

# R E A D Y

**Regulatory** **Education** **Accountability** **Dedication** **You make a difference**

## Associate Regulatory Readiness Handbook 2019

### Important Phone Numbers

Employee Assistance Program:	719 634-1825
Operation Center:	89-2111 or 776-2111
Infection Control:	PH 89-5253 SFMC 81-2125
Patient Safety/Risk Mgmt:	PH 89-5828 SFMC 81-2108
Patient Reps:	PH 89-5379 SFMC 81-2121
Regulatory:	PH 89-5865 SFMC 81-2110
Safety Officer:	PH 89-2122
Security:	PH 89-5596 SFMC 81-1122



**Centura Health®**

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# The Why of this Booklet

## You will:

1. Be able to answer frequently-asked survey questions and feel confident in your responses.
2. Understand your role in the survey process.
3. Know policies and procedures and where they are located. Policy Tech/MyVirtualWorkplace/Reference/Policy and Procedures
4. Speak to and locate unit performance improvement projects, and the role you played.
5. Understand your role in our patient safety culture including reporting near misses.



## Accreditation

### When will we be surveyed? (EVERY DAY IS SURVEY DAY!)

Our last Triennial survey was May 15<sup>th</sup> 2016 therefore we can anticipate survey anytime between Dec 1<sup>st</sup> 2018 and May 15<sup>th</sup> 2019 but will likely be surveyed between March 1<sup>st</sup> 2019 and May 15<sup>th</sup> 2019.

### Who is The Joint Commission?

The Joint Commission (TJC) evaluates and accredits nearly 21,000 healthcare organizations and programs in the United States. An independent, not-for-profit organization, TJC is the nation's predominant standards-setting and accrediting body in healthcare. The Joint Commission Mission Statement: To continuously improve healthcare for the public, in collaboration with other stakeholders, by evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

### Why do we seek accreditation?

In order for a healthcare organization to participate in and receive payment from the Centers for Medicare or Medicaid (CMS) programs, it must meet the eligibility requirements for program participation, including a certification of compliance with CMS conditions of participation (CoPs), standards, set forth in federal regulation/law. Because The Joint Commission has and enforces standards that meet or exceed the federal Conditions of Participation, CMS had "deemed" authority to TJC to evaluate compliance with CMS' CoPs as part of their survey process. We have elected to achieve accreditation via TJC for several reasons:

- TJC is a widely-recognized standard-setting organization known for driving patient safety and risk reduction efforts.
- TJC is known for its collaborative approach and works predominantly with professional health-related organizations in the development of those standards.
- We are not subject to full annual validation surveys by CMS through our "deemed" accredited elections.
- The majority of our payers (insurance carriers) will not contract with healthcare entities that are not accredited.

### What is the survey process?

Since 2006 all TJC surveys have been unannounced. We are subject to an unannounced survey between 18 and 36 months after a previous full, unannounced survey. Most surveys occur between 32-36 months after the previous triennial accreditation.



## Accreditation

The Joint Commission accreditation survey process provides an assessment of an organization's compliance with standards and their elements of performance. Our organization's compliance will be based on:

- Patient, family and caregiver interviews via tracing actual patient care including the documentation of that care.
- Performance improvement data/trends.
- Verbal information provided to the Joint Commission.
- Surveyor observations of care, activities and the environment.

### What is tracer methodology?

The tracer is the method surveyors use to determine how well we are delivering patient care. **Surveyors want to know what you do and how you do it.**

During the tracer, surveyors will:

- Review the medical record with the caregivers caring for the patient.
- Interview caregivers.
- Observe care.
- Assess the environment.
- Evaluate data.

### Can the surveyor talk to my patient or his/her family?

Yes! However, it is expected that you will ask the patient for permission for the surveyor to ask him or her questions. This does not violate any confidentiality or privacy regulations, nevertheless, you are the caregiver and you know the patient's condition. You may say it is a not the right time to visit the patient if that is the case.

### Survey etiquette

#### 1. Be positive!

- Talk about things that you, your unit and the facility does well.
- Talk about improvements that your department has made and how you participated in the improvement.
- Be professional. Please do not place blame or criticism on other caregivers or other departments.

**2. The surveyors are our guests. Let's be the best hosts** possible and observe common courtesies. All behaviors are observed by the surveyors.

## Accreditation

### 3. When a surveyor is in your area:

- Surveyors may ask anyone a question – any person in any role and at any time.
- Do not avoid surveyors - we want them to feel welcomed by our organization and for caregivers to convey confidence.
- Know your resources: clinical and safety policies and procedures (P&Ps), other online resources like SDS sheets, physician directories, National Patient Safety Goal posters, unit specific bulletin boards and PI data, etc.
- Perform a quick environmental assessment-make sure medication is secure, halls are clear, protected patient information is private, and that the department is clean and safe.
- Refresh your memory on the location of fire extinguishers, oxygen shut-off valves and general fire procedures.

### 4. If a surveyor asks you a question:

- Don't panic. You know your job the best!
- Think about the question before you answer.
- Answer only the question that was asked.
- If you get scared and go "blank:"
  1. Ask the surveyor to restate the question.
  2. Someone else in the group may answer, but the same person shouldn't be answering all the questions. Managers: offer supportive comments like, "*Amber, tell her about \_\_\_\_\_*" or remind caregivers of the relevant policy, etc.
- If you don't know the answer, **know where to find it**. You may refer to policies. The survey escort will ensure items requested are communicated and provided.
- If you do not know the answer, it's okay to say, "*I don't know, but I would ask my supervisor, or, I don't know but I would tell the nurse.*"
- If you are involved in a true emergency, explain this and make a respectful exit. Please do not say "*I am too busy*" and walk away.
- Remember: a surveyor is not asking questions outside of your scope or practice or work to trick you.

## Accreditation

- If you disagree with a surveyor, it is okay to discuss the issue and request clarification. Please, **do not** argue with a surveyor.
- Always, always tell the truth in your own words. Falsification of information may result in less than full accreditation.

**Surveyors would rather know that we have identified an issue and are working on it, even if it isn't fixed, than to see that we did not realize there was a problem.**



## Culture of Patient Safety



### Culture of patient safety

Quality and patient safety are linked. In healthcare, quality is the degree to which processes and results meet or exceed the needs and desires of the people served—including aspects of safety. Patient safety, as defined by the World Health Organization, is “the prevention of errors and adverse effects to patients that are associated with healthcare.” Safety is what patients, families, caregivers and the public expect from our facility. While patient safety events may not be completely eliminated, harm to patients can be reduced and the goal is always **ZERO harm**.

#### Be prepared to talk about patient safety culture:

- *Have you ever completed a safety culture survey?*
- *Have you seen the results of a safety culture survey? Does your manager/supervisor discuss the results?*
- *Is there a process for reporting intimidating behavior? Do you feel comfortable reporting intimidating behavior?*
- *When an error occurs, do you have confidence that leadership will take an appropriate look at how the system or process is accountable as opposed to an individual?*
- *What process do you have in place for reporting “near misses” or an error that occurred but did not reach the patient?*
- *Does leadership conduct Root Cause Analyses (RCA) of “near misses” that are reported?*

#### What is a sentinel event?

Any event resulting in unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying conditions, or the event is one of the following:

- Death.
- Permanent harm.
- Severe temporary harm.

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital’s emergency department (ED).
- Unanticipated death of a full-term infant.
- Discharge of an infant to the wrong family.
- Abduction of any patient receiving care, treatment, and services.

## Culture of Patient Safety

- Any elopement (any unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to the death, permanent harm, or severe temporary harm to the patient.
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups).
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital.
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a caregiver, licensed independent practitioner, visitor, or vendor while on site at the hospital.
- Invasive procedure, including surgery on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure.
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery.
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field.
- Delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care. Any intrapartum (related to the birth process) maternal death.
- Severe maternal morbidity (not primarily related to the natural course of the patient’s illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm.

#### • [Adverse Clinical Event Reporting Policy](#)

#### What is the process for handling a potential sentinel event?

Your role is the recognition of the sentinel event or potential sentinel event, preserving the equipment/supplies involved and environmental conditions and alerting your immediate supervisor/department director.

## Culture of Patient Safety

### What is a root cause analysis?

*Root cause analysis (RCA) or critical event analysis (CEA)* is a systematic review of sentinel events and other potentially catastrophic events to identify basic and contributing causes of the event.

RCA's/CEA's have the following characteristics:

- An interdisciplinary team, involving those closest to the process under review, performs the review.
- The review focuses primarily on systems and processes rather than on individual performance.
- The analysis digs deeper by asking “what” and “why” until all aspects of the process are reviewed and contributing factors are considered.
- The analysis identifies and suggests changes that could improve the systems and processes evaluated.
- These changes could include redesign of processes/systems or development of new ones that could improve performance and reduce the risk of future adverse events or close calls (insert facility specific).



### What is an FMEA?

It is a *failure mode effects analysis* – a proactive way to evaluate a process, identify possible failures and to correct them before an occurrence happens

### What FMEAs have been done at Penrose St.

**Francis Hospital** A FMEA was recently completed on Suicide Prevention - Identification and Care of the At-Risk Patient Please familiarize yourself with the At-Risk Policy

## Environment of Care

The leader assigned responsibility for compliance of this chapter is Director of Facilities

### Safety and security

#### Who is your Safety Officer?

Heidi Baird 719-776-2122 heidibaird@centura.org

#### How often do caregivers receive safety training?

Minimum of annually

#### How does the facility identify individuals entering its facility, including non-facility personnel?

Per policy: “Identification Badges (Centura)”, all Centura associates and other non-facility personnel are required to wear an identification badge when performing services for Centura Health.

#### What should I know about MRI safety?

Only authorized caregivers with appropriate training should enter the MRI area.

#### Is smoking allowed?

All Centura Health campuses including parking lots are smoke free.

### Hazardous Materials and Waste

#### What hazardous materials are used in your area?

- It is important to know what hazardous materials are stored in your department.
- Information from hazardous materials is available online via *Safety Data Sheet (SDS) Online*: [MyVirtualWorkplace/Reference/Resource/MSDS Online](#)
  - SDS includes manufacturer information, including hazardous ingredients, physical and chemical characteristics, safe handling, and spill and exposure procedures.

#### When do you have to label a container into which you pour chemicals?

Always

#### Know where personal protective equipment (PPE) is located and what is the department's process to replenish PPE

Penrose Central Supply 719-776-5442 or St. Francis 719-571-1626

## Environment of Care

### Who do you call for a chemical spill?

Call #1234 to announce a hazardous material spill. Caregivers who are properly trained may clean up the spill while using appropriate PPE if safe to do so.

### How do you properly dispose of pharmaceutical waste?

Refer to posted instructions in all medication disposal areas.

### PHI should be defaced as much as possible

If PHI can't be defaced on an empty medication container it may be placed into red bag waste.

### Oxygen tank safety

#### How should oxygen be stored?

Full/partial tanks should be segregated from empty oxygen tanks. The racks they are stored in should be properly labeled. There should never be more than 12 cylinders in a given storage space.

- Oxygen tanks should be stored vertically and properly secured. Damaged oxygen cylinders can turn into deadly projectiles.

#### How do I move oxygen safely?

- When moving oxygen cylinders, even for short distances, use a cart or carrier designed for their transport.
- If transporting via hospital bed or stretcher, ensure the cylinder is safely secured. It should not be removed from its carrier and laid on patient beds.

#### What is needed for a safe hand-off of a patient with oxygen?

- O2 flow rate for patient.
- Amount of oxygen/time left in tank (O2 tank duration chart).

#### What types of security incidents do you report?

Any potentially dangerous or threatening situation involving safety of caregivers, patients or visitors, which includes any observations of physical or verbal abuse.

#### How do you contact security?

Emergent: 89-2111

Non-Emergent: PH 89-5596

SFMC 81-8465



Rocky Fails,  
Security -  
keeping us  
safe at the  
Mineral  
Office

## Environment of Care



### Fire safety

#### What is the process used if you were to discover a fire?

RACE and PASS (note: order of process is important)

#### What does the acronym RACE stand for?

- R** = Rescue anyone in immediate danger
- A** = Alert (activate the fire alarm by calling #1234 and/or activating the nearest pull station)
- C** = Contain the fire (close all doors to help prevent smoke and fire from spreading)
- E** = Extinguish/evacuate (only attempt to put out small fires if you have been trained to do so. Follow evacuation procedures as directed.)

#### Where is the nearest fire extinguisher and how do you activate it?

Know location within your work area. Activate a fire extinguisher using **P-A-S-S**

**P**= Pull the pin

**A**= Aim the extinguisher at the base of the fire

**S**= Squeeze the handle holding the extinguisher upright

**S**= Sweep from side to side at the base of the fire

#### If patients need to be evacuated in an emergency, how would you proceed?

- Listen to the person in charge.
- Evacuate horizontally first past the smoke/fire doors. **Red "SSSSSSSS" across the door**
- Know your department's emergency route.

### Medical equipment

#### How do you know equipment is working properly?

- The user checks equipment before it is used.
- Clinical Engineering inspects equipment upon delivery. If the equipment is determined to be functioning according to manufacturer specifications, it is calibrated and evaluated for appropriate setting of functional, audible alarms and in safe working order. The equipment is then tagged. The tag indicates the date it was checked, and the date it is due to be rechecked.
- Any equipment not functioning properly will be tagged and immediately removed from service.

## Environment of Care

### What do you do with broken or expired medical equipment?

- Tag it and remove it from service.
- Notify clinical engineering PSF 719-776-5301

### What do you do if equipment has harmed the patient or malfunctioned?

- Pull the equipment from service.
- Leave the equipment in its original state and include all associated disposables (tubing, etc.).
- Tag it and send to clinical engineering along with disposable items.
- Complete an occurrence report.

### How do you learn to use new equipment?

- In-services.
- Company representatives.

- Posters, pamphlets and videos.

## Utilities

### What do you do if there is a utility system failure, i.e. water, power, etc.?

Refer to **Failure of Utilities (PSF)** policy

### How is your facility prepared for a power outage?

- The facility has emergency generators that provide power during power outages.
- Essential equipment is always to be plugged into **red outlets**. All non-essential equipment is to be removed from red outlets during power outages.
- Fire safety equipment is powered by emergency generators, such as exit lights, smoke detectors, and emergency lighting.

### What should you do if the water supply to your department is cut off?

Use waterless hand disinfectant. Assess your immediate water needs and await instructions.

### Where is the oxygen shut-off valve in your work area?

Know the oxygen shut-off valve locations in your area.

### Who is permitted to shut off the oxygen zone valve in your unit?

Fire Department or Nursing Administrative Manager

**If important to your area, know your temperature, humidity and pressure monitoring requirements.**

## Emergency Management

### Construction

### How does the hospital minimize risk during a demolition, construction or renovation project?

The hospital should perform a pre-construction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services. Based on the results of the risk assessment extra fire drills may be performed and barriers may be put into place, etc.

### Patient care areas

### How do I maintain a safe functional environment?

Areas should be clutter free with continual access to exits (egress) Areas should be kept clear of offensive odors (perfumes, etc.) Furnishings and equipment should be kept in good repair

### Employee injuries

### If you are injured on the job, what would you do?

Notify your Supervisor immediately.

Refer to Workers' Compensation Program (Centura) policy

### If you were exposed to blood or body fluids what would you do?

Notify your Supervisor immediately.

Refer to Workers' Compensation Program (Centura) policy

### The leader assigned responsibility for compliance with this chapter is Emergency Preparedness Manager PSF Safety

The hospital's emergency operations plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, caregivers' responsibilities, utilities, and patient clinical and support activities during an emergency.

**Refer to the Emergency Operations Plan for initial actions and more information**



Steve Weaver,  
Plant Operations  
- 40 years of  
caring for our  
community at  
Porter Adventist  
Hospital

## Human Resources

The leader assigned responsibility for compliance with this chapter is **Director of Human Resources**

### Caregivers

#### – Qualifications

**What makes you competent to do your job?**

- Skills competencies with preceptor validation and signatures.
- Annual education via computer-based training or other mechanism.
- Maintaining current licensure and required certifications.
- Department specific orientation and competencies.
- Ongoing professional development.

**Do you oversee students as part of your job? What is your role?**

- Student rotations are coordinated via school and department manager. All students are supervised by faculty. Discuss how you act as preceptor to student if applicable. Be prepared to address whether students can enter information into the patient's record and what procedures are in place to countersign notes, if applicable Refer to Student Rotation Procedure, Clinical and Non-Clinical Areas (PSF) policy for more information

#### – Orientation

**How were you oriented?**

- All associates participate in orientation, unit-based orientation and complete ongoing education which are documented upon completion .

#### – Training and education

**What are some ways you receive ongoing education?**

- Newsletters, flyers, e-updates.
- BLS/PALS/ACLS and other certifications.
- Orientation to new equipment, new services, documentation changes, etc.
- Validation of competencies for low volume/high risk procedures.



## Human Resources

**What education/training have you received that incorporates team communication?**

Refer to Handoff Communication Policy

**How are caregivers educated on cultural diversity?**

Orientation and annual competencies, e-learning communication updates, and policies.

**What are the ages/populations of the patients you care for and do you have specific competencies related to caring for these populations?**

Yes- if you care for different age/populations (i.e., neonates, infants, pediatrics, and geriatrics) you should have age/ population specific competencies.

**What is the process to orient contract workers?**

- There is a Centura Health P&P entitled “Non-Facility Personnel File, Orientation, Evaluation, and Check In Requirements.” The purpose of this policy is to ensure that the requirements for on-site contract caregivers entering patient care areas unescorted is consistent with that required of employed caregivers, and to provide guidance for determining pre-employment, health screening, orientation, and required records for those contracted parties. This policy also outlines procedures for contract staff entering patient care areas to sign in and obtain a badge prior to performing work functions.
- Any contractor entering a patient care area should have a badge. If someone does not have a badge, ask questions and report this to your supervisor or Human Resources.

**Are there HR requirements for pet therapy animals?**

Yes. Each animal must meet several requirements to ensure it is healthy, clean and has current vaccinations. These animals must also demonstrate they have passed behavioral and training criteria as evidenced by current certification from an accredited pet therapy organization. See the Animal Visitation Policy in PPM for further information.

## Infection Prevention and Control

The leader assigned responsibility for compliance with this chapter is Infection Preventionists

How do you contact our infection preventionists?  
719 776-5253.

What precautions do you take to help prevent the spread of infections in patients?

- All healthcare providers who have direct patient contact will not wear artificial nails, extenders, or wraps. Fingernails must be clean and of a length that allows the associate to accomplish job tasks efficiently (recommended at or shorter than ¼ inch).
- Proper hand hygiene is the single most effective way to stop spread of infection.



When are you required to use soap and water?

Wash your hands with soap and water when:

- hands are visibly dirty.
- contaminated with blood or body fluids.
- caring for a patient with Clostridium difficile (C diff), Norovirus, or other unidentified diarrhea.

## Infection Prevention and Control

When are you required to sanitize your hands?

- Waterless hand disinfectant or soap and water must be used:
  - 1. Before Patient Contact**

**When?** Clean your hands before touching a patient.  
**Examples:** Examinations, helping a patient to move, checking name bands.
  - 2. Before an Aseptic Task**

**When?** Clean hand before and after an aseptic task  
**Examples:** Oral care, secretion aspiration, wound care, catheter placement, patient feeding, medication administration.
  - 3. After Body Fluid Exposure Risk**

**When?** Clean your hands immediately after an exposure to a bodily fluid and after removing gloves.  
**Examples:** After contact with any bodily fluids to include urine, saliva, sputum, feces, blood, etc.
  - 4. After Patient Contact**

**When?** Clean your hands after every patient contact.  
**Examples:** After activities of daily living, handling of a patient personal effects, after positioning a patient for exam or procedure.
  - 5. After Contact with Patient Surroundings**

**When?** Clean your hands after you have had contact with a surface that a patient may have touched.  
**Examples:** After cleaning up the patient's bedside and over bed table, making up the bed, moving wheelchairs or walkers.

What are transmission-based precautions?

All require isolation signs

- Standard precautions are used for ALL patients, regardless of diagnosis.
- Provide visitor, patient and family education about hand and respiratory hygiene and isolation practice.
- Patients with previously identified MDROs are to be immediately placed into contact precautions and their medical record flagged to all admissions until cleared.

What are contact precautions?

Spread by direct or indirect contact – MRSA, VRE, CRE, ESBL, and open draining wounds that cannot be covered.

- Use gown, gloves, and dedicated equipment.
- For C. difficile you must use soap and water for hand hygiene after glove removal and bleach for cleaning room and equipment.

## Infection Prevention and Control

### What are droplet precautions?

Spread by respiratory secretions – Pertussis, RSV, Influenza, Bacterial Meningitis –

- Use a mask when entering room, the door to the room may be left open.

### What are Airborne Precautions

Respiratory particles spread by air currents – TB, chickenpox, measles, disseminated shingles –

- Use particulate respirator (N95 or PAPR) while in patient room. (must be fit tested)
- Negative pressure room required.
- Door to the room must remain closed except for entering and exiting the room.

### What precautions are in place to prevent infections to employees?

Personal Protective Equipment (PPE)

- Use when there is a risk of contamination/exposure.
- Know how to don/doff.
- Discard PPE immediately when no longer required. No mask around neck, take off shoe protectors, do not wear gloves in hallways.
- Employee health screening (completed at hire and annual TB testing).
- Sharps protective devices, no recapping of needles – dispose of in sharps containers.
- Screen recent travel, exposure and symptoms for all patients
- Place pharmaceutical waste in appropriate container.
- Label all biohazardous material and dispose of properly. Only biohazardous materials should go in the red bags.
- Dispose of infectious waste in bins labeled for biohazardous waste in bin closest to area of use.
- Place specimens and completed blood bags in zip-lock bags with biohazard label; attach any paper work to the outside of the zip-lock bag.
- Keep the “next person” that will handle potentially infectious items in mind when you discard.

### Environmental cleaning and low level disinfection

- Who cleans what, when? (Does EVS clean? Does nursing clean? Do we clean after every use? Does the WOW get cleaned after leaving the patient room?) You need to have a process and be able to speak to it! You will be asked: How can you tell that equipment is clean?

## Infection Prevention and Control

High Level (semi-critical)	Low Level (non-critical)	Sterile Processing (critical items)
Used for mucous membranes or non-intact skin, patient care equipment (laryngoscope blades/handles, glidescopes, GI Scopes).	Use for intact skin, items like (stethoscopes, blood pressures and tourniquets cuffs, EKG leads, bedside equipment, portable pumps, computer keyboard and environmental surfaces)	Used for devices that are introduced directly into the bloodstream or sterile areas of the body. Since the risk of infection is very high, they require sterilization before each use.
Instrumentation to be put through the pre clean cleaning and decontamination process	Use appropriate disinfectant wipes based on isolation status.	Instrumentation to be put through the pre clean cleaning and decontamination process
Point of use PRE-CLEANING is done with an enzymatic cleaner or per manufacture instruction for use.	Manufacturers' instructions for cleaning noncritical medical equipment are followed	Point of use PRE-CLEANING is done with an enzymatic cleaner or per manufacture instruction for use.
Use enzymatic cleaner according to manufacturer instructions for use.	Use disinfectant wipes according to manufacture instructions for use	Use enzymatic cleaner according to manufacturer instructions for use.
Remove bioburden and follow point of use precleaning above	Use norovirus outbreaks. What are contact times?	Remove bioburden and follow point of use precleaning above
Equipment goes in designated BioHaz bin & goes to sterile processing WET.	You can say “let me show you on the container”	Equipment goes in designated BioHaz bin & goes to sterile processing WET.
If not wet <b>RESPRAY!</b>		If not wet <b>RESPRAY!</b>

### Do we allow corrugated cardboard (shipping boxes) to store items in patient care areas?

No – items should be removed from corrugated shipping boxes before they reach a patient care area.

## Information Management

The leader assigned responsibility for compliance with this chapter is Clinical Informatics Manager

Every episode of care generates health information that must be systematically managed by the hospital. All data and information used is categorized, filed and maintained. The privacy, security and integrity of health information is vital.

### What is health information?

Any information, whether verbal or recorded in any form or medium, that:

- Is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university or healthcare clearinghouse.
- Relates to the past, present or future physical or mental health or condition of an individual, the provision of healthcare to an individual, or payment for the provision of healthcare to an individual.

### What is HIPAA and why is it important?

**HIPAA** stands for the *Health Insurance Portability and Accountability Act* of 1996. HIPAA outlines the regulation which provides guidelines that ensure protected health information is kept private throughout our organization. Violations may result in fines. Confidential information must be kept secure and confidential in accordance with Centura Health policies and applicable laws, including HIPAA.

### What is a notice of privacy practices? Do patients receive a notice of privacy practices when they enter our organization?

All patients entering our hospital should receive a *notice of privacy practices* (NPP). Patient Access is responsible for providing information upon registration. For patients that bypass registration (i.e. direct admissions), patient access will distribute this information when they visit the patient on the unit. The NPP:

- Provides individual notice of the ways the organization uses and discloses protected health information (PHI).
- Explains an individual's rights to confidentiality and access to his/her PHI.

## Information Management



*"No peeking at my entries!"* Bridget Clarke, Health & Wellness, St. Catherine Hospital

### If I discover a concern regarding privacy or security who do I contact?

The efforts of Centura Health to maintain privacy and security extend beyond compliance with HIPAA and cover a wide range of regulations and standards. Privacy and security often overlap in their functions because while keeping information private is of utmost importance, it is also important to maintain the appropriate levels of security so that data is not compromised in any way. If you have any questions, please contact:

- Corporate Responsibility and Privacy Officer
- Data Security: 719-776-4200

### What if law enforcement requests protected health information (PHI)?

The Centura Health ["Release of PHI to Law Enforcement"](#) policy governs our facility's response when law enforcement officers request medical records or another confidential patient information. Like anyone else requesting medical records, law enforcement officers must have the required legal authorization for their requests. This means that unless the officer has a court order, or a search warrant signed by a judge, the general rule is that patient authorization is required before releasing confidential medical information. There are, however, a few, limited exceptions to this general rule. You can refer to the corporate policy referenced above or contact Corporate Responsibility

### If information systems were to fail, have you established downtime procedures?

Downtime procedures have been established for all EPIC applications for all types of delays outages and downtimes. Refer to Centura Health ["EPIC downtime/Recovery \(Centura\)"](#) posted in PPM/Policy Tech.

## Leadership

The leader assigned responsibility for compliance with this chapter is DIR MEDICAL AFFAIRS & EDUCATION

### Who are the members of our leadership team?

- Chief Executive Officer – Brian Erling MD
- Operational leader – Lonnie Cramer
- Nurse leader – Rose Ann Scibona
- Physician leader – David Dull MD
- Chief Financial Officer – Patrick Ballard

### Do we have an integrity program?

Yes. Each associate is required to read and sign that they have read and acknowledged the Centura Integrity booklet. All associates are encouraged to report integrity concerns to the Centura Health Hotline at 1-888-424-2458. The integrity help line is located in My Virtual Workplace at

<https://secure.ethicspoint.com/domain/media/en/gui/10681/index.html>

### How do management and caregivers gather information and share it with each other? How do you learn about new things in your department and in the hospital?

- Town hall and/or employee forum meetings.
- Various governance councils.
- Medical Executive Committee.
- Hospital Board.
- (Insert title of entity quality council or quality subcommittee)
- System, group, hospital and/or department newsletters.
- Talking points.
- Communication books.
- Unit and department meetings.
- E-mail, flyers, pamphlets, education carts, unit rounding.
- On-line learning management system.
- In-services, CME offerings.



Mike Cafasso,  
CEO,  
St. Mary-Corwin  
Medical Center

## Leadership

### Do you have opportunity to give feedback on the culture of patient safety?

We receive culture of patient safety surveys periodically. The last survey was conducted January 2019. Initiatives to address the results of that survey include. Stroke Alert, Fall Alert, SPD Stop the Line Initiative, No Pass Zone, Five Moments Hand Hygiene, ALTO (Administration of Alternatives to Opioids), Peds Sepsis Protocol, DVT/VTE Nursing Protocol, CAUTI Protocol, Readmission project.

### How does leadership support a culture of patient survey?

- Participation in or being represented at safety huddles.
- Identification of patient safety imperatives: patient identification, time-out and use of personal protective equipment.
- A model of shared accountability that we call “just culture” where we want everyone to feel safe in reporting errors and treat errors as opportunities to improve systems and keep people safe. This ensures we holds the hospital accountable for the systems they design while also holding caregivers accountable for the quality of their choices, without focusing on human error.

### Are you aware of any initiatives to improve patient flow throughout the organization?

ED Through Put PI project, Readmissions Project, Discharge Process

### What is the process if I have an ethical concern?

The hospital ethics committee is available to clinicians to assist with value conflict as it arises. Contact Patient Safety Manager.

### How do we identify vendors that enter patient care areas?

Those contractors required to sign in at the vendor management kiosk obtain a daily temporary ID badge. Contractors that provide direct patient care or to whom the hospital has chosen to provide a key function through an external company, will receive hospital badges upon completing onboarding procedures. Refer to [Non-facility Personnel Requirements \(Centura\)](#) for more information.

## Life Safety

The leader assigned responsibility for compliance with this chapter is Life Safety Manager.

### Are you allowed to leave items unattended in exit corridors?

If items are on wheels and readily movable, they may be kept in the corridor. However, any item left unattended in the same location and that is not actively being used should not be left for more than 30 minutes. Additionally, items should never be parked in front of electrical panels or oxygen shutoff valves. We keep our corridors free from clutter because it is in the best interest for the safety of our patients. For this reason, ***the best practice is to keep corridors free of any items.***

### Are we allowed to use extension cords?

Extension cords can be used on a temporary basis only; therefore, it is best that they not be used at all. Contact Facilities Management if you do not have adequate access to outlets. Call 719-776-5851 if you have questions.

### If I notice that doors do not close or latch properly, what should I do?

Notify Facilities Management as appropriate.

### What are the requirements related to storage?

You must maintain at least 18 inches of clearance from the sprinkler head to items stored on the top shelf or any other tall object. Items should never be stored directly on the floor due to infection control purposes.

### Why is it important to keep trash chutes and laundry chutes closed?

Access to these openings are restricted in high risk areas to prevent potential harm to visitors, i.e. children. These chutes create vertical openings. If there was a fire involving unlatched chutes the fire could rapidly spread to other floors and be spread throughout the facility. If you notice chutes are not closing and latching properly, contact Facilities Management.

### Are we allowed to use portable space heaters?

Portable space heaters are not permitted in smoke compartments that contain patient sleeping or treatment areas. If bringing in personal space heaters, Bioengineering must be contacted to have it be approved prior to use.

## Life Safety

### Are we allowed to prop doors open?

**NO.** Contact your manager or Facilities Management for alternative devices to hold doors open if your department props doors open.

### What is the maximum capacity that should be used for trash and soiled linen containers?

Any soiled linen and trash containers larger than 32 gallons must be kept in a room designated as a hazardous room. Containers used to collect papers for shredding are included in the purpose of this requirement.

### Are we allowed to put up decorations?

- Live trees, wreaths or garland must be coated in fireproofing and approved by Facility Services.
- Decorations must be fire retardant or fire resistant based on NFPA or UL standards. Decorations such as tissue paper, crepe paper, cotton balls, angel hair, or spider webbing are not allowed.
- Lighting used must be UL approved and have a UL sticker on the light string and total wattage less than 40 watts. Lighting must be plugged directly into an electrical outlet (no extension cords, or multi-strip outlets) and may not pass through doorways or across traffic areas. Lighting can be placed on doors if it is battery powered and cords do not pass between the door and doorframe.
- Fire and smoke doors may not be covered with any device (decorations, mirrors, draperies) that could obstruct or confuse occupants as to its use.

Contact the Life Safety Manager if you have questions.

## Medical Caregivers

The leader assigned responsibility for compliance with this chapter is Chief Medical Officer.

**How do I know that a provider (physician, PA, CRNA, etc.) is qualified to care for my patients?**

All providers that care for patients are required to apply and meet rigorous standards before they are credentialed to practice here.

**What is credentialing?**

Credentialing is a multi-faceted process in which evidence of a practitioner's professional training, experience, and clinical competence is collected, verified and assessed prior to being appointed as a member of the medical caregivers.

**Who makes the final decision of credentialing?**

The Hospital Governing Board makes that determination with input from the Medical Executive Committee and Credentialing Committee (made up of physicians).

**If a provider you didn't recognize came to your area to provide care to a patient, or is scheduled to perform a procedure, how would you find out if they are credentialed and privileged to provide that care or perform that treatment?**

The Centura Health Medical Staff Services Group Directors are pleased to announce ePrivileges which is an Intranet based mechanism whereby you may search for clinical privileges on a provider. The application (ePrivileges) connects directly with the credential software, Visual Cactus, so all the data is real time. You may search by name or by privilege. To access the application go to the following link:

<https://intranet.centura.org/sites/ePrivilege/Pages/default.aspx>

**How are you notified if a provider has been suspended?**

There are times that the hospital suspends a provider, meaning the physician will not be permitted to admit, care for, or perform procedures/surgery while the suspension is in place. As suspensions occur the process of notification is e-mail to all leadership, central scheduling, and medical records staff.

**What is the process to approve order sets and protocols?**

Order sets and protocols are developed with input from medical caregivers, nurses and pharmacists who are subject matter experts. Order sets are reviewed every three years. Entity protocols are reviewed annually. See [Orders for Patient Care - EPIC on PPM](#). Also see [Governance of Printed & Electronic Order Sets & Protocols \(Centura\)](#).

## Medical Caregivers

**Are you allowed to initiate order sets and protocols without prior LIP order/approval?**

Protocols designed to protect critical patients from treatment delays or gaps in medical care may be initiated without LIP prior approval when applied in a very limited and focused manner. Order sets typically require the practitioner to check, approve or fill in certain aspects of orders and therefore are not allowed to be initiated without prior LIP approval.

Caregivers initiating such protocols without prior practitioner approval will immediately notify the patient's LIP to obtain a telephone order (TO). Document the order to use the protocol using appropriate read-back procedures. Enter as a telephone order to ensure that the practitioner can authenticate the order.

ED protocols may be initiated without prior approval or LIP notification. These orders will be authenticated by the ED LIP responsible for the care of the patient.

**Is medical staff involved in performance improvement initiatives? Can you name some of those initiatives and what kind of medical staff representatives were involved?**

ALTO (Administration of Alternative to Opioids) this was led by ED physicians, the Readmissions project was led by Director of Medical Affairs, and the Pain Committee Nonpharmaceutical Interventions is being led by Pain Management Providers.

Also consider department specific initiatives of which you may be aware.



Our  
Incredible  
Caregivers  
serving  
Garden City  
and beyond

## Medication Management

The leader assigned responsibility for compliance with this chapter is the Director of Pharmacy.

### What is considered a medication?

A medication is any product designated by the *Food and Drug Administration (FDA)* as a drug, as well as any sample medications, herbal remedies, vitamins, nutraceuticals, over-the-counter drugs, vaccines, diagnostic and contrast agents, respiratory therapy treatments, parenteral nutrition, blood derivatives, and intravenous solutions (with and without additives). This definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, or other medical gases.

### How to handle normal saline? Does it need to be secured?

IV fluid bags containing normal saline or other fluids are considered medications and must be kept secured. Individually packaged saline flushes are considered a medical device and do not need to be secured.

### How do we know what medications are available?

The facility has a formulary which designates which medications are available. If medications are ordered but not on formulary, the pharmacy will apply “therapeutic substitutions” and clarify the order with the physician.

### What should you do if patients bring in their own medications?

After documenting the medications in the patient’s record, the medications should be sent home. Refer to your facility’s policy

#### ***Patient Personal and Sample Medications (Centura)***

### How is security of medication ensured in your department?

ALL MEDICATION is to be secure **at all times** (see medication definitions above). Therefore, we store medications as follows:

- In secure PYXIS system.
- In locked refrigerators.
- In locked drawers in the nurse servers.
- In clean medication rooms.
- In locked emergency kits or code blue carts.

*Secure* is defined as being in a locked room, locked container or under constant surveillance.

## Medication Management

### What are our injection safety guidelines?

- Use proper hand hygiene and aseptic technique prior to drawing up and/or administering medications.
- Never administer medications from the same syringe to more than one patient, even if the needle is changed. Once they are used, the syringe and needle both are contaminated and must be discarded. Remember, **only one needle, only one syringe, and only one time!**
- After a syringe or needle has been used to enter or connect to a patient’s IV, it is contaminated and should not be used on another patient or to enter a medication vial.
- Never enter a vial, bag or bottle with a used syringe or needle.
- Never use medications packaged as single-dose or single-use for more than one patient. This includes ampules, bags and bottles of intravenous solutions.
- Prior to entering any vial, bag, bottle or IV port, SCRUB the access stopper with alcohol or other approved disinfectant wipe for 15 seconds! Do this even if a cap or cover is in place. If using a multi-dose vial, the hub must be scrubbed for 15 seconds every time it is entered.
- Use fluid infusion and administration sets for one patient only.
- Do not combine (pool) leftover contents of single-dose vials or store single-dose vials for later use.
- Finger stick devices, including their lancing devices (i.e. insulin pens) are to be used on only one patient.
- Multi-dose vials should not be taken into the immediate patient treatment area (i.e., patient room or procedural area). When preparing medications for administration from multi-dose vials, this should be done in the medication room, not at the patient’s bedside.
- Multi-dose vials must be labeled with a new expiration date after being opened. The timeframe for expiration is 28 days, unless otherwise specified by the manufacturer.

## Medication Management

### What role does the pharmacy play prior to the administration of medications?

- Pharmacy verifies that the medication is appropriate for the patient's weight, age and diagnosis, and that drug interaction, allergies or other contraindications are not apparent. Both pharmacy and nursing need to check for therapeutic duplication, which occurs when multiple medications are prescribed for the same indication without a clear distinction of when one medication should be administered over another.

### Can medications be removed from PYXIS without pharmacy verification?

- There are times when medication is needed immediately and can be removed from PYXIS.
- PYXIS overrides need to be linked to the medication order as soon as possible. Please refer to the: Pyxis Med-station & Anesthesia System (Centura) Policy

### Who can dispense medications?

Pharmacy is responsible for dispensing medications throughout the hospital.

### What must be verified prior to administering a medication?

- Right patient (first and last name and date of birth).
- Right medication.
- Right dose.
- Right route.
- Right time.
- Expiration date of medication.
- Visually inspect medication for correct color and clarity.
- Barcoding verification is done and correct.

### Process for Controlled Substances:

- Each controlled substance must be signed out by the person administering it, except in emergent situations.
- Wastage of controlled substances must be witnessed by two associates and documented in PYXIS.
- Refer to policy "[Controlled Substances \(Centura\)](#)"

## Medication Management

### What's the process for discrepancies with controlled substances?

- Discrepancies are resolved at the time the discrepancy is identified or no later than prior to change of shift. An occurrence report must be completed for any unresolved discrepancy.

### What must be included as part of titrated orders?

Titrated orders must contain all the following:

- A starting dose, a maximum dose and the dose to use to incrementally increase or decrease the medication.
- A parameter as a goal and the frequency to adjust the medication.

Refer to policy "[Medication Orders \(PRN, Range, Taper, Titratable\) \(Centura\)](#)".

### What do you do if you suspect an adverse drug reaction (ADR)?

- Stop the medication.
- Monitor the patient.
- Call the doctor .
- Complete the ADR in the occurrence reporting system
- Call the Pharmacy.

Refer to policy "[Medication Occurrence and Adverse Drug Reactions \(Centura\)](#)".

### How is the patient educated about food and drug interactions?

Pharmacy, Nursing and/or Nutritional Services can provide education to patients on food and drug interactions, for example: interactions between food and anticoagulation therapies.

### What actions do we take to prevent errors involving look-alike, sound-alike (LASA) medications?

- LASA medications are stored in separate PYXIS drawers.
- Tallman lettering is used on labels.

Refer to policy "[LASA: Look-Alike/Sound-Alike Medications \(Centura\)](#)".

### Where can you find a list of high alert medications?

- Pyxis contains a list.
- Refer to the list provided in the policy "[High Alert Medications \(Centura\)](#)".
- All NICU and pediatric medications and infusions are considered high alert medications.

## Medication Management

### What are the new 2018 requirements related to pain?

- Routinely offer the patient non-pharmacologic pain interventions, such as ice/heat, massage, etc.
- Identify patients who are at highest risk for opioid induced respiratory depression, such as smokers, presence of obstructive sleep apnea, elderly, etc.
- Involve and educate patient/family during hospitalization on pain management plan, safe use of pain medications and supportive interventions (ice/heat, massage, etc.).
- Monitor documentation of pain: pain scale, pain reassessment, pain goal, pain goal met, non-pharmaceutical interventions.
- Facilitate ordering providers and Pharmacy access to prescription drug monitoring services.
- Refer to policy "[Pain Management \(Centura\)](#)".

### What's the purpose of our antimicrobial stewardship program?

The goal is to reduce antibiotic resistance, reduce adverse patient outcomes related to antibiotics, (such as C difficile) and encourage best practices for antibiotic prescribing.

### What are the requirements for timely medication administration?

- Time-critical scheduled medications must be administered within 30 minutes before or after the scheduled dose.
- Medications that aren't time critical must be administered within one hour before or after the scheduled time.
- Refer to **Medication Administration (PSF) Policy**

*If administering a medication beyond the above noted timeliness requirements, you must document why the medication was late and the actual time administered. Consider completing an occurrence report for late medications.*

## National Patient Safety Goals

### The leader assigned responsibility for compliance with this chapter is Infection Preventionists

Refer to National Patient Safety Goal posters for detailed information about the goals and how they are implemented.

If you have questions about the National Patient Safety Goals, contact your leadership



Barbara Young, RN,  
helping patients  
navigate at St. Mary-  
Corwin Medical  
Center

## Nursing

The leader assigned responsibility for compliance with this chapter is Chief Nursing Office

### Who is our Chief Nursing Officer?

Rose Ann Scibona 719-776-5802

### What is the role of the Chief Nursing Officer?

The nurse executive is responsible for promoting quality by incorporating current evidence-based practice, nationally recognized professional standards and other expertise into policies and procedures governing provision of nursing care, treatment and services.

### Are nurses working in ancillary departments required to report to an RN?

Yes – when the leader of a department is not a nurse, a nurse leader must be designated to provide consultation and oversight for nursing practice.



## Performance Improvement

The leader assigned responsibility for compliance with this chapter is Value Optimization Manager)

The goal of performance improvement is to continuously improve patient health outcomes. It involves measuring process and services and, when indicated, identifying changes that enhance performance. Changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that improvements are sustained.

### What performance improvement methodology(s) do we use?

Lean, and A3.

### Who has ultimate responsibility for the quality of care and performance improvement?

The Hospital Board of Trustees is responsible for quality of care and for prioritizing the performance improvement activities. However, each associate in the organization must be able to articulate the quality measures and significance of performance improvement in his or her own department.

### How are caregivers and physicians involved in performance improvement?

All caregivers and physicians are responsible for and involved in performance improvement activities through data collection, analysis of results, action plan development, implementation of those plans, measurement and for PI team participation.

### How are performance improvement projects chosen?

Recommendations for PI activities may come from caregivers, leaders, physicians and Patient Safety Survey results. Leaders set priorities for both departmental and organizational PI activities, giving priority to high-volume, high-risk, or problem-prone processes. PI team activities are prioritized and re-prioritized in response to significant changes in the internal or external environment.

Depicted to the left are, from the top, clockwise: Mark Goldstein, RN, St. Anthony's Hospital, Blaine McLaughlin, RN, Littleton Adventist Hospital, Katherine Atherton-Wood, RN, APN Longmont United Hospital, and Kristin Cesare, RN, Summit Medical Center.

## Performance Improvement

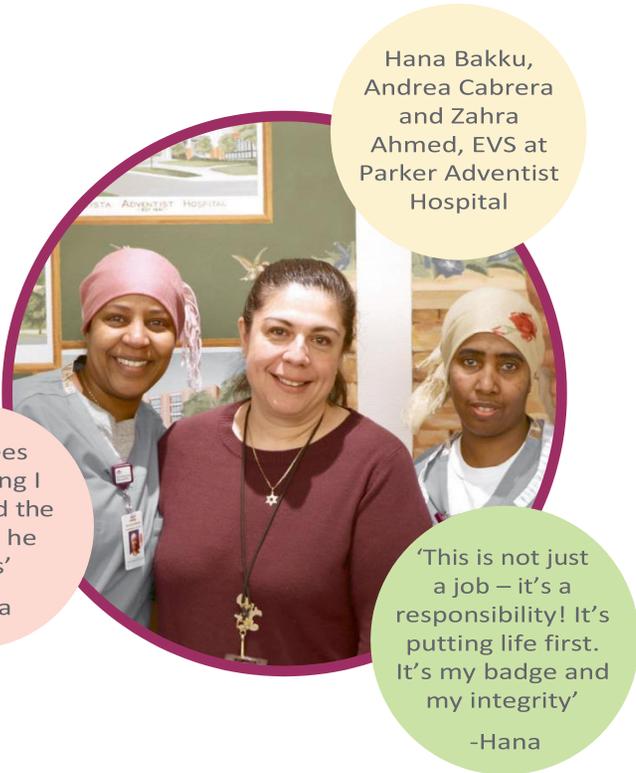
What is your unit currently working on? What data do you collect? What does your data show? And, what are you doing about it?

Know where this information is available on your unit.

What is your role in PI activities?

For example:

- How have you been involved in improving patient satisfaction?
- Your role and understanding core measures.
- Your participation in a departmental PI team.



## Provision of Care

The leader assigned responsibility for compliance with this chapter is **Director of Acute Care Services**

The *Provision of Care, Treatment and Services* chapter outlines requirements relative to core processes of planning, implementing and discharge or transfer of care. It also provides guidance relative to special conditions, for example restraint and seclusion.

**Can you describe your process of interdisciplinary care planning?**

Upon admission, the care plan is initiated by the RN, and added to by other licensed disciplines, depending on special needs identified in the patient assessment, reassessment, treatment goals and results of diagnostic testing and discharge plan. The plan of care is found throughout the patient's medical record including:

- Patient care orders for medication, labs, imaging, etc.
- History and physical.
- Notes, including event, progress, consult, post-op, etc.
- Documentation flowsheets and assessments.
- Patient/family education.
- Transition readiness.

Goals are established with the patient, their agent, family, and/or designated caregiver. The interdisciplinary care team evaluates the patient's progress toward goals. Care plans should be individualized and updated at least daily.

**How frequently do you update the plan of care?**

At least daily. Refer to [Plan of Care for Acute Care – EPIC \(Centura\)](#)

### Assessment and reassessment

**What is the time frame for the initial assessment of patients on your unit?**

- The patient's **H&P** must be completed within 24 hours of admission or registration, but prior to operative and other high-risk procedures and procedures requiring anesthesia or deep/moderate sedation.
- The completion of initial nursing assessment should be performed soon as possible and within 24 hours of admission.

## Provision of Care

All disciplines document their assessments at least once per shift. Insert facility-specific.

### When are further shift reassessments completed?

Many other areas document additional reassessments dependent on departmental standards, the patient's condition, and plan of care. Minimally reassessments should always occur:

- When a significant change occurs in the patient's condition.
- When a significant change occurs in the patient's diagnosis.

### Discharge or transfer

#### How do we provide for coordination of care, including discharge or transfer?

During the admission process, patients are assessed for ongoing care needs and need for possible services. Case managers collaborate with other disciplines on continuous care and the discharge plan. Communication regarding patient care occurs via:

- Formal and informal case management rounds/staffing.
- Review of documentation by various disciplines, including the plan of care.
- Family/significant other case conferences when needed.

#### How do patients and families learn what their care needs will be after leaving the hospital?

- Patients, families, **post-discharge caregivers** and providers are included in the discharge planning process.
- If being referred or discharged to other agencies, the patient's right to choose is protected .
- After assessment and planning, nurses and/or case managers discuss anticipated needs with the patient and their family.
- Patient and family education including:
  1. Specific discharge instructions.
  2. Referrals to other community services.
  3. Current home medication lists and medication instructions.
  4. Arrangements for home health, hospice, support groups, rehabilitation services, etc.

## Provision of Care

### What is a post-discharge designated caregiver?

All inpatients can designate at least one post-discharge caregiver who will assist them with basic tasks following discharge. The patient or authorized surrogate decision maker along with the designated caregiver should provide consultation on the discharge plan. Patients should be asked about the post discharge caregiver no later than 24 hours after admission and prior to discharge from the hospital or non-emergent transfer to another facility. It is the hospital's responsibility to notify the designated post-discharge caregiver of the patient's discharge as soon as practicable. The designated post discharge caregiver should also be provided with instruction on aftercare tasks.

### When is the discharge planning process initiated and how is it handled?

On admission to the hospital by all disciplines! All patients are continually reassessed up until discharge, to determine their needs. The plan of care is developed as the patient progresses through the course of treatment and plans are revised, as needed, to transition the patient to the next level of care. Discharge planning is discussed during rounding to evaluate, prioritize and implement the patient's plans.

### Is there a resource for discharged patients who need help at home, yet aren't eligible for home care or other services?

- Anyone can refer patients to case management for further information.
- Case managers work with the physician and other healthcare providers to coordinate care.

### Abuse and neglect

#### If you suspect that a patient is a victim of abuse or neglect, what are your responsibilities?

Whenever any member of the care team suspects abuse or neglect, immediately notify the licensed practitioner (MD, DO, PA, APN) and case management. Treatment is provided for treatment and supportive measures as ordered by the licensed practitioner. Refer to [\*Abuse, Neglect, Assault and Domestic Violence \(Centura\)\*](#).

## Provision of Care

### What criteria do you use to identify whether a patient is a victim of abuse?

There are several categories of abuse: physical, emotional, domestic, and sexual.

- Physical abuse: unexplained injuries, burns or bruises.
- Sexual abuse: bloody underclothing, unexplained genital infections/disease.
- Psychological abuse: excessive fears, insomnia, weight changes, loss of interest.
- Domestic abuse: any of the above.

### What criteria do you use to identify victims of neglect?

Neglect can be more challenging to assess than abuse. Some patient clues might include: feels hungry often, does not regularly attend school (for school age), does not have adequate clothing, parents/caregiver do not provide medications as scheduled, has had many accidents, is homeless or does not feel supported or cared for by parent/caregiver.

### End of life care

#### What is the priority of care for patients at end of life?

Priorities for end-of-life care include providing comfort to the patient and family. This involves:

- Patient and family comfort, for example, pain management, cots, recliners/sleepers, extra chairs and large rooms.
- Privacy and dignity.
- Psychosocial, emotional and spiritual support, including pastoral care and social services.

#### What training do you receive for “end of life” issues? What resources are available to the patient and for caregivers?

- Spiritual Care staff
- “Nobody dies alone” program
- Designated Requesters and/or Donor Alliance coordinators

### Procedural sedation

#### What is procedural sedation?

A method of sedation or analgesia where pharmacological agents are used to create a drug-induced state while not losing consciousness. Procedural sedation assists the patient to comfortably tolerate diagnostic, therapeutic or invasive procedures while maintaining protective reflexes and the ability to respond to verbal and physical stimuli. Procedural sedation includes moderate and deep sedation.

## Provision of Care

### Who can administer procedural sedation?

- Moderate:
  - Qualified, privileged and credentialed non-anesthesiologist MD/DO, anesthesiologist or medically-directed CRNA or supervised anesthesia assistant.
  - Trained and competent ACLS or PALS certified RN or a non-credentialed APRN or PA, and medically delegated RCIS. This cannot be an RN assisting with the procedure – they must be dedicated to just that task.
- Deep sedation.
  - Qualified, privileged and credentialed non-anesthesiologist MD/DO, anesthesiologist or medically directed CRNA, or supervised anesthesia assistant.

### What age-appropriate equipment needs to be immediately accessible?

- IV access if clinically indicated.
- Oxygen and related equipment.
- Suction.
- Emergency resuscitation cart and medications.
- Reversal agents, as applicable.
- Capnography is highly encouraged unless precluded or invalidated by the nature of the patient, equipment or procedure.
- Positive pressure ventilation.

### What are the requirements for a patient to receive sedation?

- Complete nursing assessment.
- History and physical must include an airway evaluation.
- Assessment of the patient’s ASA classification.
- Consent for both the procedure and the sedation.
- REMEMBER: If the procedure is invasive, universal protocol applies. This includes a pre-procedure verification (must use a checklist), site-marking, if applicable and a “time-out” is done immediately before the procedure. All elements of the universal protocol are documented.

### Immediately prior to administering sedation or anesthesia, what must be done?

The patient must be re-evaluated immediately, no more than 5 minutes prior to administering first dose of sedation. Minimum components of the immediate reevaluation include:

- HR, BP, SaO<sub>2</sub>.
- Capnography preferred; required when etomidate, ketamine and methohexital are used.

## Provision of Care

### What are the monitoring requirements for procedural sedation?

Every 5 minutes:

- Level of consciousness.
- Pain.
- Respiratory frequency and adequacy.
- SaO<sub>2</sub>.
- Blood pressure.
- Cardiac monitoring.
- Capnography preferred; required when etomidate, ketamine and methohexital are used.

### Nutrition

How do we screen and assess a patient's nutritional status?

Based on initial nursing assessment in the EHR, nutrition will be automatically notified for follow-up if patient meets clinical triggers. The clinical nutrition caregivers also re-screens all patients, based on criteria including: certain diets (nutrition support, prolonged NPO or clear liquid diet status), weight, ALB/pre-ALB, diagnosis, and other risks factors and assigns a risk.

### Where can you find the diet manual?

The diet manual can be found on My Virtual Workplace under the reference tab.

### Pain management

#### How is a patient's level of pain assessed?

We use a pain scale appropriate to the patient's age and cognitive development.

- Numerical scale, 0 to 10.
- Verbal scale, no pain to worst possible pain.
- Happy to sad faces.
- CPOT – Critical care pain observation tool.
- FLACC – (*face, legs, activity, cry, consolability*) for pediatric patients 2 months–7 years.
- NIPS – *Neonatal infant pain scale*.
- PIPP – *Premature infant pain profile*.

Patient's sedation level is also assessed for patients receiving opioids including:

- Pain level using an appropriate pain scale.
- Sedation level when giving opioid.

## Provision of Care

### What do I need to know about pain management?

- Pain must be assessed: upon admission, at least every shift, after intervention (pain medication or nonpharmacologic intervention), as needed and prior to discharge.
- Interventions for pain must be addressed and documented: for example, medications, nonpharmacologic interventions, referral for chronic pain, etc.

Reassessment timeframe and/or interval of pain will be determined by clinical judgment of the RN (based on patient assessment and intervention provided). Documentation of reassessment will be within 2 hours of PRN pain medication.

See [Pain Management \(Centura\) policy](#) for more information.

### Patient/family education

#### Who is responsible for teaching patients?

All clinical caregivers and practitioners are responsible for patient education. Whenever possible, family members/significant others that are involved in the care of the patient are included in this education. Education must be documented. Referrals for health education classes or counseling are made as needed.

What are the critical components of patient education that must be documented?

- Assessment of individual learning needs. What do they need to know?
- Assessment of individual learning style: How do they learn best? Then, deliver education based on the learning style
- Assessment of the patient's readiness to learn and/or barriers to learning.
- Response or effectiveness of education including teaching back.

Be prepared to demonstrate above aspects in your documentation.

#### What resources are available to teach patients and families?

Support materials include printed patient information sheets, booklets, videos and patient education channels. Patient education materials are approved and reviewed regularly to ensure they are current and reflective of evidence-based practice.

## Provision of Care

### Restraint and/or seclusion

#### What is considered a restraint?

Restraints include all manual, physical, mechanical and material devices used to involuntarily limit freedom of movement, for example, wrist, ankle, and elbow restraints, leather restraints, physical holds, geri-chairs, specialty beds, and side rails for beds with 4 side rails and all 4 raised. Chemical restraints are comprised of a medication(s) used as a restriction to manage a patient's behavior or restrict freedom of movement and when its use is not a standard treatment or dosage for the patient's condition.

#### What is our policy about restraint use?

Refer to Restraint or Seclusion: Non-behavioral Facility policy.

General tenets for the use of restraint are as follows:

- We recognize the right of patients to be free from restraints in any form—therefore our goal is to limit restraint use.
- Restraints may only be used when alternatives have been deemed ineffective.
- An order for restraint is required. Orders may never be written as a standing or PRN order.
- Type of restraint used must be the least restrictive.
- Restraint must be discontinued at earliest time possible, regardless of the length of time identified in the order.
- Once a patient in restraint or seclusion meets criteria for release, they will be removed from restraint or seclusion.
- Refer to Restraint and Seclusion: Behavioral P&P to identify other specific requirements (i.e. face to face evaluation, reevaluation requirements, debriefing and administrative review requirements).

#### Do we use seclusion here?

Only in the Emergency Department Designated Safe Rooms

#### What is the difference between a behavioral restraint and non-behavioral restraint?

While both forms of restraint involuntarily limit freedom of movement, the purpose of the restraint differentiates between the two. Non-behavioral restraints are to be used to assess, stabilize or treat a patient receiving medical or surgical services and situations where unlimited movement would prevent or seriously hinder efforts to provide those services, resulting in serious harm to the patient or others. Behavioral restraints are to be used when the patient demonstrates violent or self-destructive behavior (danger to self or others). Location of the patient is not a factor for

## Provision of Care

determining whether a restraint is to be ordered for behavioral or non-behavioral purposes.

#### Can posey vests be used as restraints?

NO

#### What must be included in an order for restraint or seclusion?

- Type of restraint to be used.
- Time-limit for order (which should be age appropriate if behavioral).
- Date and time of the order.

#### If a patient is in restraints and it looks like he/she can do without them, and I take them off, can I then put them back on, if after 30-40 minutes it looks like he/she is going to need them after all?

No, you may not. That is called a trial release, which constitutes an as-needed (PRN) situation and is prohibited by regulation. Once a caregiver ends a restraint intervention, caregivers should only reinstate after obtaining an order, unless emergent.

#### If a patient has been assessed for continued need of a chemical restraint and you cannot order any form of restraint PRN, does the nurse have to call for orders for new medications when the time-limit expires?

Yes, the nurse would have to call. When chemical restraint is used for behavioral purposes (patient is a danger to self or others) a physician or practitioner in charge of the patient must reorder the medication.

#### If a patient needs to be restrained for behavioral (violent, or self-destructive) reasons:

- Restraint or seclusion must be ordered by a physician or other licensed practitioner who is responsible for the care of the patient.
- If the attending physician did not order restraint or seclusion, the attending physician must be consulted ASAP.
- Patients in behavioral restraint or seclusion must be monitored through continuous in-person observation by an assigned caregiver.
  - After the first hour, a patient in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment which are in close proximity of the patient, if consistent with the patient's condition or wishes.
- Assessment and monitoring will be documented every 15 minutes.

## Provision of Care

- The physician or other LP responsible for care of the patient must perform a face-to-face evaluation within one hour of a behavioral restraint or seclusion to evaluate underlying conditions and need for further behavioral restraint or seclusion.

### Resuscitation services

**Where is the nearest Code Blue cart for your department located?**

*Know location of carts*

**How often are Code Blue carts checked?**

The following are checked daily for 24/7 departments:

- Integrity of the lock.
- Critical equipment is functioning (defibrillator, EKG monitor) and plugged into red outlet, portable oxygen supply is sufficient.
- Caregivers should also observe carts for when next medication or supply is to expire.

**How do you activate a Code Blue?**

- Dial 1234.

**When is a rapid response team called?**

The rapid response team can be called to provide specific early assessment and stabilization recommendations when

- Any caregiver is worried about the patient.
- When criteria have been met.
  - {insert facility specific criteria}.
- It is a patient responsibility to notify caregivers to request assistance with changes in condition or symptoms.
- {insert facility specific information if families are to be educated and enabled to call a RRT- example provided: “Condition HELP” will empower patients and families to call an RTT}.

## Provision of Care

**What is our standardized process for hand-off communication?**

(Insert facility specific process). At a minimum, information exchanged should include the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes to any of these. Hand-off communications occur during shift changes, staff relief and transfers. The receiver of information always has an opportunity to ask questions.

### Fall prevention program

**How do we assess and manage the patient’s risk for falls?**

- Initial and on going fall risk assessment is conducted in all settings and for all patient populations.
- Interventions are implemented based on the patient’s assessed risk.



## Record Of Care, Treatment And Service

The leader assigned responsibility for compliance with this chapter is **Director of HIM (Health Information Management)**

The goal of this chapter is to define the components of a complete medical record, which comprises all data and information gathered about a patient during their stay. Whether the hospital keeps paper records, electronic records or both, the contents remain the same.

### Do you know how to navigate the medical record?

If a surveyor asks you a question about your patient, be prepared to find the appropriate documentation in the medical record.

### How often do you receive telephone and verbal orders?

**We discourage the use of verbal and telephone orders.** The only verbal orders we accept are those that are emergent. When taking a telephone order, write down what was stated and then read-back what was written and verify the accuracy of information with the prescriber. Write or enter the order into the medical record order source as *verbal order repeat back (VORB)* to indicate a read-back occurred.

### IMPORTANT RECORD OF CARE REMINDER:

**All paper entries in the medical record must be SIGNED, DATED and TIMED AND LEGIBLE**



Matthew Morgan,  
MD, CHPG -  
serving the St.  
Anthony North  
community

## Rights and Responsibilities Of The Individual

The leader assigned responsibility for compliance with this chapter is **Director of Quality**

When the hospital recognizes and respects patient rights, it is providing an important aspect of care that has been shown to encourage patients to become more informed and involved in their care. Recognizing and respecting patient rights directly affects the provision of care. Care, treatment, and services should be provided in a way that respects and fosters the patient's dignity, autonomy, positive self-regard, civil rights, and involvement in his or her care. Care, treatment, and services should also be carefully planned and provided regarding the patient's personal values, beliefs, and preferences.

### Where can patients get information about their rights and responsibilities?

- Separate document offered to all patients at the time of registration, in the consent for treatment.
- On the Centura Health website\_ <http://www.centura.org/index.php?s=77>
- Also found on *Patient Rights and Responsibilities* posters located in all major hospital entrances.
- Additional patient rights can be found for neonatal, infant, pediatric, adolescent and behavioral rights.

### How do we protect the patient's privacy?

HIPAA is an acronym for the *Health Insurance Portability and Accountability Act*. It sets strict rules about how we handle a patient's confidential health information in our medical records, computer systems and even the conversations we have. Be prepared to answer. For example:

- I do not discuss patients in public areas (elevators or cafeteria).
- I do not look at a patient's record of medical care manually or electronically, unless needed to provide their care.
- Close or minimize computer screens displaying protected health information when completed and ensure that printed patient-specific information is secure.
- Any patient-sensitive written material is shredded after use and not being put in a regular trash can.

## Rights And Responsibilities Of The Individual

### What do you do if you see another caregiver breaking confidentiality of a patient's medical information?

Approach the caregiver directly and remind him/her of our obligation to patient confidentiality. If you are uncomfortable doing this, you may report your concerns to the manager. You may also call the Ethics and Compliance Hotline at 1-888-424-2458.

### Advance directive

Advance directives include:

- Living will.
- Medical durable power of attorney.
- A physician order is needed for a "DNR" status.
- Colorado MOST form (*medical orders for scope of treatment*).

### How do we ascertain whether a patient has an advance directive or whether they need information on ADs?

- Ask the patient/family if he/she has an AD.
- If "yes," ask the patient/family for a copy and place it on the patient's chart. If copy has not been provided, ask patient or family to bring so that information may be placed in the record ASAP and give them a reminder card.
- If "no," offer information and provide an opportunity to establish ADs. Contact Chaplain Services 719 776-5660 for assistance.
- Physicians should document the status of the patient's AD in the progress notes.

### What are the requirements for do not resuscitate (DNR) orders?

- If a patient arrives with a Colorado CPR directive, notify the physician and obtain "DNR" order.
- Place a purple alert wristband on patient with any level of *DNR* order. This indicates that the patient wants less than a full code performed should his/her heart stop. If your patient has a purple alert wristband, check the patient's chart to determine specifics of the DNR status.
- During certain procedures a DNR may be suspended (please refer to *Advance Directives Policy*).

## Rights and Responsibilities Of The Individual

### Informed Consent

LIPs are responsible to obtain informed consent from a patient. The LIP has the medical knowledge necessary to provide pertinent information to the patient concerning the patient's condition, the probable results of a proposed treatment, and the risks of alternatives of the treatment. The extender credentialed under the responsible physician may obtain informed consent on behalf of the physician if the physician has delegated this duty to the extender.

Other procedures example-PICC line RN, can obtain their own consent. All fields must be addressed (no blanks), areas initialed as applicable, and must be initialed dated and timed prior to receiving treatment. [See Informed Consent Policy](#).

### Personal beliefs, values and ethics

- A referral can be sent by anyone to the Ethics Committee.
- Discuss with the doctor and manager.
- 719 776-5855 to contact the ethics-on-call-person/ Ethics Committee for an ethics consult.

### How do you manage complaints from patients, family members or visitors?

- Try to resolve the concern at the time the complaint is voiced. If unable to resolve the complaint by involving your supervisor call 719 776-5370.
- Patient and family complaints are referred to patient representative and/or Complaints and Grievance Policy.

***All complaints and grievances must be entered into the appropriate tracking system.***

### Does a patient have a right to receive critical and medical information and their preferred primary language?

Yes, use only certified interpretive services i.e. MARTI, Cryacom Record in the patient record the interpreter's certification number.

- Do not use family members of non-English speaking patients to interpret medical information for their patient-relatives. If the patient insists on using family, document this request. Family members may not know how to interpret complex medical terminology or may misinterpret information that they feel is too difficult for the family members to accept.
- Use the Cryacom interpreter phones, which are available on

## Rights and Responsibilities Of The Individual

patient care units or direct dial # 84002 if available at facility.

- Associates cannot be used for interpretation unless they are certified and part of their job description.

Refer to the facility *Communication Barriers Policy*.

### What are examples of critical medical information

An official interpreter must be used during all critical points of care including ANY interaction with the physician (consent, H&P, daily assessment), assessments and teaching including discharge instructions. As defined per Medical Records.

### How do you communicate with patients who are hearing impaired?

- MARTII (*My Accessible Real Time Trusted Interpreter*).
- Contact manager for sign-language interpreter if MARTII is not adequately meeting the patient's needs.
- Look for alternative ways to communicate example: dry erase board, pictures, pen and paper.

### What considerations are there for the visually impaired?

- Refer to Communication Barriers Policy.

### Patients from other cultures

We honor and are sensitive to the diverse cultural needs of our patient population.

### How do we inform patients and/or families about unanticipated outcomes?

Centura Health associates and medical staff have an obligation to inform patients about the outcomes of all care including unanticipated outcomes of care and the treatment and services related to serious preventable adverse events. See [Adverse Clinical Event Reporting, Analysis, Disclosure and Non-Payment \(Centura\)](#) policy for guidelines intended to assist medical providers and other professionals when disclosing serious preventable adverse events to the patient.

### How are patients/family members asked about organ or tissue donation?

Only caregivers trained as designated requesters and/or donor alliance coordinators approach families about organ donation.

## Transplant Safety Organ and Tissue Donation

### The leader assigned responsibility for compliance with this chapter is Director of Perioperative Services

This chapter focuses on the development and implementation of policies and procedures for safe organ and tissue donation, procurement and transplantation. Organ transplants are often life-saving procedures. Tissue transplants are most often performed to enhance the lives of recipients. Tissues often transplanted include bones, tendons, corneas, heart valves, veins and skin.

### Who are the organ procurement organizations we have agreements with for organ and tissue procurement?

*The Donor Alliance and Rocky Mountain Lions Eye Bank.*

### When a patient dies, or death is imminent, when are we required to notify an organ procurement organization?

The hospital notifies the organ procurement organization of patients who have died, and of mechanically ventilated patients whose death is imminent, according to defined clinical triggers and timelines. *See the Organ and Tissue Donation policy.*

### Who is allowed to approach the family regarding the option to donate or decline to donate organs, tissues or eyes?

An organ procurement organization representative or a designated requestor may approach the family. A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation.

### How does Penrose St. Francis Hospital ensure that tissues are acquired, received, stored and issued according to a standardized process?

PSF uses a standardized tissue tracking form or tissue tracking software that follows the tissue from receipt in the hospital to use in the patient.

### How does PSF maintain the integrity of tissues?

The verification of package integrity is completed upon receipt, and maintenance of storage temperatures includes a backup system.

## Waived (Point Of Care) Testing

The waived testing chapter addresses those tests performed at the patient's bedside or point-of-care. Waived tests are not error proof and the intent of the chapter is to ensure that waived testing requirements are followed, that caregivers are competent, and that quality control is maintained.

### What is waived testing (point of care testing?)

Lab testing performed on a patient care unit or at the patient's bedside.

### What kinds of lab tests do you perform on your patient care unit?

Know what "point of care testing" is done on your unit. Examples of point of care tests used throughout the facility include: glucometer, occult blood, urine specific gravity or pregnancy, breath alcohol, INR, iSTAT, hemoglobin, amniocentesis and rapid strep. It will also be important to know the location of *Point of Care P&Ps* on PPM on My Virtual Workplace.

### How does this facility assess a caregiver's competency to perform waived testing?

Training is completed, and competency is assessed prior to any associate administration of point of care tests. Competence for waived testing is assessed on orientation and annually thereafter. Training and competency is always conducted prior to new instrumentation being introduced.

### What are our quality control standards for waived testing?

Again, know your unit's specific waived testing information. For example, blood glucose meters are quality checked daily prior to using the high and low glucose control. Know where to locate results of QC testing.

### Do I have to label point of care tests with patient identification information?

When testing is being performed away from the patient's bedside it must be labeled. If done at the bedside, labeling is not required.

## Resources

### If you have questions or would like to learn more:

1. Call or visit the PSF Regulatory office at PenNorth (building where CPR classes are held) or the Quality department at SFMC: Rosemary Myers 719-776-5865  
rosemarymyers@centura.org or Victoria Cameron 719-571-2110 victoriacameron@centura.org We will be happy to answer any questions or concerns you have.
2. Visit The Joint Commission website at <http://www.jointcommission.org/>. The standards are not on the website, although the National Patient Safety Goals are, along with FAQs for many of the standards. There are interesting articles and updates. We follow "hospital" standards only.
3. Look at the Joint Commission standards. Go to My Virtual Workplace/Reference/Quality/Joint Commission Manual. You may search by word or topic or search standards chapter by chapter.
4. CMS standards, along with survey guidelines and other information for hospitals, may be found at My Virtual Workplace/Reference/Quality/CMS Conditions of Participation. Joint Commission standards are more frequently mirroring CMS standards and we must be compliant with both sets of standards.
5. It is your responsibility to know how to access and be familiar with *Clinical, Infection Control and Environment of Care/Safety* policies as we will likely be surveyed to many of these.

Get involved with departmental performance improvement activities. It takes many sets of eyes and commitment to be compliant.



Remember,  
it begins and  
ends with You!  
Cheers from  
OrthoColorado

# Non-Discrimination Statement

Each Centura Health facility complies with applicable Federal civil rights laws and prohibits discrimination on the basis of race, color, national origin, age, disability, or sex. Centura Health facilities do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Each Centura Health facility provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats which may include: large print, audio, accessible electronic formats, or other formats

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please request assistance from staff. If staff is unable to assist you, please contact the facility Sections 504/1557 Coordinator.

It is against the law to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance. If you believe that a Centura Health facility has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Antionette Garcia, or designee, and Sections 504/1557 Coordinator | 9100 E Mineral Circle, Centennial, CO 80112  
Phone 303-643-1000 | TTY: 711 | Fax 303-673-7102 | CHPG\_Patient\_Advocate@Centura.Org

You can file a grievance in person or by mail, fax, or email within 60 days of the date you become aware of the alleged discriminatory act. If you need help filing a grievance, the above mentioned Sections 504/1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW., Room 509F, HHH Building  
Washington, DC 20201  
1-800-368-1019  
1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

## Proficiency of Language Assistance Services

Attention: If you speak a language other than English, assistance services, free of charge, are available to you. Call 1-303-643-1000 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-303-643-1000 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-303-643-1000 (TTY: 711). 注

意: 如果您使用繁體中文, 您可以免費獲得語言技術服務。請致電 1-303-643-1000 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-303-643-1000 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-303-643-1000 (TTY: 711).

ማሳሰቢያ: የሚናገሩት ቋንቋ ኢንግሊዝኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በገንዘብ ለማግኘት ተከራኝተዋል። ወደ ሚኒሶታው ቁጥር ይደውሉ 1-303-643-1000 (ጣሰማት ለተነጻጻፊዎች: TTY: 711)።

ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-303-643-1000 (رقم هاتف الصمم والبكم): (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-303-643-1000 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-303-643-1000 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-303-643-1000 (टिडिवाइ: (TTY: 711) ।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-303-643-1000 (TTY: 711).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。13036431000 (TTY: 711)

まで、お電話にてご連絡ください。

Ntj: O buru na asu lbo, asusu aka oasu n'efu, defu, aka. Call 1-303-643-1000 (TTY: 711).

AKIYESI: Bi o ba nso edè Yorùbù ofé ni iranlowò lori edè wa fun yin o. E pe ẹrọ-ibanisọrọ yi 1-303-643-1000 (TTY: 711).

LA SOCO: Haddii aad ku hadashid Soomaali, waxaad heli kartaa adeegyada kaalmada luqadda, oo lacag la'aan ah. Wac telefoonka 1-303-643-1000 (TTY: 711).

توجه: اگر از صحبت کنندگان زبان فارسی باشید، خدمات کمک زبانی رایگان برای شما قابل دسترسی است.

لطفاً روی شماره 1-303-643-1000 تماس بگیرید (TTY: 711).

Dè dè nà ke dyédé gbo: ɔ jù ké m̄ [Bàsɔ ɔ -wùdù-po-nyɔ ] jù ní, nií, à wuɖu kà kò dè po-poò b̄e in m̄ gbo kpáá. Dá 1-303-643-1000 (TTY: 711).



# EMERGENCY CODES Dial – 1234 for Emergencies

Code Blue Cardiac Arrest
Code Black – Bomb Threat
Active Shooter – Active Shooter
Code Pink- Abducted Infant
NEW: Missing Person - Pediatric through Adult
Code White - OB Hemorrhage
NEW: Transfusion Protocol - Non-OB Hemorrhage
NEW: Controlled Access- ED or Facility-Wide Lockdown
NEW: Hospital Command Center Standby or Activation

## Refer to the Emergency Operations Plan for initial actions and more information

### In Case of Fire:

- R: Rescue those in danger
- A: Alarm – Pull & Dial -1234
- C: Close doors/Clear halls
- E: Extinguish/Evacuate

### To use an extinguisher

- P: Pull the Pin
- A: Aim at the fire's base
- S: Squeeze the handle
- S: Sweep from side to side