low, but can be adjusted based on preference or activity. 1: Low ~190 liters/minute ~6.7 cubic ft/min 2: Medium ~215 liters/minute ~7.6 cubic ft/min 3: High ~240 liters/minute ~8.5 cubic ft/min  		Low/Med/High or Airflow is for comfort setting. It does not provide more filtration, only more aeration based on the user's preference.

CODE-19 (COVID-Code Blue PPE)

- Code-19 is the overhead page for a confirmed or suspected Covid-19 patient.

The crash cart remains **outside** of the room. The monitor/defibrillator is detached from the cart and brought into the room as well as the backboard.

The door to the patient's room remains closed, It is opened only to allow for items to be handed into the room and for staff to enter or exit or for the team members inside to communicate with the team members outside.

To minimize aerosol generating procedures: (Bag-Valve Mask) must have viral filter when used on COVID positive patients or Patients suspected of COVID (PUIs). Avoid placement of oral airways or nasal airway devices.

Compression are paused for intubation by the most experienced airway provider with video laryngoscopy and Rapid Sequence Intubation.

HIPAA ~ SECURITY COMPLIANCE

Health Insurance Portability and Accountability Act (HIPAA) and PHI

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 outlines the basics of the Rule and some of the security safeguards that may affect the way you do your job. PHI includes any health info that can be tied to an individual. PHI must be de-identified in order to not be subject to the restrictions of the HIPAA Privacy Rule.

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 used to limit who can access PHI and apply awareness to keep it secure. Do not discus patient information in public areas (café, elevators).

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

- An 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

Keep PHI under lock and key! Use locked shred bins for disposal. PHI must be destroyed and/or de-identified.

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 from 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

NEVER SHARE PASSWORDS

Technical safeguards include all the technology that makes physical safeguards possible. In most cases, your IT department will put these systems in 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 form malicious software.
- Transmission safeguards to protect ePHI transmitted over open networks form 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 alter 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 HIPPA 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