

Colleague Guide Continuous Survey Readiness



TogetherHealth: **Holy Cross Health**

People	Performance	Portfolio	Purpose
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Holy Cross Health operates under regulations set forth by various Federal, State, and Local governments. With guidance provided by Trinity Health, we know our Colleagues are committed to providing the highest quality of care to those in need.

Whether a seasoned professional or new to the world of healthcare, it is common for individuals to experience heightened anxiety during times of survey activity.

This Guidebook is designed to provide our colleagues what they need to know both during and outside of an accreditation survey.

Colleagues should feel free to reference this Handbook if interviewed by a surveyor, and if answers cannot be located within its contents, colleagues should know that they may report to their immediate supervisors for further guidance.

table of **CONTENTS**

Introduction and Mission, Core Values, Strategic Plan	3-5
COVID-19 Resources	6
Facts about Accreditation	7,8
Patient Experience	9
LGBTQ+ inclusion	10
Foundations of Safety	11, 12
National Patient Safety Goals	13-30
Pain Management	31, 32
Safe Use of Restraints	33-35
Falls Prevention	35
Interdisciplinary Plan of Care	36
Record of Care	37, 38
Medication Management	39-41
Medical Staff and Provision of Care	42
Transplant Safety and Waive Testing	43
HIPAA	44
Environment of Care, Life Safety, and Emergency Management	45-50
Process Improvement	51
Lavender Alert	52
Workplace Violence Prevention	53, 54
Human Resources	55
Notes	56

Introduction

The Joint Commission (TJC) and the Centers for Medicare and Medicaid (CMS) are regulatory agencies that monitor safety and quality to improve care. Surveys are important because they validate quality for the organization and are required for reimbursement for services by CMS.

This guide provides information to improve quality and safety. It is necessary to maintain an ever-ready state as surveyors may arrive at any time, without notice and may visit any area of the hospital or affiliated ambulatory sites. Use this as a handy reference.

Our Vision

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. As a mission-driven innovative health organization, we will become the national leader in improving the health of our communities and each person we serve. We will be the most.

Trusted Health Partner for Life.

Holy Cross Health's Promise



Holy Cross Health is your **people centered, faith-based partner** that provides **health and wellness services**. We emphasize **access and convenience** to quality & safe healthcare along the coast. Holy Cross Health will be available when and where our members in **southeastern Florida** need us most.

Holy Cross Health provides care for *all* in body, mind and spirit, demonstrating that:

We Listen

We Partner in Achieving Health Goals

We Make it Easy



TogetherHealth: Holy Cross Health

People

Performance

Portfolio

Purpose

TogetherHealth: Strategic Focus Holy Cross Health, Florida

CATHOLIC MISSION Apply mission discernment and Catholic social teachings in our choices about the communities we serve, the use of our assets, our selection of partners and recruitment of providers

COMMUNITY HEALTH Promote optimal health for poor and vulnerable populations and communities, by addressing social needs, connecting social and clinical care, and reducing health inequities

ELIMINATE RACISM Advocate for, and take actions to, eliminate systemic racism both externally and internally

PERFORMANCE Optimize clinical program service mix and improve operating efficiency to drive sustainability. Achieve targeted operating performance consistently by optimizing capacity and performance in selected service lines and areas of demand. Hard wire improvements throughout the ministry.

ZERO HARM Create a safe / zero harm environment for colleagues, providers and those we serve

SYSTEMSNESS Leverage skill and scale through implementation of system-wide common platforms/programs to improve operating performance and deliver connected care. Ensure our EPIC workflows are hardwired and optimized to ensure our quality, care, and coordination is beyond reproach.

CARING COLLEAGUE CULTURE Recruit, engage and retain colleagues into a culture of service and new care models that results in a passionate focus on meeting the needs of the members we serve

MEMBER EXPERIENCE Demonstrate and communicate to our members that we listen, partner in achieving their health goals, and make it easy and connected through our innovative approach to care coordination and convenience.

INTEGRATED MEDICAL GROUPS & AMBULATORY NETWORK Develop and grow an integrated, multi-specialty medical group across our region. Make strategic ambulatory investments and decisions to serve as the front door to attracting and retaining members and coordinating their total care.

GROWTH AND DIVERSIFICATION Focus on access, non-hospital / non-SNF segments and APM/TCOC arrangements organically, acquisitively, and through partnerships. Grow attributed lives while expanding our borders north and south for a more sustainable footprint. Gain scale by making strategic community-based investments (e.g. FSEDs, ASCs etc.) to "own the coast"

MINISTRY SUSTAINABILITY Assess the sustainability of our ministry annually to proactively identify where and how we need to transform our services to best address community needs. Optimize owned assets and target service lines to drive new growth.

TECHNOLOGY ENABLERS Harness the power of technology to drive innovations, enhance operational efficiency in business processes, reimagine workforce care models, and fulfill our commitment to providing an exceptional member experience



We listen. We partner. We make it easy.

Our Values

As a faith-based healthcare ministry, it is vitally important that we meet both our challenges and opportunities in the context of and in accordance with our "Core Values.":

Reverence

We honor the sacredness and dignity of every person.

Justice

We foster right relationships to promote the common good, including sustainability of Earth.

Commitment to those Who are Poor.

We stand with and serve those who are poor, especially those most vulnerable.

Safety

We embrace a culture that prevents harm and nurtures a healing, safe environment for all.

Stewardship

We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

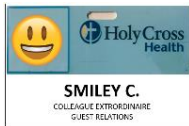
Integrity

We are faithful to who we say we are.

Living Our Core Values: Defined Actions tied to Core Values

EXAMPLE: REVERENCE – "I use preferred names, introduce myself, my role, and what I am doing."

REVERENCE: PLEASE WEAR
YOUR AUTHORIZED
IDENTIFICATION BADGE AT
ALL TIMES



Regulatory Survey Preparation

Q: Why are accreditation surveys important?

A: A survey is important to determine if we are meeting TJC standards, AHCA regulations, and CMS Condition of Participation. Survey activities allow us to fulfill our goals of being a "High Reliability Organization" that aims to achieve "Zero Harm". Survey activities also provide the following:

- An assessment of medical staff and the quality of care provided to our patients.
- Eligibility for reimbursement through Medicare when post-survey accreditation award is achieved.

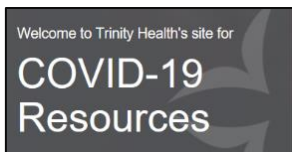
CORONAVIRUS DISEASE 2019

COVID-19



COVID-19 has challenged the healthcare system in many ways. Working under the umbrella of Trinity Health has truly been our shelter in a storm. Trinity Health has provided PPE and operational guidance for its regional health ministries since the onset of the pandemic to allow us to focus on what is truly important: ourselves, our families, and those whom we serve.

For the latest information regarding COVID-19, please refer to the following:



<https://www.trinity-health.org/covid-19-resources/>



<https://www.trinity-health.org/covid-19-resources/find-a-resource/vaccine/>

Facts about Accreditation



Q: What is The Joint Commission (“TJC”)?

A: *TJC is a not-for-profit organization that accredits and certifies health care organizations and programs in the United States. Approximately 88% of accredited US hospitals receive accreditation through TJC.*

Q: Where can I find TJC standards?

A: *Joint Commission e-dition can be accessed by the Manager of Joint Commission Compliance. Please contact (954) 542-7025 for standards questions.*

The screenshot shows the 'WELCOME TO E-EDITION' page. The left sidebar contains a navigation menu with categories like 'Accreditation', 'Certification', and 'Verification'. The main content area includes a search bar and a list of 'Getting Started' instructions for navigating the site. At the bottom, there is a copyright notice for 2023 The Joint Commission.

Q: Where can I find policies and procedures?

A: *Policies are found in  PolicyStat which is accessed from the ZENworks window via the **HCAP Application Links**.*



Q: What is the Tracer Methodology?

A: *Tracer methodology is an evaluation method where surveyors select a patient and use that individual's record as a roadmap to move through the organization to assess and evaluate the organization's compliance with selected standards and the organization's systems for providing care and services. In addition to tracer activities performed during a survey, our organization has a team of subject matter experts who perform tracer activities across the organization throughout the year.*



Q: What is a "Deemed Status Survey"?

A: *The Joint Commission has been deemed by the Centers for Medicare and Medicaid Services (CMS) to survey organizations on their behalf. This allows The Joint Commission to evaluate organizations as being compliant with both Federal and State regulations as it regards operations and care provided to patients. Once a survey is complete and the organization corrects any deficiencies identified, The Joint Commission will provide the organization "deemed status accreditation". A deemed status accreditation allows our organization to receive payment from Medicare, Medicaid, private insurers, etcetera. During direct observation, TJC will want to be sure colleagues are mindful of focuses including but not limited to:*

- ✓ **SAFETY:** be aware of your surroundings
- ✓ **Using 2 patient identifiers (name and date of birth)** when delivering care, treatment, or services
- ✓ Prevent healthcare associated infections by **performing hand hygiene** before and after all patient care.
- ✓ **Universal Protocol Time Outs:** all team members must be actively participating (intentional pause) so they can speak up if there is an error or concern.

Q: What will the surveyor do during a tracer? A:

- *Review the medical record with caregiver.*
- *Observe direct patient care and colleague interaction.*
- *Observe the medication process.*
- *Observe the care planning process.*
- *Observe equipment use.*
- *Review competencies, evaluation, and continuing education for caregivers with whom the surveyor has interacted.*
- *Interview the patient and/or family.*
- *Assess colleague knowledge via inquiries to staff.*
- *Observe the environment of care and environmental safety.*
- *Discuss National Patient Safety Goals and improvements made to patient care and services.*

Patient Experience

Q: Why is the Patient Experience important?

A: *Studies show that a positive patient experience directly correlates with better healthcare outcomes and a healthier population. Holy Cross Health places a strong focus on our Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) performance as this tool provides data driven information that validates our people centered work. Data is quantified in various "Domain" focuses. All colleagues are encouraged to speak with their leaders to understand strengths and opportunities for domain performance.*

Q: How are individual complaints handled?

A: *Colleagues attempt to resolve complaints immediately or find someone who can resolve.*

Complaints that cannot be resolved are considered a Grievance and are required to be reported to the Immediate Supervisor/Manager or Guest Relations Department for formal investigation (ext. 23024).

Service Recovery Model

Hear

Empathize

Apologize

Respond

Thank



Q: What resources are available to you for ethical issues?

A: *Representatives from the Ethics Committee are available to clinicians and patients to help address ethical issues and can be reached by calling the operator.*

Holy Cross Health is Inclusive



We at Holy Cross Health and Trinity Health celebrate and honor our LGBTQ colleagues, patients, families, allies, donors, and community members.

We welcome all to Holy Cross Health

Trinity Health honors the sacredness and dignity of every person, complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Trinity Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Non-Discrimination

It is the intention of Holy Cross Health to comply with Federal and State law and local ordinances pertaining to non-discrimination in its operations and activities. Pursuant to these laws, Holy Cross Health will not discriminate based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation or expression, national origin, a patient's oral or written communication needs, including the patient's preferred language for discussing healthcare, or source of payment in its activities and operations.

Visitation Policy

It is the intention of Holy Cross Health to promote patient/visitor interactions and honor cultural preferences while respecting each patient's individual need for privacy and rest for respecting the overall safety of the unit.

Holy Cross Health recognizes the vital role that families and support persons play in the health and wellbeing of patients. The family may include spouse, domestic partner, significant others or other individuals not legally related to the patient.

Holy Cross Health will not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.



TogetherSafe

TogetherSafe is our shared journey
toward high-reliability and our goal
of zero harm.



BEHAVIORS



**Prepare for the Process
and Manage the Task**

- Daily Huddles
- Timeouts / Briefs / Debriefs
- Score the Risk



Support the Team

- Peer Checking
- Peer Coaching
- 200% Accountability



Communicate Clearly

- 3-Way Communication
- Phonic/Numeric Clarification
- Share Information using SBAR



Questioning Attitude

- Stop the Line
- Validate and Verify
- Speak up for Safety using ARCC



Attention to Detail

- 3 Self-Check with STAR
- Make Things Visible

TOOLS





Our Safety Promise to Patients, Families and Colleagues



We are guided by our core values.



We stand up with those who speak up.



We hold ourselves and each other accountable to safe behaviors.



We respond to system failures and individual behaviors in a fair, just and accountable manner.



We share errors openly to learn and find solutions.



We appreciate constructive feedback to protect our patients and colleagues.



Your safety is our most important priority: ZERO harm is our relentless focus!

Hospital National Patient Safety Goals

(Easy-To-Read)

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.

Identify patient safety risks

NPSG.15.01.01

Reduce the risk for suicide.

Improve health care equity

NPSG.16.01.01

Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.

Prevent mistakes in surgery

UP01.01.01

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

UP01.02.01

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

UP01.03.01

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

Improving Health Care Equity

Holy Cross Health Community Health Needs Assessment (CHNA) was performed in conjunction with Broward County and adopted by the Board of Directors on April 25, 2022. The following health needs are the focus for Fiscal Years (FY) 2023 – 2025. Ways in which these health needs have been addressed include, but are not limited to:

- YMCA @ Sistrunk
- Family Health Center at 5601
- Cultural Proficiency Training and Anti-Racism Training

Hospital Implementation Strategy

Significant health needs to be addressed

Holy Cross Health, in collaboration with community partners, will focus on developing and/or supporting initiatives and measure their effectiveness to improve the following health needs:

- 1 Health Care Access & Quality
- 2 Food Environment
- 3 Diabetes/Obesity



Community Health Needs Assessment (CHNA)
Implementation Strategy
Fiscal Years 2023-2025



Improve Patient Identification

- ✓ Identify the patient when doing the following:
 - Each time administering medication or blood products.
 - Collecting blood samples or specimens for testing
 - Providing care, treatment, or services

Help eliminate blood transfusion errors.

- ✓ Match the correct patient with the correct blood type **at the bedside.**
- ✓ Verification process for blood or blood components prior to administration to the patients should be done by **TWO** qualified staff using **TWO** patient identifiers.

Improve Effectiveness of Communication among Caregivers

Quickly report critical tests and critical results

- ✓ Contact the physician or licensed caregiver as soon as possible. Document the notification to the LIP.

Improve the Safety Medication Administration

Label ALL medications, medication containers or other solutions on and off the sterile field when removed from original container.

- ✓ Including syringes, cups, and basins.
- ✓ This applies to ALL areas that perform procedures.
- ✓ Label should include name, strength, amount, expiration date (if not used within 24 hrs.) and expiration time (if expiration occurs < 24 hrs.).

Reduce harm for patients taking anticoagulants.

To prevent errors, we use only oral unit dose products and pre-mixed infusions. Smart pumps are required when heparin is administered intravenously and continuously. In addition, **we must provide the patient education regarding anticoagulant therapy.**

Maintain and communicate accurate patient medication information.

- ✓ Obtain the patient's current medication information upon admission or outpatient visit.
- ✓ Compare the patient's current medication list with medications ordered to identify and resolve discrepancies.
- ✓ Provide the patient a written medication list upon discharge or after an outpatient visit.
- ✓ Explain the importance of medication information to the patient upon discharge or after outpatient visit.

Reduce harm associated with clinical alarm systems.

Dedicated monitor technicians constantly observe telemetry monitors. Batteries and electrodes are changed daily. Clinical alarms must be heard and responded to timely.

Reduce the Risk of Healthcare- Associated Infections (HAI)

What is a HAI?

Hospital-acquired infection: An infection acquired while hospitalized. The medical term for a hospital-acquired infection is nosocomial infection.

The Problem

1.7 million HAIs in hospitals

100,000 deaths per year

\$28-33 billion in added healthcare costs.

HAI Prevention

Implementing what we know for prevention can lead to up to a 70% reduction in HAIs.

Q: What is Hospital-Acquired Conditions (HAC) and Present on Admission (POA)? A:

Medicare will no longer reimburse hospitals for certain conditions acquired during a hospital stay. HAC's are thought to be reasonably preventable using evidence-based practice.

POA relates to the diagnoses of a patient that are present at the time the order for inpatient admission occurs. Conditions that develop on an outpatient basis, including those in the emergency room, observation, or outpatient surgery, are POA. If at discharge, there is a selected condition that was not identified at admission or could not be determined through the documentation to be present, it is a HAC.

Hospital Acquired Conditions (HACs)



HAC categories include:

1. Pressure Injury Rate Stage III, Stage IV, and Unstageable
2. Iatrogenic Pneumothorax Rate
3. In-Hospital Fall with Hip Fracture Rate
4. Perioperative Hemorrhage or Hematoma
5. Postoperative Acute Kidney Injury requiring Dialysis.
6. Postoperative Respiratory Failure
7. Perioperative Pulmonary Embolism or Deep Vein Thrombosis
8. Postoperative Sepsis
9. Postoperative Wound Dehiscence
10. Unrecognized Abdominopelvic Accidental Puncture/Laceration
11. Foreign Object Retained After Surgery
12. Air Embolism
13. Blood Incompatibility
14. Falls and Trauma (includes fractures, dislocations, intracranial injuries, crushing injuries, burns, other injuries)



Q: How do HAIs occur?

A: *Most nosocomial infections are due to bacteria. Since antibiotics are frequently used within hospitals, the types of bacteria and their resistance to antibiotics is different than bacteria outside of the hospital. Nosocomial infections can be serious and difficult to treat.*

The most common types of infection acquired in hospitals are:

- Bloodstream infection
- Urinary tract infection (UTI)
- Wound infection
- Pneumonia (lung infection).

Q: How do you prevent hospital acquired infections?

A: *Several methods to prevent them:*

- *Use hand hygiene before and after patient contact or contact with patient environment.*
- *Maintain Standard Precautions with all patients.*
- *Use Personal Protective Equipment (PPE) appropriately with patient in Isolation Precautions.*
- *Correctly dispose of all PPE*
- *Cleaning, disinfection, and sterilization*

Q: What should be placed into red trash bags?

A: *Items with blood or other body fluids*

Q: What is a blood-borne pathogen?

A: *These are diseases that can be transmitted by contact with a person's blood and bodily fluids through accidental needlestick, splash, etc. The "big three" are Hepatitis B, Hepatitis C, and HIV.*

Q: How do you prevent central line-associated bloodstream infections (CLABSI)?

A: *Several methods to prevent them:*

- *Educate patients about CLABSI prevention.*
- *Use the central line insertion checklist.*
- *Avoid the femoral site if possible.*
- *Perform hand hygiene, use full body drape, wear mask, cap, sterile gown and sterile glove, use CHG skin prep in patients older than 2 months.*
- *Hand hygiene, gloves, and mask before dressing change or port access.*
- *Scrub the hub 15 seconds before all access.*
- *Daily assessment of line necessity*
- *Remove the line as soon as possible.*
- *Ensure dressing change and site care every 7 days and when the dressing is moist; or as needed.*
- *Put alcohol impregnated caps on all unused ports.*

Q: How do you prevent surgical site infections (SSI)?

A: *Several methods to prevent them:*

- *Bathe with chlorhexidine the night before and the morning of surgery.*
- *Educate patients about SSI prevention.*
- *Perform proper surgical scrub on hands.*
- *Use proper antibiotics for prophylaxis at right time.*
- *If hair removal is needed, use clippers instead of razors in pre-op area.*
- *Ensure proper surgical site scrub.*
- *Minimize traffic in OR during surgery.*
- *Do not flash sterilize equipment.*
- *Hand hygiene before and after caring for wound.*
- *Do not routinely use Vancomycin as prophylaxis unless history of MRSA or beta lactam allergic, or if organization has high incidence of MRSA isolates.*
- *Keep patient's core temperature > 36°C intraoperatively. Consider active warming.*



Q: How do you prevent catheter-associated urinary tract infections (CAUTI)?

A: *There are several methods to prevent CAUTI:*

- *Use approved indications for urinary catheter.*
- *Document the indication for catheter insertion.*
- *Assess urinary catheter daily; use Nurse Driven Protocol to remove the catheter.*
- *Remove any unnecessary urinary catheter ASAP.*
- *Insert catheters only when the patient meets CDC criteria and remove when the patient no longer meets criteria.*
- *Consider other methods such as condom- catheters and straight catheterization.*
- *Perform hand hygiene immediately before and after insertion and any manipulation.*
- *Do not change catheters routinely.*
- *Do not treat asymptomatic bacteriuria in catheterized patients (except for urologic procedures)*
- *Do not use systemic antibiotics routinely as prophylaxis.*
- *Appropriate maintenance bundle includes:]*
 - *Keep foley below level of bladder.*
 - *Assure tubing is not kinked.*
 - *Assure the foley is anchored with a Statlock.*
 - *Separate graduate containers should be used for each patient for measurement to assure no cross contamination.*
 - *Perineal care should be performed twice daily.*
- **Organization goals are to reduce the utilization rate of an indwelling catheter < 15%.**

Q: What is the #1 way to prevent the spread of infections?

A: Perform hand hygiene (we follow CDC Guidelines):

- Indications for Hand Hygiene in Healthcare Settings:
 - Perform hand hygiene with soap and water when hands are visibly soiled.
 - If hands are not visibly soiled, use an alcohol-based handrub for routine decontaminating of hands.
- Specific Indications for Hand Hygiene:
 - Immediately before touching a patient.
 - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
 - Before moving from work on a soiled body site to a clean body site on the same patient
 - After touching a patient or the patient's immediate environment
 - After contact with body fluids or excretions, mucous membranes or non-intact skin, wound dressing, or contaminated surfaces
 - Immediately after glove removal

We Track Compliance with the Hand Hygiene Observation Tool





Q: Name the types of isolation and precautions: A:

- **Airborne** – wear respiratory protection (N-95 particulate respirator mask) when in patient's room; keep door closed; patient must be in a negative pressure room.
 - TB
 - Measles
- **Droplet** – wear a surgical mask the entire time you are in the patient's room.
 - Bacterial meningitis and meningococemia
 - Pertussis
 - Influenza
 - Mumps
 - Rubella
 - Parvovirus B 19
 - COVID-19
- **Contact** – gloves and gown are worn the entire time you are in the patient's room.
 - Resistant bacteria (MRSA, VRE, C. difficile, other MDROs-Multidrug resistant organisms)
 - Scabies & Lice

Break the chain of infection



Q: How do you prevent *Clostridium difficile* infection (CDI)?

A: Several methods to prevent them:

- *Infected patients should be placed in isolation for **CONTACT PRECAUTIONS** until discharge.*
- *Use hand hygiene (soap and water instead of alcohol-based hand rub), gloves, gowns.*
- *Clean equipment and room with bleach*
- *Provide education to patient and family members about the disease.*
- *Do not test patients without signs or symptoms of CDI for *C. difficile* (i.e.: must have liquid stools and not on laxatives)*
- *Do not repeat *C. difficile* testing at the end of successful therapy for a patient recently treated for CDI.*

Q: How do you prevent the spread of multi-drug resistant organisms (MDRO) – these include MRSA, VRE, ESBL?

A: Several methods to prevent them:

- *Adhere to precaution guidelines when patients are in isolation inclusive of donning appropriate PPE and hand hygiene.*
- *Disinfect equipment between patients (i.e., stethoscope, computer, etc.)*
- *All patients with known or suspected MDRO should be under **CONTACT PRECAUTIONS***
- *Provide education to patient and family members about the MDRO.*

**DON'T GET THE FLU.
DON'T SPREAD THE FLU.
GET VACCINATED.**

Q: Why is it important to receive the influenza vaccination?

A: *Immunized health care workers minimize the risk of transmitting influenza to patients, coworkers, and family members:*

*Adults shed the infectious influenza virus at least **1 day before** any symptoms appear and continue to shed for **5-10 days after symptoms appear**.*

Approximately 50% of influenza infections can be asymptomatic.

*Both **symptomatic** and **asymptomatic** individuals can **shed** the virus and be a source of infections to others, especially patients.*

It is mandatory for staff to report their vaccination status for both influenza and COVID-19 vaccination. Colleagues should follow Occupational Health Protocols when reporting. Those who are not compliant with reporting protocols are subject to disciplinary action.

Q: Can I get the flu from the flu vaccine?

A: NO. *The influenza vaccination offered by HCH is "inactive", which means there are no live viruses to cause illness.*

PREVENT Needlestick Injuries

Be Prepared

Organize your work area with appropriate sharps disposal containers within reach.

Work in well-lit areas.

Receive training on how to use sharps safety devices.

Before handling sharps, assess any hazards—get help if needed.

Be Aware

Keep the exposed sharp in view.

Be aware of people around you.

Stop if you feel rushed or distracted.

Focus on your task.

Avoid hand-passing sharps and use verbal alerts when moving sharps.

Watch for sharps in linen, beds, on the floor, or in waste containers.

Dispose of Sharps with Care

Be responsible for the device you use.

Activate safety features after use.

Dispose of devices in rigid sharps containers; do not overfill containers.

Keep fingers away from the opening of sharps containers.

Q: What should you do if stuck by a contaminated needle or splashed in the eyes, nose, or mouth with blood or body fluids?

A:

Thoroughly wash the area exposed.

Notify your supervisor.

Complete an THEIR report.

Contact Occupational Health for further guidance.



Concerns about patient safety or quality of care should be reported to your immediate supervisor.

Should your immediate supervisor not be available, staff may also contact the following:

Patient Safety Officer (ext. 25868) Risk Management (ext. 28568)

Staff may report concerns anonymously through the **Corporate Compliance Hotline: 1-800-477-4661**

Staff may also report events to the following external agencies:
The Joint Commission 1-630-792-5636
Agency for Health Care Administration (AHCA) 1-888-419-3456

Event Reporting: Adverse events are reported via the **Midas** event reporting system. Midas can be found in the Zenworks Folder on computer desktops.

Sentinel Event: A sentinel event is an unanticipated death or permanent loss of function not related to the patient's illness. Examples: death after a fall or overdose of a medication.

Colleague Injuries: Colleague injuries are reported in the THEIR system. THEIR can be found in the Zenworks Folder on computer desktops.

No retaliation or disciplinary action will be taken against individuals who report safety concerns.


Suicide Risk Screening is completed on admission

- If positive:

Positive Suicide Screen

- **Place patient on 1:1 continuous observation**
- Notify the attending physician to assess for need for Baker Act order
- Notify clinical lead, who will notify the nursing supervisor and security
- If physician determines patient at risk for harm to self or others, the RN must ensure:

- Paper Baker Act Order is completed
- **“Legal Status: Involuntary” order is entered in EHR**
- “Suicide precautions” order is entered in the EHR
- “1:1 Observation” order is entered in the EHR

 New Orders	
Suicide precautions Order details	
Patient Safety Attendant (1:1 Observation)	
Continuous, Starting today at 1500, Until Specified	
Legal Status:Involuntary Order details	

Patient under the Baker Act (The Florida Mental Health Act)

- Private room when available
- Continuous PSA/PCT/Security Officer
- Patient wears hospital gown
- Belongings are removed from room and searched/secured by security
- Visitors and phone calls MAY be restricted or prohibited based on professional judgment and patient need
- “Patient Safety Tray” for meals is ordered in the EHR for plastic utensils and safety tray
- Remove all ligature risks, items that may be used for self-harm, unused furniture and medical equipment: (corded phone, oxygen flowmeter, suction regulator, extra tables/chairs, etc.)
- Patient must be visible when using bathroom
- If the patient must leave the room for medical need, he/she is accompanied by staff trained in the care of a patient under the Baker Act

Frequency: Effective now Effective 1000 (lunch) Effective 1400 (dinner) Effective mid-night

Starting: 1/17/2023 Today Tomorrow

For: Hours Days Weeks

AT: 1236

Starting: Today 1236 Ending: Until Specified

Location: Holy Cross Hospital Fort Lauderdale

Diet Type (req): General Plant Restriction Modified Consistency Options for Liquids and Solids Celiac Diabetic Bariatric/OI

General Diet: Regular Gluten Free/Celiac Kosher Low Fiber Low Phosphorus Potassium 2 gm Restriction (50 mEq) Potassium 3 gm Restriction (75 mEq) Protein 60 gm Restriction Renale Chronic Kidney Disease Vegan (no dairy, eggs, or meat) Lacto-vegetarian (milk only, no eggs/meat) Lacto-ovo-vegetarian (milk & eggs, no meat) Ovo-vegetarian (eggs only, no meat) Pescatarian (No Meat or Dairy) Palliative Diet

Miscellaneous: No Red Liquids No Straws Stress Test Patient Safety Tray Tyramine Restricted Diet Low Iodine Diet

Diet Comments: [Add Diet Comments](#)



Universal Protocol



Better prevent surgical mistakes

Prevent Wrong Site, Wrong Procedure, Wrong Person Surgery

- Conduct a pre-procedure verification process.
- At the time the surgery/procedure is scheduled.
- At the time of admission or entry into the facility.
- Before the patient leaves the preoperative area or enters the procedure/surgical room.

Licensed Independent Practitioner marks procedural site.

- When possible, the patient is involved with identification and site marking.
- Performed when there is an opportunity to select right or left.
- Use consistent format for site marking.
- Applies to bedside procedures except when the LIP is in continuous attendance with the patient.

ALWAYS perform a time-out before the procedure – ALL STOP

- Correct patient identity, side, site, and position.
- Agreement on the procedure to be done.
- Correct implants, special equipment or requirements are available.

Any colleague may STOP the LINE if needed!

Q: What procedures are done to ensure correct procedure, patient, side/site and/or treatment?

A: A **Time Out** is conducted prior to each procedure which includes:

- Correct patient identity (Name, DOB, MR#)
- Agreement on procedure to be done.
- Correct patient position
- Correct side/site is marked (“Yes” is visible after prepping/positioning/draping)
- Any special requirement, equipment, or implant (relevant images are properly labeled and displayed)
- Accurate Procedure Consent form
- Antibiotics given within 60 minutes of incision and/or fluids for irrigation purposes.
- Any safety precautions based upon the patient’s history and/or medication use.

Universal Protocol happens in the OR, all procedure areas and for procedures at the bedside.

Q: Can you give me examples of interventions to prevent Pressure Injuries?

A: Match interventions to the specific risk. Some suggested interventions include consult dietician; consult PT to mobilize the patient, reposition, protect elbows and heels; use perineal cleanser with each incontinent episode, scheduled toileting, use absorbent incontinent pads, skin barrier dressing, and the use of a pressure redistribution surfaces/beds.

Q: What is your process when the laboratory reports a critical result by phone?

A: The person receiving the call writes it down and reads it back to laboratory personnel and receives confirmation. The RN notifies the physician as soon as possible, not to exceed 25 minutes. The nurse documents the action taken by the provider, even when the decision is no action in the record.



Q: What tools are used to assess pain?

A: *The patient's self-report of pain on a numeric scale of 0 to 10 is the tool of choice for assessing pain. Additional tools include:*

- *Wong-Baker Tool – used for the child, cognitively impaired population or when a patient speaks a language other than English.*
- *NIPS and FLACC – used for newborn, infant, children, and unconscious patient.*
- *CPOT (Critical Care Pain Observation Tool) is designed to scale the pain of patients who are unable to report it themselves through objective findings.*

Q: What treatments options are available for pain management? A:

- *Non-pharmacological treatments include but are not limited to:*
 - *Heat and cold therapies*
 - *Massage*
 - *Exercise*
 - *Immobilization*
 - *Repositioning*
 - *Acupressure*
 - *Deep breathing exercises*
 - *TENS (transcutaneous electrical nerve stimulation)*
- *Pain medication*
 - *Orders must include specific details regarding indications and dose.*

If multiple medications are ordered, specific guidelines for which medication to give for each type of pain must be provided inclusive of if the order is for:

- **Mild (numeric scale 1-3)** level of pain
- **Moderate (numeric scale 4 – 6)** level of pain, or
- **Severe (numeric scale 7- 10)** level of pain

**There can only be one active medication order per level of pain
(prevent Therapeutic Duplication)**

Q: How is pain assessed? A:

- *Initial Assessment and each shift: a comprehensive pain assessment is completed.*
- *If the patient reports pain, gather additional information such as location, intensity, duration, etc.*
- *Assess pain intensity every 30 minutes for one hour after initiation of bolus dose, then every four hours.*
- *Reassess at least every shift and no longer than one hour after provision of medication and alternative pain therapies.*
- *Assess sedation level prior to administration of opioids.*

Q: When do you reassess a patient?

A: *We follow department specific "Standards of Care" that define minimum reassessment intervals when:*

- *There is a change in patients' condition.*
- *In response to care (e.g., after pain medication)*
- *Procedure/treatment is completed.*
- *Patient goes to a different level of care.*
- *At routine times during the stay based on standards of care*



+ The 4 P's Checklist

1 POSITIONING

Is there anything I can do to make you more comfortable?

2 PERSONAL NEEDS

Are all of the personal items you need within reach?

3 PAIN

Are you experiencing any pain that I can assist with?

4 POTTY

Would you like for me to help you use the bathroom?



Q: What must be considered when placing a patient in restraints?

A: *Least restrictive measures must be tried first. Physical restraint is the last resort.*

Violent/Behavioral Restraint (Danger to self or others)

If a restraint is used because of severely violent or self-destructive behavior that poses an imminent danger to the patient or others, the behavioral standard applies. A face-to-face evaluation of the patient must occur by the provider within 1-hour of restraint initiation (one-hour rule). The Nursing Supervisor must be immediately notified of violent restraints. New Orders (for adult) for continued behavioral restraint is required Q4 hours. A face-to-face reassessment by physician occurs every 24 hours for continuous violent restraints.

Non-Violent/Non-Behavioral

Restraints used for acute medical and post-surgical care should be considered non-violent/non behavioral.

*There must be a signed, dated and timed complete order by the physician on the chart **every calendar day** for the patient to remain in restraints.*

PRN or standing orders for restraints are unacceptable and Against Policy

- **Every shift must document the rationale for the patient to remain in restraints.** Examples include but are not limited to:
 - "Patient continues to attempt to climb out of bed."
 - "Patient continues to disconnect and/or remove essential therapeutic devices."
 - "Patient is potential harm to self."

Restraints should be discontinued when the patient meets the criteria outlined in the order.

Restraint Monitoring

Monitoring and Reassessments	Non, Violent Acute Medical Surgical	Violent & Self-Destructive Behavioral Restraint
<ul style="list-style-type: none"> -Signs of injury associated with restraint -Restraint is intact -Side rails are up -Call light is within reach -Limb check 1-2 fingers fit (if limb restraint used) -Offer/Provide hydration/nutrition -Offer/Assist with toileting/ hygiene -Release restraints for exercise ROM -Turn/ reposition and observe skin integrity 	Every 2 hours (RN, LPN or PCT, ED Techs)	Every 15 minutes (RN, LPN or PCT, ED Techs)
<ul style="list-style-type: none"> -Signs /symptoms of distress -Response to restraint (tolerance, anxiety) -Assess continuance of at risk" behavior as indication for readiness to discontinue restraint 	Every 2 hours (by RN)	Every 1 hour (by RN)
<ul style="list-style-type: none"> -Vital Signs 	Per department policy or as warranted by patient condition	Per department policy or as warranted by patient condition

The actual monitoring may be delegated to LPNs and other unlicensed assistive personnel (PCTs, ED Techs) with oversight by the registered nurse. However, the RN is responsible for **reassessments of "at risk behavior"** and the **need for continued restraint or readiness to discontinue restraint**

Q: What has been done in your area to reduce the use of restraints?

A: *Restraint alternatives and training in the use of de-escalation techniques so that restraints are not required.*

Q: What can I do if my patient's condition begins to deteriorate?

A: *You can activate the Rapid Response Team (RRT) (Code Rescue) by calling ext. 25555. The Rapid Response Team should be called when you notice unexpected changes in the patient's condition. These concerns may include:*

- *A change in level of consciousness*
- *Significant respiratory changes*
- *Something just doesn't "seem right."*

Q: Describe your falls prevention program.

A: *All inpatients are assessed for fall risk on admission, upon changes in level of care, and q shift and as required using a standardized tool. Fall risk is documented by the nurse.*

- *Match Interventions to the specific risk.*
- *Instruct Patient/family about fall risk and interventions.*

Q: Can you give me examples of interventions to prevent falls?

A: *Stay with me initiative (remain within 3 feet of fall risk patient during toileting), Hourly rounding, call light within reach, placement near nurses' station, consults to PT/OT, frequent toileting, assistive devices, bed alarms, low bed and mats, teaching regarding side effect of medications, clutter and obstacle-free floors, yellow fall risk identification arm bands and yellow non-skid socks.*

Remote sitter monitoring is available via AvaSure Units maintained in the Sterile Processing Department.

Q: What is the fall rate on your unit? A: _____

(Fill in with the current fall rate)



Q: What is the time frame for initiation of the interdisciplinary plan of care?

A: *The plan of care is initiated within 4 hours of admission and reviewed every 24 hours and as needed throughout the admission so updates to patient care plan can be made.*

Q: How do we encourage patients to “speak up” and participate in their care?

A: *Patients and families are encouraged to:*

- Participate in decision making regarding their care.
- Ask if caregivers have washed their hands.
- Request explanations of what tests and treatments you receive in order to understand the results.
- Tell the doctor and caregiver immediately if they think their condition is changing for the worse
- Notice if caregivers check identification band or ask for name and/or date of birth prior to diagnostics, treatments, blood products, medications, and specimen collection.
- Expect answers to questions regarding diagnosis, medical tests, and treatment plan.
- Review medications and allergies with caregivers
- Share ideas for improving patient safety.
- Ask about new medications, their purpose and side effects.

Record Of Care

Q: How do you communicate with a non-English speaking patient or a patient who is deaf or hard of hearing? What resources are available to you? What do you do on weekends and off shift?

A: *For Limited English Proficiency (LEP) patients, we must use certified medical interpreters (**few colleagues are not acceptable**):*

MARTTI – available 24/7 via unit IPADs or Nursing Supervisor Office

Accommodating Ideas: Onsite Sign Language

1-800-257-1783

Certified Languages (use speaker phone):

1-800-225-5254

Customer Code "HolyCH"

For deaf or hard of hearing patients, we may also provide **TDD devices maintained in the PBX** department. Written communication is also acceptable.

Q: What procedure is followed during computer downtime?

A: *In clinical areas, Netsafe downtime workstations, designated with a red keyboard and mouse, can be used during downtime and downtime forms are available.*

Q: What is Informed Consent?

A: *Informed consent indicates the patient has discussed and understands nature of proposed care, benefits, risks, likelihood of achieving goals, alternatives, and relevant risks and benefits related to alternatives, including possible results of not accepting the procedure. In cases where recommended treatment involves the performance of a complex or invasive procedure, Florida Statute Title XLV Chapter 766 Section 103 allows for the following individuals to obtain informed consent:*

- Physician
- Osteopathic Physician
- Chiropractor
- Podiatrist
- Dentist
- Advanced Registered Nurse Practitioner
- Physician Assistant

Q: What is the staff role for obtaining an informed consent?

A: *Staff has a responsibility to assure the presence of informed consent documentation before a procedure begins. If a patient is unwilling to sign the consent form, the physician should be notified. All fields of the informed consent form must be completed inclusive of the type of procedure and acknowledgement that all risks, benefits, and alternatives were explained to the patient and are understood. To finalize the signing of the consent form, the following components must be present:*

- **Date**
- **Time**
- **Physician/LIP signature**
- **Patient/patient representative signature**
- **Witness signature**

Q: What is an Advanced Directive?

A: *Instructions that the individual may provide in writing specifying end of life care wishes in the event he/she is unable to communicate them to the medical staff.*

Q: What opportunities can we provide for patients to complete an Advance Directive?

A: *We give patients information upon admission that explains the Advance Directives. Social Services, Nurses and Spiritual Care can assist a patient in completing an advanced directive.*

Did you know? Experts suggest beginning conversations regarding the importance of Advance Care Planning with persons as young as **18 years of age**. To learn more, visit the Institute for Healthcare Improvement:

the
conversation
project





Medication Management

Q: Why do we utilize formulary drugs?

A: *A formulary is designed to limit the number of commonly used medications within the facility to those required to meet our individuals' needs. By limiting the number of medications commonly used, we hope to decrease the chance for medication errors.*

Q: What does your pharmacy do to prevent errors with sound-alike/look-alike drugs (SALAD)? Can you give me examples of these drugs?

A: *Pharmacy uses "Tall man" lettering and visual warnings. Tall man (uppercase) letters are used within a drug name to highlight its primary dissimilarities and help to differentiate look-alike names. The pharmacy also physically separates SALAD (Sound-Alike-Look-Alike) medications in Pyxis and Pharmacy. Examples include:*

- **oxyCONTIN** and **OXYcodone**
- **hydroCODone** and **hydroMORPHone**.

Q: How are medications secured so unauthorized persons cannot obtain access?

A: *Majority of meds are secured in automated dispensing machines (Pyxis) or med carts. When meds are not locked, the area is under continuous observation by an individual who is authorized (per policy) to handle medications.*

Q: How is insulin stored in order to prevent administering the wrong one?

A: *Different types of insulin are physically separated in Pyxis*

Q: What is the "revised expiration date" for an open Multi-Dose vial?

A: *Revised expiration is 28 days from when the multi-dose vial is opened, or sooner if required by the manufacturer. Staff are responsible to label an opened multi-dose vial with the revised expiration date.*

Q: Does a patient who receives a new medication receive special monitoring during the first dose?

A: *Patients are monitored after a first dose for toleration and adverse effects and anaphylaxis. Adverse responses are documented in the progress notes/EHR and Midas.*

Q: What do you do when you have questions about a medication order?

A: STOP. *Contact the physician for clarification before the medication is administered.*

Q: Who makes IV solutions with additives?

A: *The pharmacy prepares all sterile medication, intravenous and chemotherapy drugs. The pharmacy purchases some pre-mixed IVs and TPN admixtures from compounding pharmacies and manufacturers. Some nurses may prepare certain IV medications with additives depending on the medication and/or urgent need.*

All medication must be prepared in a clean, uncluttered, and functionally separate area for product preparation to avoid contamination of medications.

Medications may not be prepped at the patient's bedside.

Q: What is a medication error and how is it reported? What are “near-misses”? A:

- A **medication error** is any unintended act in the process of ordering, dispensing, transcribing or administering a drug.
- A **“near-miss”** is an error caught anywhere in the process before patient received the medication.
- **All medication errors and “near-misses” are required to be reported through Midas event reporting system (online)**

Q: Should I report errors in Medication Reconciliation in Midas?

A: Yes, there is a category called “Med Rec”.

Q: If a patient experiences an adverse drug reaction, what is done?

A: An Adverse Drug Reaction (ADR) is any undesirable or unexpected event that requires discontinuing a drug, modifying a dose, prolonging hospitalization or providing supportive treatment. If an ADR occurs:

- Notify the physician.
- Document the event in the clinical intervention documentation section.
- All significant ADRs must be reported in the Midas event reporting system (online) as defined in the Medication Event Policy.

Q: What are High-Risk/High-Alert Medications?

A: Medications where the consequences resulting from a variance from the intended or desired administration are significantly more devastating to the patient than with most medications. Physician should be notified if patient refuses any prescribed medication.



**MEDICATION
SAFETY
STARTS
WITH YOU**



Medical Staff

Q: If a new physician comes to your unit to perform a procedure, how do you know he or she is credentialed?

A: *You can contact the Medical Staff Services office at ext. 25768 during business hours. After hours and on weekends, contact the Nursing Supervisor Office to confirm privileges (Nursing Supervisor Office retains copy of all physicians Delineation of Privileges).*



Patient Care – Provision of Care

Q: What do you consider when you are teaching the patient and family?

A: *Their ability to learn, preferences, desire, motivation, and readiness. We also consider cultural and religious practices and emotion, physical, cognitive, or language barriers. The teach-back method is also used to confirm patient's understanding of information.*

Q: How does the assessment process help identify suspected child/elder abuse or domestic violence?

A: *Criteria for identification of abuse have been defined in policy and there are questions/statements asked during the assessment and reassessment process.*

ORGAN DONATION

Transplant Safety



Q: What is the hospital's policy on Organ Donation?

A: *We provide an opportunity for patients and families to consider organ & tissue donation.*

Waived Testing

Q: What is Point of Care Testing (POCT)?

A: *Point of Care Testing is laboratory testing that is performed outside the laboratory.*

Q: When is POCT done?

A: *POCT is done at the bedside for monitoring the patient's blood glucose levels; as well as in Physician Practices for PT/INR and urinalysis*

Q: What is required for Quality Control? A:

- *Quality Control (two levels of control) is done daily.*
- *Document the open date and the new expire date on each control vial. Control materials expire 90 days after the opened date.*

Q: Who can perform POCT?

A: *Any person with specific training and orientation to perform the tests and demonstrate satisfactory levels of competence prior to performing testing.*

Q: How is my competency assessed for POCT?

A: *Competency can be assessed in a variety of ways including:*

- *Direct observation of testing*
- *Monitoring each user's quality control performance*
- *Proficiency testing*



Health Insurance Portability and Accountability Act

Q: What is considered Protected Health Information (PHI)?

A: *Information that is used and/or disclosed by the facility that is individually identifiable, such as: names, addresses, social security numbers, medical record numbers, facial photographs, and diagnoses.*

Q: What is your role in patient privacy and confidentiality? A:

- *Keep medical records closed, when not in use*
- *Use privacy screens on computers if necessary and/or lock computer when unattended.*
- *Properly dispose of paper with patients' names or information in the bins for shredding*
- *Only access the information needed for my job. Unauthorized access of any patient PHI may result in disciplinary action/termination.*
- *Lock my computer screen when leaving my desk.*
- *Take reasonable steps to ensure that a fax transmission is sent to and received by the intended recipient (use fax cover page and double check numbers that are manually entered for accuracy*
- *Do Not Do the following:*
 - *Discuss patient information in open areas such as in the cafeteria or elevator.*
 - *Share passwords or access codes.*
 - *Announce or confirm admission or treatment of any prior or current patient to anyone without a need to know this information.*



Environment of Care & Life Safety

Q: How do I maintain a safe environment?

A: *Examples include, but are not limited to:*

- *Report suspicious persons to security.*
- *Always keep your personal belongings stored and secured. Personal items must be stored outside of Patient Care areas and should not be placed where supplies are maintained.*
- *Security is available 24/7 to escort you to your car if requested.*
- *Do not prop fire doors open.*
- *Do not block fire doors or extinguishers.*
- *Keep patient hallways clear. Equipment/carts must be on the same side of hallways and relocated within 30 minutes to maintain safe egress.*
- *Food or drink spills should be cleaned up immediately.*
- *Report general safety issues/concerns (i.e., lights out, trip hazard, etc.) to department management.*

Service requests for facilities/engineering, biomedical, and environmental services departments can be made by opening tickets via portals found on the SharePoint Homepage.

Additional contacts are as follows:

Patient Safety Officer: ext. 25868

Safety Officer: ext. 27025

Blood/Body Exposure: Occupational Health ext. 25776

Buildings & Grounds: Facilities ext. 25760

Infection Control: ext. 23196

Compliance Integrity Alert Line: ext. 1-800-472-8776

Medical Equipment Problems: ext. 23245

Environmental Services: ext. 25785

Security: ext. 23099

Q: What is the process if there is a recall or hazard alert on a piece of equipment?

A: *Rasmas is the system utilized for receiving alerts and reporting recalled equipment. In addition, Risk management and Materials Management work together to keep the organization up to date on alerts received.*

Q: What is your policy regarding checking the defibrillator?

A: *Nursing staff check the defibrillator every 24 hours "unplugged". This includes checking to see that the defibrillator is plugged in and tested, and that all the needed supplies are there (paddles, pads) and that the pads are not expired. Make sure that the test plug is also attached. Nursing staff should document that the defibrillator was checked.*



Q: What is your role in a simulated or real disaster?

A: *If anyone was in immediate danger in my area, respond appropriately (reference Badge Buddy for Codes). Otherwise, wait for instructions from the Hospital Command Center while carrying out my normal duties. If you are not in my department, return and report to your immediate Supervisor.*

Q: Am I required to report onsite during a Hurricane?

A: *Each department has a staffing plan if a Hurricane Warning is issued by Broward County. Your leadership team should clarify what your reporting responsibilities are when a Code Brown is activated.*

Q: What is the Staffing Plan?

A: *The staffing plan assures appropriate staffing by using historic data, budgetary data, census information and projected acuity levels to calculate staffing needs. Staff is adjusted on a shift-by-shift basis determined by acuity, requirement of the service line, and volume of patients and staffing ratios.*



Q: What do you do if you see smoke or flames or just smell smoke?

A: Activate a *code RED*

- *Find the nearest pull station to activate the fire alarm immediately.*
- *Dial 25555 (on campus) or 911 (off-campus).*
- *Tell the operator what you have seen, where it is, and what the impact is on the area.*
- *Follow direction of fire response team.*

R.A.C.E. Action Plan if Fire Occurs

R-Rescue

A-Alarm

C-Contain

E-Extinguish or Evacuate

To Use an Extinguisher with the PASS Method

P-Pull Pin

A-Aim at the base of fire

S-Squeeze handle of extinguisher

S-Sweep from side to side until fire is Extinguished.

Q: What do you do in the event of a Hazardous Material spill?

A: Isolate the spill, deny access to others, and dial 25555 to report a *code orange*, location & nature of event.

Q: How do you know a medical device is safe to use?

A: *Medical equipment serviced by the biomedical engineering department has a "Spot the Dot" label that indicates the date when preventative maintenance (PM) was performed to assure the equipment is safe for use. Equipment with a "Spot the Dot" is evaluated annually, and the color of the dot changes with each calendar year.*

Any medical equipment that is not maintained by the biomedical engineering department should have a label that reads "Inventory Only". This equipment is typically serviced by an outside vendor or may not require a preventative maintenance schedule.

Q: What do you do if a piece of medical equipment malfunctions or fails? A:

- *Remove the device from Service.*
- *Sequester*
- *Call Biomedical Engineering to report (ext. 3245)*
- *Submit a safety report (Midas).*

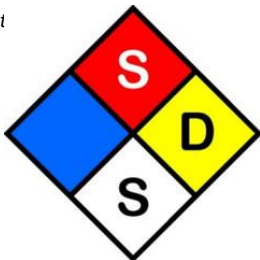
Q: What is SDS?

A: *Safety Data Sheet (formerly MSDS) is the information sheet from the manufacturer on chemicals. The SDS describes the chemical's composition, its hazardous properties, instructions on its safe use, and the response actions in case of harmful exposures. SDS can be accessed through:*

- *Zenworks Folder on computer desk*
- *SDS hotline 1-888-362-7416*
- *Binders in select departments*

Joint Commission Surveyors frequently ask where staff can find SDS, especially our Environmental Services Colleagues.

BE PREPARED



Q. What does Code ____ stand for? A:



Code	Descriptor
Amber	Abducted Infant or Child
Assist	Non-Combative Behavior/Security Needed
Black	Bomb Threat
Blue	Cardiac/Pulmonary Arrest
Blue Jr.	Cardiac/Pulmonary Arrest: Child 29 Days - 16 years
Brown	Hurricane
Clear	Emergency is Over
Elopement	Vulnerable Adult is Missing
Emergency Evacuation	Evacuation of Area/Premises
Emergency Lockdown	Lockdown of Area/Premises
Green	Mass Casualty Incident (MCI)
Heart	Thrombolytic Therapy: Heart
Lavender Alert	Emotional Support for Care Givers Needed
Orange	Biological/Chemical/Radiation Incident
Pink	Cardiac/Pulmonary Arrest: Infant 29 Days or Less
Red	Fire
Rescue	Patient's Condition is Deteriorating
Stroke	Stroke/Thrombolytic Therapy: Brain
Security Alert: Active Shooter	Active Shooter
Security Alert: Armed Person	An armed person threatening harm/hostage situation
Strong	Out of Control Behavior
Strong with Physician	Out of Control Behavior/Physician needed
White	Induced Hypothermia
Yellow	HAZMAT/Decontamination Team response needed

Note: Code chart listed on your Badge Buddy

Q: When handing off to the next caregiver, what information must be communicated? A:

- *Diagnosis and current conditions of the patient*
- *We utilize "SBAR" to communicate recent changes in condition:*
 - S** – *situation (what is the problem, condition)*
 - B** – *Background (history, protocols in place, code status)*
 - A** – *Assessment (current labs & meds)*
 - R** – *Recommendations (what you want done for patient)*
- *The receiver of hand-off communication must have an opportunity to ask questions pertinent to patient care.*

Q: What is "Bedside Shift Report"?

A: *We follow a standard of care for handoff communication occurring in the patient room at the patient bedside with the patient or family member as an active participant, whenever possible.*

Performance/Quality Improvement

Q: What process (or method) do you use for Performance Improvement (PI)? A:

- *PDSA (Plan-Do-Study-Act)*
- *Huddle Boards*



A3 Storyboard Layout	
Background	Future State and Countermeasures
Current State	
Goals and Objectives	Check Results and Impacts
Root Cause Analysis	Follow-up

Q: How are you involved in Performance Improvement (PI) activities?

A: _____

Your answer should be individualized to your area. Possible examples may include participation in a PI project (such as an A3), acting as a resource, assisting with data collection, and/or participation in a Root Cause Analysis (RCA) or involvement in implementation of improvement strategy from an RCA.

Q: What are some examples of the PI projects being addressed in your area?

A: _____

Possible examples may include:

- *Hand hygiene*
- *Patient falls.*
- *Patient identification*
- *Pressure Injuries*
- *Patient restraints*
- *National Hospital Quality Measures: AMI, CHF, Pneumonia*
- *Medication reconciliation*
- *Preventing readmissions*
- *Reducing length of stay*
- *Stroke measure*
- *Patient experience*

Q: Why is data important?

A: *Data provides an objective measure of how often and/or how well we're doing something. Data can help guide decisions and allow us to show improvement over time.*

Lavender Alert

Code Lavender is a crisis intervention tool designed to support any patients, family, and staff after any stressful or traumatic event. A Code Lavender provides emotional first aid where support is requested to patients and staff by providing:

- Purposeful physical presence
- Individual or team support
- Debriefing and follow up.
- Complementary therapies
- Prayer and other affective based interventions
- Tea and snacks.

What are we doing at Holy Cross Health to develop our Lavender Alert response?

- A Grant was awarded for the organization to provide training to interdisciplinary team members and develop response carts.
- Colleagues are actively being recruited across the ministry so that all shifts may be covered, inclusive of nights, weekends, and holidays.
- The program will begin at the main Hospital Campus and will gradually be expanded to offsite locations.

Workplace Violence: Protect Yourself from Harm

Safety Tips

Colleagues:

- Be **alert**.
- **Evaluate** each situation for potential violence when you enter a room or begin to relate to a patient, visitor, or colleague.
- Be **vigilant** throughout the encounter.
- **Don't isolate** yourself with a potentially violent person.
- Always keep an **open path** for exiting – don't let the potentially violent person stand between you and the door.

If you can't defuse the situation quickly:



Remove yourself from the situation.



Call for help.













Report any violent incidents to your management.



Workplace Violence: Protect Yourself from Harm

Communication

Remember the Golden Rule: Treat the person the same way you would like to be treated. Everyone deserves peace and dignity.

DO	DO NOT
 Paraphrase what they said – it shows them that you are listening!	 Try to reason.
 Even if you do not agree with the person, listen.	 Give advice.
 Be aware of your tone. It is easy to escalate your tone without knowing.	 Provoke just because you may be having a bad day.
 Monitor your posture.	 Use profanity.
 Find someone who can better address the need or situation if you cannot.	 Try to handle a situation or person when you do not feel qualified.

HUMAN RESOURCES

Q: Who is required to demonstrate competency?

A: *All physicians, staff and volunteers must be competent to provide care and services at HCH.*

Q: How is competency assessed?

A: *Through annual performance evaluation and/or competency validations such as:*

- *New employee orientation*
- *Job specific orientation*
- *Direct observation*
- *Skills lab*
- *Annual performance evaluations*
- *Annual competency assessment*

Q: What does age specific/population specific competency mean?

A: *Age specific competency refers to staff knowledge and skill (competency) to provide care that is appropriate to the age or population type of the patient.*

Conflict Resolution

HCH has policies/procedures that define acceptable and inappropriate disruptive behaviors and are guided through a Just Culture environment. The conflict management process includes:

- *Meeting with involved parties as early as possible to identify conflict.*
- *"Just Culture" Are there System Barriers, Human Error, or At-Risk Behavior*
- *Working with the parties to manage and resolve the conflict.*
- *Protecting the safety and quality of care*



Colleague Guide Continuous Survey Readiness



TogetherHealth: **Holy Cross Health**

People

Performance

Portfolio

Purpose