Providence Little Company of Mary
Medical Center – San Pedro

Student Orientation Packet

Welcome!
**MISSION STATEMENT**

As People of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.

**CORE VALUES**

- Respect
- Compassion
- Justice
- Excellence
- Stewardship

**VISION STATEMENT**

Together, as people of Providence, we answer the call of every person we serve: Know me, care for me, ease my way

**PROVIDENCE INTEGRITY REPORTING**

(for any actions that appear illegal, unethical, or in conflict with Providence policy)

Integrity Hotline: (888) 294-8455 Confidential and anonymous Regional Compliance Officer: Arnold Krauss (818) 847-3140

**Examples of Issues to Report:** Theft and fraud; billing and coding; bribes and kickbacks; falsification of records; gifts and entertainment; Code of Conduct violations; privacy of employee / patient records; any other issues or concerns where you are unable to get a reasonable resolution.

**RERAINTS**

**Non-Violent / Non-Self-Destructive Behavior:** Type of physical restraint ordered by physician. Restraint order MUST not exceed 24 hours. Patient care staff will assess and treat patient according to restraint guidelines.

**Administrative Restraint:** Type of physical restraint authorized by forensicstyled staff responsible for security/safety of patient under 24 hour surveillance. Supersedes hospital restraint policy. May include handcuffs, ankle shackles, leg irons, etc.

**Violent / Self-Destructive Behavior:** Type of physical restraint used for behavioral reason. Behavioral restraint order MUST not exceed four (4) hours and a physician MUST assess patient within one (1) hour of applying the restraint.

- Refer to Restraint Policies located in the Online Policy and Procedure Library.
- Documentation MUST be completed in the medical record for any patient in restraints.

**MANDATORY REPORTING**

All reports of abuse and exploitation, including reports of abuse and exploitation occurring in the hospital, MUST be reported to the Director/Manager, Charge RN, and Nursing Supervisor immediately.

**UOR (UNUSUAL OCCURRENCE REPORTING)**

- Access the reporting website from the Intranet site
- An unusual occurrence is anything the happens that
  - wasn’t supposed to or
  - something that was supposed to happen didn’t
  - adverse drug reactions
- Anyone can report anything they think might be reportable
- ROIs are sent to the managers to identify safety issues early and promote proactive risk management
- Records are expected to utilize the UOR process

Taking a little time to complete a UOR promotes our Culture of Safety and our goal to do the right thing for every patient, every time.
## LIFE SAFETY (FIRE)
- Four Step Plan (R-A-C-E)
  - R - rescue from immediate area of danger
  - A - alert PLCMMC-San Pedro dial **88**
  - C - contain fire
  - E - extinguish fire
- Fire extinguisher use (check for the location of the closest extinguisher in the area)
  - P - pull pin
  - A - aim at bottom of fire
  - S - squeeze handle
  - S - sweep from side to side
- Evacuation route
  - Ask unit supervisor for evacuation route map.

## EMPLOYEE HEALTH & SAFETY
For injuries sustained while on duty:
- Report immediately to supervisor.
- Complete an Employee Injury Packet.
- Bring completed packet to Occupational Health & Safety (OHS) M-F, 7:30a – 4:00p. If after hours, weekends, or holiday, take to House Supervisor for assessment and treatment direction.
- Follow-up with OHS next business morning.

For blood/body fluid exposure:
- Report immediately to supervisor and to OHS (House Supervisor when closed).
- Bring patient source information with you.
- Bring information on exact type of sharp you were injured with (if needlestick or sharps injury) brand, device name, gauge.

## MEDICAL EQUIPMENT MANAGEMENT
(Biomedical Services)
- Reporting medical equipment problems, dial **1FIX**
- Tag equipment “DEFECTIVE, DO NOT USE”
- If unfamiliar with equipment operation, **ASK FOR HELP BEFORE USING EQUIPMENT ON PATIENTS**.
- Complete an Unusual Occurrence Report (UOR) (on the intranet) if patient/staff injury was involved.

## HAZARDOUS MATERIALS & WASTE
- For chemical spills summon hazardous response team dial **88 - CODE ORANGE**
- Whenever in doubt, ask supervisor for assistance before handling unfamiliar chemicals.
- MSDS MUST be provided to the department manager when chemicals, cleaning agents, etc., are brought into the medical center premises for any reason.

## SECURITY MANAGEMENT
- To summon – Dial **SAFE (7233)**
- Call for escort to parking area after hours.
- Report all suspicious circumstances to Security.
- Wear photo ID when on duty.

## EMERGENCY PREPAREDNESS
- Code Triage = Internal & External disasters
- Employee Labor Pool = Staff available for reassignment
- Incident Command Center = Responsible for overall operations & facility buildings
- Unit role in a disaster = Reference Disaster Manual

## UTILITIES MANAGEMENT
(Plant Operations)
- Utility failures (medical gas, electricity, plumbing, heating, A/C, vacuum system, etc.)
- The Medical Gas shut off valves may be closed upon approval of Respiratory Therapy and/or Nurse Supervisor; if located in the OR, the Operating Room Supervisor.
- To report problems refer to Disaster Manual for response plan OR dial **1 FIX (1349)**

## CODES
- **Code Red** = Fire / Smoke
- **Code Blue** = Medical Emergency (Adult)
- **Code White** = Medical Emergency (Child)
- **Code Gray** = Combative Person
- **Code Silver** = Combative with Weapon
- **Code Pink** = Infant Abduction
- **Code Purple** = Missing Child
- **Code Triage** = Disaster Response
- **Code Orange** = HazMat Spill
- **Code Yellow** = Bomb Threat
- **RRT** = Rapid Response Team
- **Employee Pool** = Cafeteria

## INFECTION PREVENTION
- Use Standard Precautions for all patient contact.
- Personal protective equipment is available in all patient care areas.
- Wash hands when entering/exiting a patient room.
- Cover mouth if cough/sneeze, throw tissues in trash and wash hands after
- Please refer to Infection Control Manual for additional information as needed.

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**Emergency Dial 88**
Compliance: What You Need to Know
A Guide to Understanding HIPAA Regulations

Following policies and procedures in the workplace assures compliance with applicable healthcare laws and regulations. This tip sheet will help you stay compliant with important patient privacy regulations that could have personal financial implications if violated:

- *Never* view patient records that do not involve your scope of work. Only view records relevant to performing your job.
- Understand what qualifies as protected health information (PHI). Examples of PHI include:
  - Names
  - Telephone/Fax Numbers
  - Email Addresses
  - Social Security Numbers
  - Medical Record Numbers
  - URL/IP Addresses
  - Dates that include Dates of Birth, Death, Admission, Discharge
    - Full-Face Photos and Comparable Images of Patients

- Know where to locate shredder bins in your area to dispose of (PHI) and use them when discarding any documents containing PHI.
- Know the Providence Integrity Line phone number to report compliance concerns and suspected breaches. The Integrity Line is available toll-free 24 hours a day, 7 days a week at (888) 294-8455.
- Always safely store and keep PHI out of sight of unauthorized individuals, especially when not in use.
- Make certain to lock or log off your computer when you step away.
- Properly dispose of pill bottles/IV bags/vials or other items containing PHI. Black mark labels containing PHI before disposal into the appropriate bin. Peel labels off containers and dispose of those labels in the shredder bin, prior to disposing of the container.

- Understand what constitutes a breach. A breach is defined as the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information. Healthcare professionals that violate privacy laws and regulations, and commit a breach can face very serious consequences. These can include progressive discipline, up to and including termination. Healthcare professionals may also face criminal prosecution and civil penalties up to $250,000. The best way to prevent a breach is to always keep the information obtained at Providence confidential and practice discretion when dealing with PHI.
- Examples of breaches include:
  - Viewing patient records without the “need to know”
  - Throwing PHI in the trashcan instead of the shredder bin
  - Giving medical records to the wrong patient
  - Posting patient information/PHI to social networking sites (i.e., Facebook)
  - Sending faxes with confidential information to the wrong recipient outside of Providence
- *Never* share your ID or passwords with another individual and do not allow others to use the computer while signed in with your own login credentials.

Integrity, Compliance & Audit Services
“Doing the Right Thing Right”

Effective May 2010
• Do not post confidential information and PHI taken from Providence to social networking sites such as Facebook, Myspace etc. This is a serious HIPAA violation and constitutes a breach. The best way to avoid this kind of breach is to keep the information received at Providence confidential and make certain it does not leave the workplace.

• Understand the chain of command when reporting a compliance issue or suspected breach:
  1. Speak to your immediate supervisor
  2. Speak with your director
  3. Contact your local or regional privacy officer
  4. Call the Integrity Line at (888) 294-8455

• Always keep a copy of the Code of Conduct on hand or know where it is located at your workstation so you can use it for reference. Copies in different languages can also be found online on the ICAS site: http://phsla/phs/ca/cas/cas_conduct.cfm

• Always use a cover sheet when transmitting information. A standard Providence approved cover sheet can be found on the communications site under fax cover sheets: http://phsla/phs/ca/communications/com_tools.cfm

• Know that the HIPAA policies are located on the Integrity, Compliance & Audit Services (ICAS) intranet site: http://phsla/phs/ca/policy_library/policy_library_docs.cfm?facility=CA&category=CAS

• Know who your local and regional compliance and privacy officers are as they are an important resource for compliance issues (see next page for contact list).

Remember to always ask questions when you are in doubt!

Compliance Contacts

Regional Compliance/Privacy Contacts
Arnold Krauss
Regional Compliance Officer
818.847.3140
Arnold.Krauss@providence.org

Maureen Shaw
Regional Privacy Officer
818.847.3158
Maureen.Shaw@providence.org

Facility Compliance/Privacy Contacts
Providence St. Joseph Medical Center
Sue Kohl
Facility Compliance/Privacy Officer
818.847.4748
Sue.Kohl@providence.org

Providence Little Company of Mary Medical Center - Torrance
Pearl Hilden
Facility Compliance/Privacy Officer
310.793.8126
Pearl.Hilden@providence.org

Providence Holy Cross Medical Center
Jean-Marie Kane
Facility Compliance/Privacy Officer
818.496.4552
Jean-Marie.Kane@providence.org

Providence Little Company of Mary Medical Center - San Pedro
Mary De Los Reyes
Facility Compliance/Privacy Officer
310.514.5258
Mary.DeLosreyes@providence.org

Providence Tarzana Medical Center
Nancy Warren
Facility Compliance/Privacy Officer
818.708.5694
Nancy.Warren@providence.org

Providence Medical Institute
Mary Castaneda
Facility Compliance/Privacy Officer
714.840.3042
Mary.Castaneda@providence.org

For security concerns please contact the California Regional Information Security Officer, Charles Lee at 818.847.4536 or via e-mail at Charles.Lee@providence.org

Integrity, Compliance & Audit Services
"Doing the Right Thing Right"

Effective May 2010
PATIENT STANDARDS

DISRUPTIVE BEHAVIORS

Our core value of Compassion leads us to nurture the spiritual, physical, and emotional well-being of those we serve. We apply this value to our work with each other and to the care and service we provide to our patients.

In keeping with this core value, medical staff members and allied health professionals are held to the same conduct standards as other employees, and are expected to treat others with respect and courtesy, and to conduct themselves in a professional manner. Expected behaviors that contribute to a positive patient care environment include:

- Speaking in a respectful manner to patients, families, nurses, physicians, hospital personnel and others in private and public places;
- Responding to requests for information in a timely and supportive manner whether related to clinical care delivery, collegial and professional interactions, or to patients and families;
- Handling conflicts, disagreements and other differences of opinion through appropriate administrative channels;
- Offering constructive feedback to improve patient care and operations; and,
- Practicing in a manner consistent with medical staff bylaws and regulations.

Disruptive behavior is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Examples of disruptive behaviors may include, but are not limited to:

- Threatening or abusive comments;
- Profanity or similarly offensive language;
- Demeaning behavior such as name-calling;
- Criticizing other caregivers in front of patients or other staff;
- Racial or ethnic jokes or comments;
- Inappropriate physical contact, sexual or otherwise;
- Sexual comments or innuendo;
- Refusal to cooperate with other staff members;
- Refusal to abide by Medical Staff bylaws, and other organizational policies, rules and regulations or to perform patient care responsibilities.

For non-employed members of the medical staff, medical staff governance documents should address disruptive behaviors, educate on these behaviors, and provide a process for reviewing and acting on allegations of disruptive behaviors within the patient care environment.

References:
RESTRAINTS

A restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely or a drug when used as a restriction to manage the patient's behavior or freedom of movement, not a standard treatment for pt's condition.

1. **Lists less restrictive alternatives to the use of restraints (the goal is to be restraint free by using least restrictive alternatives):**
   - Provide for companionship and supervision (have family at bedside).
   - Modify the environment (all items within reach of pt).
   - Provide reality orientation and psychosocial interventions (involve spiritual care).
   - Offer diversionary and physical activities (provide radio/TV, ambulate pt in hallway).
   - Design creative alternatives (offer toileting q 1-2 hours).

2. **Describes three (3) situations where restraints may be used including:**
   - Physical abuse to patient, other patients and/or staff.
   - Physical injury to self.
   - Unsafe interference with therapeutic devices.

3. **Describes four (4) behaviors which may indicate the use of restraints including:**
   - Combative
   - Extreme verbal aggressiveness
   - Removal or attempts to remove tubes, lines or dressings.
   - Confusion and disorientation with potential for wandering or falls.

4. **Describe the selection and application of restraints including:**
   - Selection of least restrictive restraint first.
   - Securing restraint to bed frame only never to side rail.
   - Application according to manufacturer's instructions.
   - Never placing restraints over dressings or IV sites.
   - Elevating HOB 15-30 degrees unless contraindicated.
   - Uses a bow or slip knot to tie restraints.
   - Make sure restraints are loose enough to prevent circulation or skin problems.

5. **Describes the checks and interventions that are used to prevent complications from the use of restraints including:**
   **At least every 2 hours Non-Violent and every 15 mins for Violent/Self Destructive**
   - Assesses patient for physical and psychological distress and provide CPR first aid or appropriate interventions as needed.
   - Check respiration status for vest restraints. Respiration every 15 mins and VS every 2 hrs for Violent/Self Destructive.
   - Checks proper application of restraints, circulation, joint mobility, skin integrity under restraint and sensation of restrained limb.
   - Checks LOC, orientation, emotional status.
   - Releases behavioral restraints. One limb at a time if necessary (behavioral) every 2 hrs.
   - Performs active range of motion (ROM) exercises and changes position of patient.
   - Offers toilet, hygiene, fluid and nourishment as ordered by MD, every 1 hr for behavioral.

6. **Lists the main components of an order for non-violent restraints in the acute hospital.**
   - Attempted/considered less restrictive interventions (documented by RN)
   - Each episode of restraint has an order that is timed, dated, and signed by MD.
   - Clinical justification.
   - Each order states the type of restraint to be used
   - Each episode of restraint has time limits documented, not to exceed 24 hours.

7. **Describes the use of restraints for violent/self destructive behavior:**
   - Used for emergency behavioral management of patient.
   - Unanticipated, severely aggressive or destructive behavior that places patients or others in immediate danger.
   - RN must be trained in the application of leather restraints (4 point hard restraints).
   - MD must be notified within a few minutes.
8. Describes how the use of restraints or seclusion for violent/self-destructive behavior:
- Obtain order within a few minutes of application from attending physician who is responsible for the care of the patient.
- Document attempts of less restrictive use of restraints (medication and time out).
- MD must come in within 1 hour to physically assess the pt to evaluate pt face to face assess and document behavior. If the order is terminated, the MD is still required to do a face-to-face evaluation of the patient.
- Order time frame is every 4 hrs. After an RN assessment, an additional 4 hours is deemed necessary, a telephone order to the MD can be used to renew.
- After 8 hours if the order needs to be continued, the MD must do a face to face re-evaluation of pt. and write the order.
- If restraints terminated prior to expiration of original order, a new order must be obtained prior to re-application.
- If at anytime the MD does not respond to request for order or face-to-face evaluation, initiate the chain of command.
- Patient must be monitored continuously (uninterrupted) and physically assessed and assisted every 15 minutes.
- Debriefing must take place after restraint/seclusion is used on Bridges only.

9. Describes the use of a chemical restraint:
- It is a medication that is used to control behavior or restrict freedom of movement.
- It is not a standard treatment for the patient's medical or psychiatric condition.

10. States that having all 4 side rails up is a method of restraining a patient
- Used to prevent patient from voluntarily getting out of bed

11. Seclusion is involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. Used to prevent injury to others, pt is not harming self.
- Pt restraints are used when person has the potential or is causing harm to self

12. Describe the use of nonphysical interventions skills to deescalate the behavior (must be trained to use CPI).

<table>
<thead>
<tr>
<th>Patient</th>
<th>Staff Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Supportive</td>
</tr>
<tr>
<td>Defensive</td>
<td>Directive</td>
</tr>
<tr>
<td>Acting out person</td>
<td>Nonviolent Physical Crisis Intervention</td>
</tr>
<tr>
<td>Tension reduction</td>
<td>Therapeutic Rapport</td>
</tr>
</tbody>
</table>

13. Describe the Supportive Stance and Nonverbal communication to use when approaching a possibly violent individual.
- Proxemics (personal space) stay at least 3 feet (one leg space) away
- Kinesics (body posture and motion) less threatening is off to the side at an angle, keep your hands out in the open, at your sides if possible.
- Paraverbal Communication 85-90% of communication is not spoken. Watch tone, volume, and cadence of voice.

14. Describe when restraints can be discontinued.
- RN is responsible to assess pt's response to restraints: Level of consciousness, orientation and emotional status to determine clinical justification to continue or for potential reduction or early termination of restraints.
- If these alternative measures do not work and restraints need to be reapplied, a new order must be obtained.

15. Each episode of restraints will be documented in pt's medical record.
- RN will document:
  - Considered attempts of alternatives and least restrictive measures.
  - Reason for restraint
  - Application, reapplication or discontinuation of restraint.
  - Every 2 hour assessment for Non-violent/non-self destructive behavior.
  - Every 15 minute assessment for violent/self destructive behavior.
  - Document education provided to patient and family regarding the use of restraints.
  - Document the plan of care for the patient in restraints.

16. Death relate to restraint use must be reported.
- Hospital must report the following to CMS:
  - Any death that occurs while a pt is in restraint/seclusion.
  - Any death that occurs within 24 hrs after pt has been removed from restraint/seclusion.
  - Any death known to hospital that occurs within 1 week after restraint/seclusion where it is reasonable to assume that the restraint/seclusion contributed to death.
Policies and Procedures
The Infection Control policies and procedures that you must follow are located in the Infection Control Manual. To access the Manual online first, go to the Providence Health and Services California Intranet. From the QuickLinks click on the Policy & Procedure Library. Under the Little Company of Mary Service Area select Infection Control. To access some policies that are specific to PLCMSP go the Little Company of Mary San Pedro section and select Infection Control. For further information or questions, call the Infection Preventionist at (310) 514-5475 or beeper (310) 225-7936.

OSHA Exposure Control Plans
In accordance with OSHA regulations, exposure control plans have been formulated for the prevention of transmission of tuberculosis and blood borne pathogens. These exposure control plans are updated annually and are located in the Infection Control Policy and Procedure Manual.

Blood/Body Fluid Exposure
Exposure to blood or other potentially infectious material is defined as:
- Injury with a contaminated sharp object (e.g., needle stick, scalp cut).
- Spills or splashes of blood or other potentially infectious materials onto non-intact skin (e.g., cuts, hangnails, dermatitis, abrasions, chapped skin), or onto mucous membrane (e.g., mouth, nose, eyes)

Immediately following an exposure to blood or other potentially infectious material:
- Wash needle sticks and cuts with soap and water.
- Flush splashes to the nose, mouth, or skin with water.
- Irrigate eyes with clean water, saline, or sterile irrigant.

There is NO scientific evidence that using antiseptics or squeezing the wound will reduce the risk of transmission of a bloodborne pathogen. Using a caustic agent such as bleach is NOT recommended.

In case of blood or body fluid exposure you MUST:
- Report to Employee Health immediately. After hours, report to the Emergency Department for follow up and treatments.
- Notify your supervisor.
- Fill out supervisor’s incident report.
- Fill out worker’s compensation report.

Hand Hygiene
Be aware... Diseases in the health care workplace can easily be spread to employees and patients. To prevent this---practice good hand hygiene using soap and water or alcohol based hand rub.

Hand hygiene should be:
- Immediate and thorough if contaminated with blood or other potentially infectious materials (OPIM).
- Performed after each patient contact.
- Performed after each glove removal.
- Remove personal protective equipment and wash your hands before leaving patients’ room.

Hand Hygiene Guidelines
When to wash your hands with soap and water
- when hands are visibly soiled with dirt, blood or body fluids
- before eating and after using a restroom
- if exposed to spore-forming organisms (C. Diff, Anthrax etc.)

When to use an alcohol-based hand rub:
- before having direct contact with patients
- before putting on sterile gloves when inserting catheters or other devices that do not require a surgical procedure
- after contact with patient’s intact skin during procedures such as taking vital signs or lifting
- after contact with body-fluids/excretions, mucous membranes, non-intact skin, and wound dressings
- after moving from a contaminated body site to a clean body site during patient care
- after contact with inanimate objects (including medical equipment) close to the patient
- after removing glove

No Artificial nails for all staff with direct patient contact
Do not bring lotion from home. Use lotion provided for staff use at Nurses Station.
Standard Precautions
For all patients regardless of diagnosis, treat all blood and body fluids as potentially infectious.
It is your responsibility to understand, learn and always practice STANDARD PRECAUTIONS:
- Hands will be washed before and after direct patient contact and immediately if accidental contact with blood or body fluids from any patient occurs.
- Gloves should be worn when contact with blood or body fluids from any patient is anticipated.
- Gloves will be removed and hands will be cleaned between each patient. No gloves in the hallway.
- Gown, mask and goggles should be worn when performing or assisting in any invasive procedure which may result in accidental splattering of blood or body fluids from any patient.
- No eating, drinking, applying cosmetics or handling contact lenses at the Nurses Station and work area.

Airborne Precautions (TB, Measles, Varicella)
For organisms that are dispersed widely by air.
Patients on airborne precautions must be placed in a negative pressure room and all staffing must wear an N95 mask to enter room. At PLCMMC San Pedro, Negative Pressure Rooms are 263, 281, 381, the Bronch Room (203) in Ambulatory Care, and CCC beds 3 and 9. To maintain negative pressure, door must be kept closed, and for Rooms 263, 281, 381, and Bronch Rooms (203), fan by window must be switched on. Negative pressure monitor outside room must have green light on at all times when room is used for a patient on airborne precautions. For patient transport, place a surgical mask (not an N95) on the patient.

Droplet Precautions (Pertussis, Strep Pharyngitis, Influenza, etc.)
For organisms that are large particle that spread when patient coughs, sneezes and talks.
Place patient in a private room, (or if not possible, must be >3 feet from roommate) and wear a surgical mask when working within 3 feet of patient. Patient wears surgical mask for transport out of room.

Contact Precautions (MRSA, VRE, C. Diff, RSV, any Undiagnosed Rash, etc.)
For organisms that are transmitted when touching the patient directly or touching contaminated surface.
- Private room, or cohort with another patient with same organism (call Infection Control for assistance).
- Wear gown and gloves every time you enter the room. Wear a mask if organism is in respiratory tract and patient has respiratory symptoms (coughing, etc.).
- Remove gloves and gown and wash hands before leaving room.
- Duration of Isolation for MRSA:
Place all MRSA patient in isolation until three (3) consecutive negative cultures, taken at least 24 hours apart and, have been obtained from the original site of infection or colonization, other wounds, and nares. These cultures must be obtained after all antibiotics effective against MRSA have been discontinued for at least 24 hours. The Infection Control Practitioner should be notified for consultation prior to removing the patient from isolation.

Duration of isolation for VRE:
Discontinuation of isolation requires VRE negative results on at least three (3) consecutive occasions (at least 1 week apart) for all cultures from multiple body sites including the original positive site, stool or rectal swab, perineal area, axilla or umbilicus, wound, urinary catheter, and/or colostomy, if present. The Infection Control Practitioner should be notified for consultation prior to removing the patient from isolation.

Sharps
Handle sharps with care. Do not recap used sharps. Always activate the engineered safety device and correctly dispose of sharps in sharps container.

Biohazardous Waste
Biohazardous waste is:
- Waste which has blood, blood products, bloody body fluids, and containers or equipment containing blood.
- Waste containing discarded materials contaminated from highly communicable diseases (such as Smallpox, Anthrax, Ebola, Cholera), as defined by the Infection Control Committee.

Note: All other waste from isolation rooms will be discarded in the regular trash.

All Biohazardous waste is to be placed in a red bag and transported to the biohazardous storage room in a rigid leak proof container. This transport container is located in the soiled utility room on each unit.

Pharmaceutical Waste
- Place pharmaceutical waste in special containers marked “Pharmaceutical Waste”, or return to pharmacy in med cart cassette drawer or Pyxis return bin.
<table>
<thead>
<tr>
<th>Type of Waste</th>
<th>Regular Solid Waste (Trash)</th>
<th>Biohazard Waste</th>
<th>Sharps Waste</th>
<th>Pharmaceutical Waste</th>
<th>Chemotherapy Waste</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples</strong></td>
<td>If you do not see fluid or heavily caked blood, it goes in the regular trash!</td>
<td>Any disposable item with fluid or heavily caked blood:</td>
<td>Anything sharp that could cut or puncture skin:</td>
<td>Any partially used/residual medications for incineration:</td>
<td>Any waste items that contain or are contaminated with chemotherapy:</td>
</tr>
<tr>
<td></td>
<td>- Personal Protective Equipment (PPE): gloves, masks, disposable gowns, etc.</td>
<td>- Items capable of dripping blood when compressed or heavily caked with blood:</td>
<td>- All needles (with or without syringes attached)</td>
<td>- Vials, ampules or bottles with residual medication</td>
<td>- Empty (non-pourable) chemotherapy IV bags</td>
</tr>
<tr>
<td></td>
<td>- Dressings, pads, diapers</td>
<td>- Blood tubing, IV bags, drains (UP, Hemovac, etc.)</td>
<td>- Staples, pins, clips and wires</td>
<td>- Loose tablets or capsules</td>
<td>- Disposables contaminated with chemotherapy</td>
</tr>
<tr>
<td></td>
<td>- Foley bags, bedpans, etc.</td>
<td>- Dressings or pads capable of dripping blood or bloody fluids when compressed</td>
<td>- Glass pipettes, slides</td>
<td>- Topical medications</td>
<td>- Bedpans, urinals, emesis basins, etc. from patients receiving chemotherapy</td>
</tr>
<tr>
<td></td>
<td>- Tissues/paper towels</td>
<td>- Glass or plastic containers or bottles with bloody fluids</td>
<td>- Scalpels/scalpel blades</td>
<td>- Skin patches with topical medications</td>
<td>- Note: Place linens contaminated with chemotherapy in specially marked yellow plastic bags</td>
</tr>
<tr>
<td></td>
<td>- Syringes (without needles)</td>
<td>- Suction canisters or chest tubes with bloody fluids</td>
<td>- Trocars and introducers</td>
<td>- IV bags and tubings with residual medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Blood glucose test strips</td>
<td>- Items contaminated with highly infectious materials (consult ICP immediately!)</td>
<td>- Guidewires</td>
<td>- Opened pharmaceuticals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- IV tubing and bags (without blood or medications)</td>
<td></td>
<td>- Broken glass</td>
<td>- Note: Return unopened, unused/expired medications to Pharmacy for credit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Glass bottles (unbroken)</td>
<td></td>
<td>- Razors/razor blades</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Container</strong></td>
<td>Clear Plastic Bag</td>
<td>Red Bag in rigid, labeled Biohazard Container</td>
<td>Sharps Container</td>
<td>Pharmaceutical Waste Container (white with blue lid)</td>
<td>Yellow Chemotherapy Waste Bag</td>
</tr>
<tr>
<td><strong>Disposal</strong></td>
<td>Knot bag and place in regular solid waste container.</td>
<td>Knot bag (goose neck) and place in Biohazard Container. Transport red bags from the bedside to the Biohazard room in the rigid carrying containers.</td>
<td>When 2/3 full or reaches the manufacturer’s full line, lose container and place in Sharps Bin in Biohazard room.</td>
<td>Place in Pharmaceutical Waste Containers or return to Pharmacy. When full, call 1-FIX for pick up.</td>
<td>EVS will transport to Chemotherapy Waste storage room. Call 1-FIX for pickup.</td>
</tr>
</tbody>
</table>
Little Company of Mary

Safe Patient Hand Off

Most communication breakdowns occur in verbal communications between staff. "Hand Off" communication can provide accurate information about a patient’s care, treatment and services, current condition and any recent or anticipated changes. The information communicated during a hand off must be accurate in order to meet the patient safety goals.

A standardized list of elements for patient information can enhance hand off communication between patient caregivers can limit breakdown in communication that may contribute to error or oversight.

The critical elements of patient information and condition that is expected to be communicated in a shift-to-shift, caregiver to caregiver or any type of patient transfer report should include the following:

- Name, age and room number
- Reason for admission/diagnosis
- Admitting MD
- Code Status
- Vital signs and any trends
- Mental status
- Medications given and time given
- Allergies
- Abnormal and/or pending laboratory tests
- Abnormal and/or pending studies
- IVs, location, and type
- Skin integrity
- Pain Level and comfort/function goal
- Fall risk
- Diet/swallowing status
- Isolation status
- Restraints
- Other significant information

Communication breakdowns put patients at RISK.

According to the Joint Commission, the leading cause of adverse events is lack of or inadequate communication (65%). Of the communication root causes identified, verbal communication was the most common problem (55%), as compared to written (35%) and electronic (10%). Of the communication problems identified, 60% occurred among staff. The second leading cause is lack of or inadequate education or training.

Communication issues that lead to problems include taking and processing verbal or telephone orders. Some tips on taking telephone orders:
• Read back the order.
• Talk slowly and take your time.
• Use standardized abbreviations approved by the hospital and do not use abbreviations that have been identified as “do not use”.
• Be familiar with sound-alike medications and generic names. If unsure, ask someone or take the time to look it up.

Remember to check and double-check all orders, procedures, medications, and processes prior to administering them.

Four Keys to prevent errors
1. Pay attention to detail
• Use your critical thinking skills
2. Communicate clearly
• Be aware of your human limitations
• Use Safe patient Hand Off communication amongst caregivers
• Use S-B-A-R to communicate patient care issues to a physician: Situation-Background-Assessment-Recommendation
3. Be assertive to ensure resolution of patient issues.
• Speak up and state information with appropriate persistence until there is a clear resolution.
• State “I’m uncomfortable” to advocate for the patient.
4. Have a team-building attitude
• Be courteous and respectful of the other team members
• Be helpful and supportive to each other
• Expect others to be helpful to you

S-B-A-R to Communicate Patient Issues

1. Situation:
• State your name and unit
• I am calling you about: patient name and room number
• The problem I am calling about is:

2. Background:
• State the admission diagnosis and date of admission
• State the pertinent medical history
• A brief overview of the treatment to date

3. Assessment:
• Most recent vital signs, changes or trends
• Objective and subjective signs and symptoms
• Any potentially relevant findings:
4. Recommendations:
   - Transfer the patient to ICU?
   - Come in to see the patient? When?
   - Ask for a consultant to see the patient now?
   - Start or discontinue a treatment?

Helpful tips:
Practice with the SBAR tool.
Formulate in your mind what you are going to say before placing the call.
Have the patient’s chart and relevant assessment findings readily available before placing the call.
Place yellow color sticker on the patient’s ID near the patient’s bed indicating "Fall Risk."

Place corresponding yellow caution sign

Score

Determine the patient’s Morse Scale

Identity Risk Level

41+ = High Risk
25-40 = Low Risk
0-24 = No Risk/Prevention
Fall prevention

- Educate patient and family regarding
- Answer call light promptly
- Eliminate clutter in room and clear path to the bathroom
- Raisel. Light within reach, upper slide rails are raised.
- Bed in low position, brakes locked, call

Strategies (Morse Score 0-24)

Basic Fall Risk Prevention
Reorient patient as needed

Mental Status Issues
Provide Home Safety Checklist upon discharge
Assist with ADLs as needed
Assist patient to ambulate at regular intervals to maintain, enhance and/or restore balance
Use safety belt when up in chair

Mobility Issues
Instruct patient on how to use assistive devices (canes, walkers...)

Elimination Issues

Morse Score 25-40
Yellow Caution Sign

Low Risk Prevention Strategies –
Familiarize yourself with the use of a sitter.

If above steps are unsuccessful and patient continues to try to get out of bed and no
Encourage family to stay with patient
Use safety belt when up in wheelchair

Has an intubated patient is unable to bear weight
Observe patient every 30-60 minutes if patient is confused and overestimates abilities or

Mental Status Issues

Consider Home Health Referral for Home Evaluation for Fall Prevention

Screen for possible referral for inpatient/outpatient strengthening exercises or
Physical therapy consult to collaborate in developing a body
Seek physical and or occupational therapy consult to strengthen and prevent fatigue and muscle weakness

Mobility Issues

The transferring unit will make receiving unit aware of patients high fall risk and high

Medication Issues

Consult Pharmacist to review patient’s medication to review effects of polypharmacy and
Laxatives, bowel prep

Time medications for daytime response if possible (diuretics)

41+

Yellow Caution Sign (Morse Score)

High Risk Prevention Strategies –
The RN will complete an NUR:

- New orders or additional precautions implemented completed
- Name of physician notified and if an evaluation was
- Vital signs, any observable injuries and skin assessment

- Light within reach, upper side rails are up...
- Safety measure(s) in effect at the time of the fall (i.e., call
- If the fall was un-witnessed or witnessed by whom
- Found, and what happened
- Date, time, location of the fall or where the patient was

RN to include the following:

A "Focus note" in NUR is to be completed by the

Should a Fall Occur...
ATTEND

Fall Prevention Bundle

A
Assess fall risk using the Morse Tool at admission and every shift.

T
Turn on bed or chair alarms for patients at risk.
- Place highest risk patients in available alarmed beds.
- Place at risk patients near nursing station.

T
Toileting during rounds.
- Assess when patient was last toileted and be assertive about toileting. Rather than simply asking the patient if they have to go, say, “Let’s go to the restroom now while I am here to help you.”
- Educate patient and family about hourly rounding and the “5 Ps”
- Answer call lights promptly to avoid patients getting up without help.
Education and Environment

- Education patient/family/visitors that patient is at risk of falling
- Remind patients/family to call for assistance before getting up
- Use standardized fall signage
- Educate staff members to use gait belts and have them available
- Keep beds in low position
- Use non-slip footwear
- Keep environment uncluttered and free from tripping hazards
- Keep assistive devices & personal belongings in patients’ reach

Never leave at-risk patients alone on the toilet or commode

- Most falls are unobserved. Keep patient in sight while toileting

Debrief every fall

- Notify unit manager or Nursing supervisor as soon as a fall occurs
- Conduct a team debriefing session as soon after the fall as possible
**SECTION A: POST FALL CHECKLIST - To be completed by Charge Nurse**

- Fall Response Team to respond to patient fall and facilitate second page debriefing form.
- ☐ Assess patient/treat injuries
- ☐ MD Notified. MD to be notified for all patient falls. If the fall was un-witnessed or involved a potential head injury, complete a neuro exam every 15 minutes unless the MD directs otherwise.
- ☐ Nursing Supervisor/Manager notified
- ☐ Document in Electronic Medical Record — Use Change in Condition screen. Include all circumstances surrounding the fall, assessment/treatment of injuries, who was notified, etc.
- ☐ Care Plan Updated
- ☐ Was family/patient rep notified? ☐ No (why not?)
- ☐ UOR Completed

**SECTION B: FALL EVENT DETAILS**

<table>
<thead>
<tr>
<th>Date of fall:</th>
<th>Time of fall:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Department/Nursing Unit where fall occurred:</th>
<th>Last Time Rounding Done:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morse Fall Assessment documented every shift:</td>
<td>Last Rounding offered/done:</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>41+ High</td>
<td>Low</td>
</tr>
<tr>
<td>0-24 Prevention</td>
<td></td>
</tr>
</tbody>
</table>

- Was there a Fall Risk signage in the patient's room?  Yes | No
- Last time toileting offered/done: |

**Physical location of fall:**
- From bed
- Between bed and bathroom
- From chair
- Between chair and bathroom
- From Commode
- From toilet
- From gurney
- In hall
- Shower/tub
- Therapy/radiation/other treatment
- Other

- Was fall witnessed?  Yes | No
- Was fall assisted?  Yes | No

- If fall was assisted, what transfer equipment was in use at the time of the fall?
  - None
  - Transfer/gait belt
  - Lift
  - Walker
  - Sliding board/slip sheet
  - N/A

**Injuries:**
- No
- Yes
- Describe injuries:

**Risk factors identified:**
- Polypharmacy (4 or more meds)
- Psychotropic drugs
diuretics/laxatives
- Urinary/bowel urgency/frequency (UTI, diarrhea)
- Sedatives/hypnotics
- Orthostatic hypotension
- Poor mobility/gait
cognitive impairment
- Visual/hearing impairment
- Other

**Preventative measures in place prior to the fall:**
- Low Bed
- Bed alarm
- Chair alarm
- Posey Vest
- Wrist restraints
- 4 side rails
- Sitter
- Non-slip footwear
- Call bell/belongings in reach
- Sign by bedside
- Sign outside door
- Patient/Family reminder sign in room
- Other

**What patient/family education about fall prevention was done before the fall?**
<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Team Members attending (names/titles):

What did the patient/family report was the reason for the fall?

What were the contributing factors identified? (from Section B)

**WHY did patient fall?**

**WHY did that happen?**

**WHY did that happen?**

Root Cause(s) of fall determined:

What could have or should have been done differently before the fall that may have prevented it?

Preventive measures taken after the fall that directly address the root cause(s) of the fall:

**This form is NOT part of the medical report. One copy should be given to the unit manager and one copy sent to Risk Management.**