A Tradition of *Caring*

Annual Mandatory Educational Module

2020

Good Samaritan Hospital

A Tradition of Caring

LOS ANGELES

Annual Mandatory Educational Module

Good Samaritan Hospital

GSH Human Resources Department

1225 Wilshire Boulevard
Los Angeles, CA, 90017

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GOOD SAMARITAN HOSPITAL

For questions related to the Annual Mandatory Educational Module please contact:

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TABLE OF CONTENTS

MISSION VISION VALUES

Mission

Good Samaritan Hospital is a progressive, tertiary not-for-profit hospital. Our Mission is to provide accessible, quality, cost-effective and compassionate healthcare services that meet the needs of our patients and their families, the community and physicians.

Good Samaritan Hospital's centers of excellence focus on advancing the science of medicine and providing outstanding healthcare.

We will manage our resources responsibly, maintaining the financial viability necessary for success.

Vision

Good Samaritan Hospital will grow into a leading regional healthcare provider. As we expand the breadth of our services, we will practice continuing quality improvement.

We will accomplish our mission by seeking new opportunities and forming alliances with physicians, other healthcare providers and purchasers of healthcare services.

We will encourage improvement in the health status of community residents, advocating equal access to necessary care. We will respond to Southern California's healthcare needs in the most caring, compassionate and efficient manner.

Values

We maintain the highest level of ethical and professional conduct, treating our patients with dignity and respect.

We, as employees, physicians and volunteers will work as a team to provide outstanding and compassionate care to anyone in need, regardless of race, creed, sex or religion, age, and physical or mental disability.

We constantly strive for excellence in all we do and recognize the importance of creativity and innovation.

We recognize that the care of our patients is our primary responsibility and our reason for existence.

We believe in operating efficiently to ensure fiscal soundness and maintain the viability of this organization.

CULTURAL DIVERSITY/CULTURAL COMPETENCY

What is cultural diversity?

It is the rich mixture of all the traditions, beliefs, values, customs and rules that characterize a group of people.

Our patients, staff and physicians come from many different cultures. We value all their contributions.

What is cultural competency?

It is being aware of the culture differences of our patients and making an attempt to understand another ethnic group's customs and beliefs and how their culture may affect the way they view their healthcare needs.

Clinicians who understand their patient's cultural values, beliefs, and practices are more likely to have positive interactions with their patient and provide culturally acceptable care.

Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse patients.

Our patients present with many cultural factors that include language, gender, sexual orientation/gender identity, socio-economic status, as well as physical and mental capacity, age, religion, housing status, and regional differences.

Our community is becoming ever more linguistically and culturally diverse. The number of people who spoke a language other than English at home has more than doubled in the last three decades and at a pace four times more than the nation's population growth.

Every person is unique. Consider the patient's beliefs, needs and concerns as you interact with them.

If the patient does not speak English, or English is the patient's second language or the patient is deaf/hard of hearing or has vision impairment, make sure to use our CyraCom phone system or other communication aids during your care discussions. Do not rely on family members to translate important health information.

Determine if patients want to include other family members in their care. When appropriate, use the terms "partner" or "spouse" rather than "husband" or "wife" to avoid making assumptions about sexual orientation or identity.

Ask patients about their preferences and pay attention to patient cues and follow their lead. If they do not establish eye contact or refuse to shake your hand, a cultural custom or spiritual belief may be guiding their behavior. Set the tone for your interaction by asking questions such as:

- How would you like to be addressed? Then remember to continue calling them by their preferred name.
- Is there anyone else who needs to be involved in making medical decisions about your care?

Maintain good communication by acknowledging and respecting your patient's interpretation of illness

- Listen carefully. When you talk with your patients, let them know you are listening by nodding your head that you understand
- Maintain eye contact if that is their norm, or avoid eye contact if that is their norm.
- Remain on the same physical level if possible. For example, avoid standing over the patient, which may be seen as condescending.

Cultural competency shares many features with the concept of patient-entered care, including:

- Recognizing the personal uniqueness of the patient
- Exploring and respecting patient beliefs, values, preferences, and needs
- Maintaining awareness of one's automatic assumptions and biases
- Providing patient information and education tailored to the individual's level of understanding
- Cultivating good communication skills and using medical interpreters when necessary
- Actively encouraging patients to participate in the decision-making process as it relates to individual health needs
- Considering patient perceptions and traditions as helpful guides to clinical decisions

There are lists of common health beliefs, and key "dos" and "don'ts" that may provide a starting point for health professionals to learn more about the health practices of a particular group. HOWEVER, these should not lead to STEREOTYPING and may ignore variations within a group.

For example, the assumptions that all Latino patients share similar health beliefs and behaviors ignore important differences between and among groups. Latinos could include first-generation immigrants from Guatemala and sixth-generation Mexican Americans from Texas. Even among Mexican Americans, differences such as generation, level of acculturation, citizenship or refugee status, circumstances of immigration, and the proportion of his or her life spent in the U.S. are important to recognize.

Here are some historical Hispanic health beliefs that MAY be present in Hispanic patients depending upon their background:

- Preventative care may not be a priority
- Illness may be viewed as God's will and recovery in His hands
- May apply hot and cold principles
- Expressions of pain are culturally acceptable
- Family may not want terminally-ill patient told of condition as it prevents enjoyment of the life left
- Being overweight may be seen as a sign of good health and well being
- Diet may be high in salt, sugar, starches and fats
- High respect for authority and the elderly
- Prefer same-sex caregivers if possible

Asian American historical beliefs of SOME patients:

- May see cause of illness as based on harmony expressed as a balance of hot and cold states or elements
- Norms about touch – head is the highest part of the body and should not be touched without permission
- Modesty is highly valued
- May rely on yin and yang for balance
- Tend to have higher respect for physician
- Communication is often based on respect; be careful with familiarity
- Some may practice:
    - Coining – coin dipped in oil is rubbed across the skin to release excess force from the body
    - Cupping – heated glasses placed on skin to draw out bad force
    - Use of herbs and acupuncture

Some historical African American health beliefs

- Health and illness may be intertwined with religion and good vs bad forces
- Families often multi-generational and members of their church may be considered family
- Family is often matriarchal

- May believe that illness is preventable if they are attentive to their relationship with God and other people
- May have higher incidence of diabetes and hypertension
- Family may play a key role in healthcare decision making
- May equate good health with luck or success
- Illness or disease may be viewed as equated with bad luck or fate

Remember that each patient is UNIQUE and may have some or none of the beliefs listed above. Talk to your patient and try to understand their health beliefs and how they may affect their individual healthcare needs.

We know that language and communication problems can lead to patient dissatisfaction, poor comprehension and lower quality of care. The type of interpretation service provided to the patient and family is an important factor in their level of satisfaction. We are to use "qualified" interpreters whenever important health information or consents are given to the patient. More information on our interpretation service is included under the PATIENT RIGHTS section of this module.

Providing care for our patients who may be LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) may also warrant that all staff be aware that they may prefer to be called by a different name than the one on their identification card.

To review some common terms that patients may self identify with:

- **Lesbian** – a term used to describe a woman who is emotionally, romantically, sexually, or affectionately attracted to other women.
- **Gay** – a term used to describe a man who is emotionally, romantically, sexually, or affectionately attracted to other men. At times, "gay" has been used to refer to all people, regardless of sex, who have their primary sexual and or romantic attraction to people of the same sex.
- **Bisexual** – a person who experiences sexual, romantic, and/or physical attraction to people of their own biological sex, as well as, another biological sex.
- **Transgender** – a term used to describe all individuals whose gender identity does not align with their biological sex
- **Queer or Questioning** – the term may describe people who have a non-normative gender identity, sexual orientation or sexual anatomy; it also can describe the process of exploring one's own sexual orientation and/or gender identity.

Patients who identify in one of these groups may have experienced discrimination at some healthcare encounter. Some may have been refused care, been verbally abused, or had a healthcare professional refuse to touch them or take excessive precautions before doing so.

Some mistakes that healthcare providers make in dealing with LBGTQ patients are:

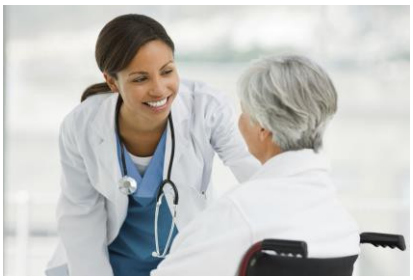
- Making assumptions about sexual orientation and/or gender identity
- Referring to a transgender person by the wrong pronoun. For instance, a man who is transitioning to a female may prefer the use of the female pronoun even if their birth certificate indicates male.
- Not acknowledging a transgender patient's gender preference
- Asking questions in a judgmental tone
- Not respecting the right of same-sex spouses to make medical decisions if the patient is incapacitated.

PATIENT RIGHTS

We have several policies that set out the rights of our patients. Please access them for more information. These policies are located on the GSH Intranet / Policies.

Patient Care Policies:

- Abuse, Neglect or Exploitation – Protecting
- Advance Health Care Directive
- AMA, Leaving Against Medical Advice
- Consent / Informed Consent
- Do Not Resuscitate



Administrative Policies:

- Health Care Decisions for the Unrepresented Patient
- Interpreter Services

The hospital posts the patient rights (in English, Spanish, and Korean) in public areas and each patient receives an admission packet that includes information on the patient rights and responsibilities.

Examples of patient rights:

1. Right to access care and treatment without regard to his/her sex, cultural, economic, educational or religious background, sexual orientation, gender identity or gender expression, or ability to pay.

2. Right to receive adequate information about the person(s) responsible for the delivery of their care, treatment, and services.

3. Right to have information of the name of the physician or other practitioner primarily responsible for their care, treatment, and services.

4. Right to have caregivers identified with name badges.

5. Right to have on-going education to the patient and family

6. The right to have informed discussions and consent prior to treatments and procedures.

7. The right to be informed about Advance Directives.

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Interpreter and Translation Services

The patient has a right to receive information in a manner he/she understands. Do not use family and friends as interpreters to provide information on medically related care, e.g. consents unless there is an emergent need for interpretation and professional/staff services are unavailable.

Use the CyraCom interpreter phone located in patient rooms and procedural areas to communicate with the patient in a language they can better understand.

LifeSign communication services are used for special needs. The TDY phone is available by contacting the Hospital Operator.

Right to refuse treatment or procedure

The patient or patient's surrogate decision maker has the right to refuse treatment from any caregiver.

Leave the hospital even against the advice of physicians.

Patient Complaint / Grievance Resolution

Complaints and grievances are taken seriously and dealt with on a timely basis.

The Patient Representative is available at ext. 2299 to assist with complaint management and resolution of complaints/grievances.

HIPAA, PROTECTED HEALTH INFORMATION and PATIENT PRIVACY

HIPAA is the Health Insurance Portability and Accountability Act (2010) that established the guidelines for the protection and use of the patient's "protected health information" known as "**PHI".**
As a healthcare organization, we must protect those valuable patient records whether they exist in an electronic form or on paper records.
The enactment of HIPAA made into law a series of patients' rights as well as new responsibilities for organizations that have and use health information.

- The **Privacy Rule:** says that individuals have a right to access their own "PHI", have a right to authorize release of the "PHI", and have it protected from improper disclosure
- The **Security Rule**: says we must have safeguards in place to ensure the security of our electronic "PHI".

Patient's Rights under HIPAA:

1. Patients must be given a copy of our Notice of Privacy Practices.
2. Patients may ask us to restrict how we use or disclose the protected health information.
3. Patients may ask us to communicate their "PHI" by an alternative method or to an alternative location.
4. Patients may inspect or get a copy of their "PHI", subject to certain limitations.
5. Patients may amend (add to) or ask us to correct the "PHI" in their records.
6. Patients, who request it, must be given an account of to whom we have disclosed/given their "PHI" and a record of who has reviewed their "PHI".

NOTE: if a patient asks an employee for a copy of information from their medical chart, contact HIM / Medical Records at extension ext. 2102 to assist with release of records.

Who has to follow the HIPAA Privacy & Security Rule?

- All employees whether they actually provide patient care or not
- All members of the medical staff i.e. doctors, physician assistants and nurse practitioners and the employees in their offices.
- Insurance companies and other companies who do business with hospitals.
- Business Associates (BA) are individuals or entities that work on behalf of the hospital providing a service involving the use or disclosure of patients' protected health information. Examples are: consultants, billing agencies, collectors, legal counsel, actuarial and accounting service providers

DO NOT LOOK AT ANY PATIENT CHART (EVEN IF AN EMPLOYEE) IF YOU ARE NOT ASSIGNED TO THAT PATIENT OR HAVE A WORK TASK THAT REQUIRES ACCESS.

Under HIPAA the following is "PHI" and is to be protected for all patients:

Name	Patient Identification Number
Address	Any Medical Record Numbers
Telephone or Fax Number	All Hospital Account Numbers
Age or Date of Birth	Health Insurance Plan Identification Number
Social Security Number	Driver license or vehicle ID number
E-mail address or URL	Finger or voiceprints, other biometric identifiers
Admission or discharge date	Full face photograph or similar image
Medical Device serial numbers	License or Certificate numbers

Any other unique identifier numbers or codes.

What are the Penalties for not Protecting Patient Confidentiality?

There are **stiff penalties for violating the privacy and security regulations** including fines and penalties for the hospital and now fines and possibly jail time for the person who made the breach:

The Office for Civil Rights is in charge of administering the law and investigating alleged privacy or security violations for the federal government. California Department of Public Health and California Office of Health Information Integrity do the same for the state of California.

The fines to our hospital can be up to $250,000 per incident.

There are also **criminal penalties for the more serious violations**. Gaining access to "PHI" under false pretenses or for harmful intent (for example, selling "PHI" about a patient) can result in fines to $250,000 and jail time up to ten years.

There are also other state and federal laws that require us to protect the privacy and confidentiality of patient information. These laws also carry the possibility of fines and jail time for serious infractions. **Licensed personnel may be reported to their boards.**

Additionally, GSH has policies in place that require any breach to be reviewed and that significant disciplinary action follow for those who do not comply with existing Privacy and other GSH Confidentiality policies.

HIPAA also Renquires that We Protect our Patients from Identity Theft

Laws called "Red Flag" regulations require that employees be on the alert for any evidence that a patient's identity, including medical identity, has been compromised or stolen. What may be signs that a person is using another patient's identity or "PHI" to receive services at GSH?

- Person not matching the patient history already on file
- Identification does not appear to match the person presenting it
- Requests to send bills to a different address than we have on file
- Signatures on Conditions of Admission and consents don't match our records

Notify the Compliance Office immediately should you have concerns about identity theft.

Make Patient's Privacy a Part of Your Work Routine

DON'T discuss patients' information in public areas like elevators, hallways or the cafeteria.

DO notify Admissions and Medical Records if a patient requests complete confidentiality about their presence at GSH or on restricting information to specific family members or other callers.

DON'T post any information about a patient on any social media site; pictures of patients are taken only as required for their medical treatment or authorized identification purposes; patient information belongs to the patient and the hospital and must NOT be shared in any form outside the hospital.

DON'T send "PHI" outside the organization by email unless it is an authorized transmission to an authorized recipient, and then only with the word "(SECURE)" in parentheses in the subject line to encrypt the data.

DON'T leave information like medical records or test results where patients and visitors in your area can see them. Deliver sensitive medical information directly to recipients- do not leave it on a counter or desk.

DO log off when you leave your computer.

DON'T share your computer access codes with ANYONE.

DON'T take medical records off the premises. Never take patient identifiable information out of the hospital. (This includes any papers that you use to keep informal information about your patients during the shift, such as diagnosis, meds, lab results, etc.)

DO use the "Confidential Trash Containers" for getting rid of any material that contains "PHI".

DON'T fax "PHI" to other health care providers until you verify the number independently. Double check the fax number you input before sending the information. When in doubt, ask Health Information Management to assist (ext 2102.)

DO use the "minimum necessary" information when dealing with "PHI"; send only what's necessary for the task at hand and store only what's necessary in ancillary record systems and databases. The less information we store or transmit, the less our risk of unintentional or improper disclosure.

DO contact Client Services at ext. 4029 if you have concerns about any suspicious emails, viruses, or other computer activity concerns. Our computer systems can be at risk if you select suspicious emails or download unauthorized software on your computer. Only laptops that have been encrypted by Information Services may be used for work related to the hospital.

DON'T reply, respond, or click on any emailed links or open attachments from email senders who you do not know or from whom you aren't expecting a message. When in doubt, verify with the sender before taking any action.

DO contact the Privacy Officer; IT Security Officer or the **Compliance Helpline** immediately when you have questions or concerns at **1-866-294-9592 (toll free).**

Good Samaritan Hospital is committed to promoting full compliance with all laws and regulations. If you become aware of illegal, unethical activity, or any misconduct, it is your responsibility to report these concerns.

MANDATORY ABUSE AND NEGLECT REPORTING

In the State of California, healthcare professionals are required to make a report anytime they suspect abuse or severe neglect of humans. The three categories of abuse are:

1. Child abuse/neglect
2. Assaultive behavior, and
3. Elder/dependent abuse/neglect.

What is Child Abuse?

Child abuse is defined as "a physical injury inflicted by other than accidental means on a child by another person."

What to report?

Under the law, when the victim is a child (a person under the age of 18) and the perpetrator is any person (including a child), the following types of abuse must be reported by all legally mandated reporters:

1. A **physical injury** inflicted by other than accidental means on a child. (Examples, bruises, broken bones, burns.)
2. **Child sexual abuse,** which includes sexual assault and sexual exploitation. Sexual assault includes sex acts with children, intentional masturbation in the presence of children and child molestation. Sexual exploitation includes preparing, selling or distributing pornographic materials involving children, performances involving obscene sexual conduct and child prostitution. (Examples, sexually transmitted diseases, pain, blood, or inflammation anywhere, especially bruises, and in the mouth, genital or rectal area.)
3. Willful **cruelty or unjustified punishment** which includes inflicting or permitting unjustifiable physical pain or mental suffering, or the endangerment of the child's health. (Examples, bruises, broken bones, dislocated arms/legs, tying up a child, locking a child in a closet.)
4. Unlawful **corporal punishment or injury**, willfully inflicted, resulting in a traumatic condition.
5. **Neglect** of a child must also be reported if the perpetrator is a person responsible for the child's welfare. (Examples, failure to thrive, bloated stomach, extremely thin, flakey and dry skin, extremely offensive body odor.)
6. Any of the above types of abuse or neglect occurring in out-of-home care.

What do I do when I suspect child abuse of any kind?

The main goals are to stop the abuse and to protect the child. Take photos if possible. Get the child to medical treatment. Make a report to the Department of Children and Family Services (DCFS).

Remember: The judgment of whether or not child abuse occurred is not on you. Anytime you **suspect** child abuse/neglect, make the call and let DCFS come to interview the family and make the decision. Contact Social Service if you need assistance to make a report.

Injuries by a Firearm or Assaultive or Abusive Behavior

Healthcare professionals, who provide medical services for a physical condition, are required to make a report when there is knowledge of, observe or reasonably suspect a patient to be suffering from any of the following.

1. Any physical injury or wound **inflicted by the patient**, when the injury is by means of a **firearm.** (Example, shooting self with a gun.)
2. Any physical injury or wound **inflicted by another person**, when the injury is by means of a **firearm.** (Example, any person with a gunshot wound.)
3. Any physical injury or wound inflicted when the injury is **the result of assault or abuse behavior.** (Example, physical or sexual assault, unexplained bruises, lacerations, fractures, or multiple injuries in various stages of healing, handprints.)

What do I do when I suspect assaultive or abusive behavior, including injuries with a firearm?

The main goals are to stop the abuse and to protect the victim. Take photos if possible. Provide medical treatment as needed. Make a report – Remember: The judgment of getting the straight story is not up to you. Anytime you **suspect** assaultive behavior, make the call and let LAPD come out and interview the patient and make the decision.

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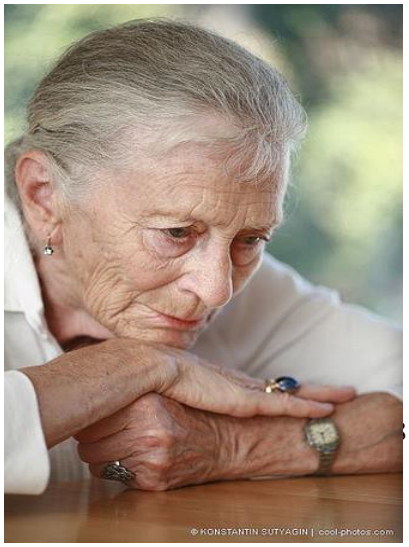
Elder and Dependent Abuse / Neglect

Any healthcare professionals who suspect or are told by the victim of abuse or neglect of an elderly person (age 65 or over) or a dependent adult (any person who is unable to care for him/herself) are required to make a report. The following circumstances are reportable:



1. **Physical Abuse:** Assault, prolonged physical/chemical restraint.
2. **Financial Abuse:** In which any person that stands in a position of trust and willfully steals money or property for any use beyond the lawful execution of his/her trust.
3. **Sexual Abuse:** Contact may involve physical sex acts, showing pornographic materials to Elder, forcing Elder to view/watch sex acts, contact with Elder without Elder's consent, sexual assault or exploitation
4. **Neglect:** Prolonged deprivation of food/water, medical care.
5. **Mental Abuse:** Subjecting a person to fear, threats, isolation, intimidation.
6. **Deprivation:** Prolonged deprivation of food/water, medical care, isolation.
7. **Abandonment**: Leaving the person when a reasonable person would continue to provide care.

What happens if I do not make a report?

As a mandated reporter, you are required to report abuse and severe neglect. If you have knowledge of such situations and do not make the report, you may have to pay fines and risk the loss of your professional license. Contact Social Service for assistance if needed.

COMPLIANCE PROGRAM

Compliance and Organizational Ethics

Good Samaritan Hospital's Compliance Program is committed to providing full compliance with all laws and regulations that govern healthcare providers. As part of our team, if you become aware of illegal, unethical activity or any misconduct, it is your responsibility to report these concerns. In order to promote and protect the integrity of its business practice, GSH has established the policy of: ***Code of Conduct and Organizational Ethics.***

Employee Responsibility:

- Refuse to participate in illegal or unethical acts.
- Refuse to conceal illegal or unethical acts of others.
- Report illegal or unethical acts to the Compliance Office ext 2338
- You may also call the Compliance Hotline at **1-866-294-9592** to report anonymously

What kind of issues should I report?

- Billing for medically unnecessary treatment or services not rendered
- Misrepresentation of products or services
- Payment of Kickbacks
- Patient neglect or abuse
- Fraud, waste and abuse of funds meant for patient care
- Hospital policy violations
- Harassment/Bullying

Conflicts of Interest

At Good Samaritan Hospital we maintain the highest level of ethical and professional conduct. Good Samaritan Hospital, its Board of Trustees, Medical Staff, and employees provide patient care and conduct all other business operations in an ethical manner consistent with its mission. Good Samaritan Hospital has developed its Conflict of Interest policy to address this mission. The purpose of this policy is to ensure the integrity of decisions made on behalf of the organization. Business decisions should be free of personal bias, interest, or gain. The intent of this policy will be met when decisions are made fairly and objectively, with the interests of the organization in mind.

Personal interests should be disclosed when they present actual or potential conflicts with the interests of the organization or appear to conflict with the objectivity and integrity of professional roles and responsibilities. When a conflict of interest is identified, there should be self-disclosure or disclosure by others aware of the situation. Disclosure should be to the Compliance Officer who will assist to determine if the disclosure is a conflict of interest.

INFECTION PREVENTION AND CONTROL

Infection Prevention Program

The purpose of the Infection Prevention and Control Program in our facility is to reduce the risk of infections occurring in our patients, healthcare workers, and our visitors. We use evidence-based practices to prevent healthcare-associated infections.

As part of our program, the ***Infection Prevention and Control Manual*** is available on the Hospital intranet. The Manual contains information about the program and important policies and procedures. Please review the following important resources:

- Bloodborne Pathogen Exposure Control Plan
- Tuberculosis Exposure Control Plan
- Aerosol Transmissible Disease Exposure Control Plan
- Standard Precautions and Transmission-Based Isolation Policies

Employee Health Policies are also available on the Hospital Intranet.

For any questions you may have related to prevention and control of infections, you may contact the Infection Prevention Department at ext. 2366:

- Valerie Lowe RN, BSN, CIC
  - Director, Infection Prevention
  - The Hospital's Infection Control Officer
- Jennifer Pitt, MPH
  - Infection Preventionist

For help with health screening, exposures, vaccinations, fit testing and return to work issues, you may contact the Employee Health Office at ext. 2395:

- Christy McNease RN,
  - Director of Employee Health
- America Morales, MA, BS
  - Employee Health Office Coordinator

Standard Precautions

Standard precautions means **ALL** blood and body fluids are treated as if known to be infectious for HIV, Hepatitis B, Hepatitis C or other bloodborne pathogens. Standard Precautions are used for all patients, regardless of diagnosis. Protect yourself from all body fluids, including, blood, urine, feces, amniotic fluid, spinal fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, wound drainage, vomitus and saliva (when contaminated with blood). Standard Precautions include but are not limited to:

- Hand Hygiene
- Personal Protective Equipment (PPE)
- Cleaning and Disinfection of Equipment and Environment
- Respiratory Etiquette
- Safe Injection Practices

Hand Hygiene

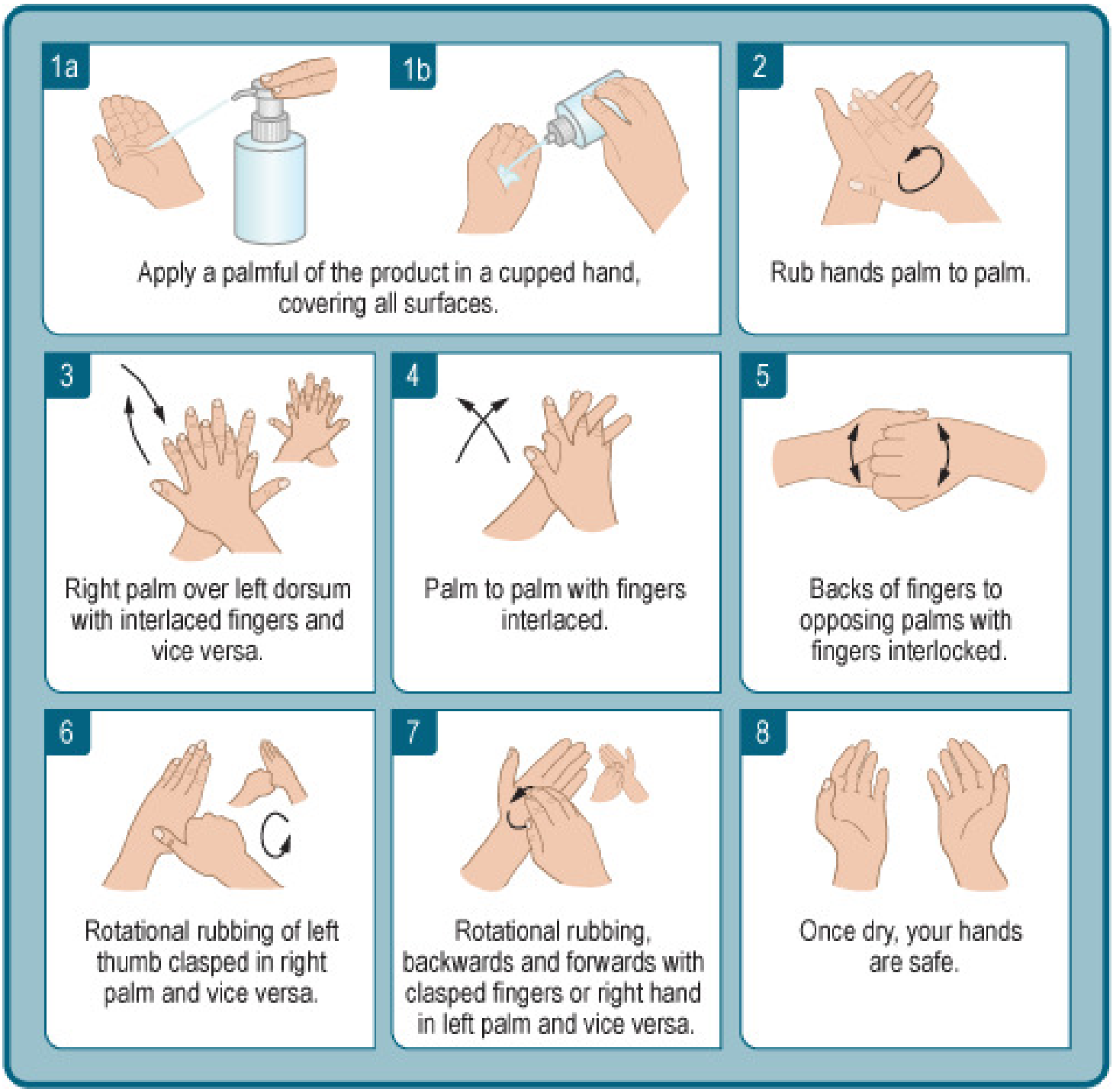
Hand hygiene is the single most important means of preventing the spread of infections to yourself or others. Hand hygiene can be accomplished by the use of alcohol-based hand sanitizer or washing your hands with soap and water. Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations. Only a few situations require soap and water and they will be outlined below. Good Samaritan Hospital follows the CDC Hand Hygiene Guidelines.

When to Use alcohol-based hand sanitizer:

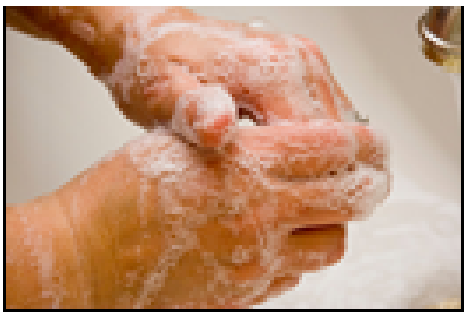
- Immediately before touching a patient
- Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical device
- Before moving from work on a soiled body site to a clean body site on the same patient
- After touching a patient or the patient's immediate environment
- After contact with blood, body fluids or contaminated surfaces
- Immediately after glove removal

How to use alcohol-based hand sanitizer:

- Apply alcohol gel
- Spread over hands
- Rub until dry
- Do not dry off with paper towel



When to wash your hands with soap and water:



- When hands are visibly soiled
- After caring for a person with known or suspected infectious diarrhea (includes C. *difficile*).

How to wash hands with soap and water:

- Use soap and warm water
- Rub hands together with friction for a minimum of 15 seconds
- Rinse hands thoroughly to remove all the soap
- Gently pat hands dry with paper towels
- Use paper towels to turn off the faucet and open bathroom door

Artificial nails, nail enhancements, overlays, gel nails, and nail tips are prohibited for all facility employees, students, LIPs or contract workers who provide direct, "hands-on" patient care, prepare products, or process patient care products.

Monitoring Hand Hygiene

Hand hygiene compliance is monitored by secret observers. All clinical staff rotate through the role of secret observer to promote hand hygiene awareness and knowledge of hand hygiene requirements. Compliance rates are compiled by Infection Prevention and shared with departments monthly. Compliance rates are also available on screensavers and taken to Medical Staff Committees.

Personal Protective Equipment (PPE)

Some of the **PPE (personal protective equipment) in addition to hand hygiene** we use are as follows:

Gloves:

Wear gloves when contact with blood/body fluids, mucous membranes and surfaces soiled with body fluids is anticipated. Gloves should **not** be worn outside of a patient's room unless the healthcare worker is providing direct patient care.

Gloves are not used to protect your hands from the environment. Surfaces and equipment should be cleaned and disinfected prior to touching (e. g., beds and wheelchairs used to transport patients should be disinfected prior to transport and no gloves should be worn by the transporter). **Gloves are not a substitute for hand hygiene**.

Eye/face protection and Masks:

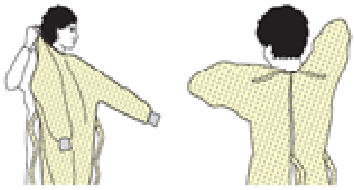
Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. Masks are not to be worn in hallways unless providing direct patient care or by unvaccinated personnel during flu season. **Masks should not be dragged across the mucous membranes and left dangling around the neck.**

Gowns:

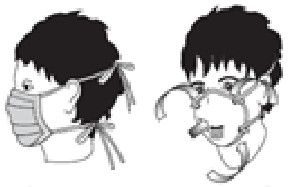
Fluid resistant gowns are available when soiling of your uniform is likely. Do not reuse gowns even for repeated contact on the same patient.

DONNING PPE

1. GOWN
   - Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
   - Fasten in back of neck and waist

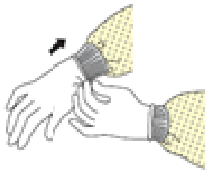


2. MASK OR RESPIRATOR
   - Secure ties or elastic bands at middle of head and neck
   - Fit flexible band to nose bridge
   - Fit snug to face and below chin
   - Fit-check respirator



3. GOGGLES OR FACE SHIELD
   - Place over face and eyes and adjust to fit

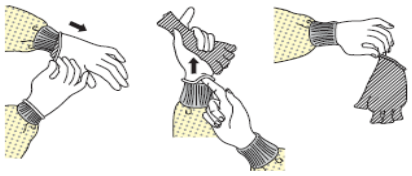
4. GLOVES
   - Extend to cover wrist of isolation gown



REMOVING PPE

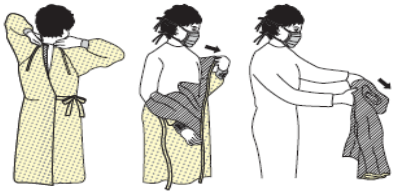
Your PPE must be removed before leaving the patient's room or procedure room.

1. GLOVES
   - Outside of gloves is contaminated!
   - Grasp outside of glove with opposite gloved hand; peel off
   - Hold removed glove in gloved hand
   - Slide fingers of ungloved hand under remaining glove at wrist
   - Peel glove off over first glovet
   - Discard gloves in waste container

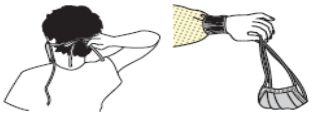


2. GOGGLES OR FACE SHIELD
   - Outside of goggles or face shield is contaminated!
   - To remove, handle by head band or ear pieces
   - Place in designated receptacle for reprocessing or in waste container

3. GOWN
   - Gown front and sleeves are contaminated!
   - Unfasten ties
   - Pull away from neck and shoulders, touching inside of gown only
   - Turn gown inside out
   - Fold or roll into a bundle and discard



4. MASK OR RESPIRATOR
   - Front of mask/respirator is contaminated — DO NOT TOUCH!
   - Grasp bottom, then top ties or elastics and remove
   - Discard in waste container



Cleaning and Disinfection of Equipment and the Environment

- Patient Care equipment must be cleaned after every use and stored in a clean equipment or supply room
- Equipment cleaned by Central Issue Department and ready for use has a plastic bag over the equipment or tag to indicate clean and ready for patient use
- If you use a piece of patient care equipment, you are responsible for cleaning or returning to Central Issue for reprocessing. Contact your manager if you have a question about the cleaning procedures in your area

Disinfectants for Cleaning Equipment and the Environment

These are the hospital approved disinfectants for use on patient-care equipment or environmental surfaces.

Purple Top Super Sani-Cloth
2 minute WET contact time
For use on patient care equipment and on hard non-porous surfaces

Grey Top Super Sani-Cloth
3 minute WET contact time
For use on oxygen tanks and other medical gas tanks

Sani-Cloth Bleach Wipes
4 minute WET contact time
For use on equipment and surfaces in C. *diff* patient rooms

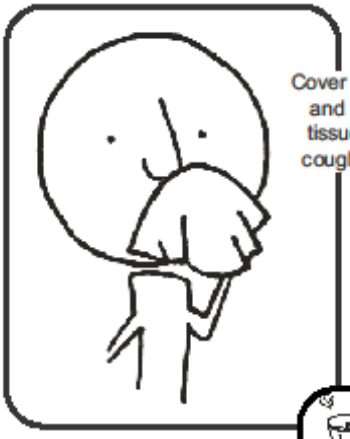
Respiratory Hygiene / Cough Etiquette

When a patient presents with cough, fever or respiratory illness:

- Provide tissues, mask, hand sanitizer, and separate waiting area if feasible.
- Post visual signs in departments to alert patients to cover their cough.
- Practice these control measures for your own cough or sneeze.

Stop the spread of germs that make you and others sick!

Cover your Cough



Cover your mouth and nose with a tissue when you cough or sneeze

or

cough or sneeze into your upper sleeve, not your hands.

Put your used tissue in the waste basket.

You may be asked to put on a surgical mask to protect others.

Clean your Hands

after coughing or sneezing.

Wash hands with soap and warm water for 20 seconds *or*

clean with alcohol-based hand cleaner.

Safe Injection Practices

- Use one needle, one syringe, one patient, ONE TIME
- Use aseptic technique
- Do not administer medications from a syringe to multiple patients
- Needles, cannulae and syringes are sterile, single-use items
- Use single-dose vials for parenteral medications whenever possible
- Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use
- If multidose vials must be used, both the needle and cannula and syringe used to access the multidose vial must be sterile

DISCARD after every use!

Transmission-Based Isolation Precautions

Standard precautions should be used on all patients, all the time to prevent the transmission of microorganisms. When Standard Precautions are not enough to prevent transmission, Transmission-Based Isolation Precautions should be initiated. There are three types of transmission-based isolation precautions:

Airborne Precautions:

- To prevent the spread of diseases that are spread by droplet nuclei that remain suspended in the air or in dust particles for long periods of time
- Use Airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route
  - Examples: tuberculosis (TB), chickenpox, **disseminated** herpes zoster, measles
- Patient must be placed in an Airborne Infection Isolation Room (AIIR)
  - Room has negative pressure and other specific requirements
  - Door must remain closed at all times
- PPE: N-95 respirator mask should be worn when entering the patient's room and discarded upon exiting the room. A PAPR (powered air purifying respirator) should be used if an N-95 respirator mask cannot be worn
  - Fit testing and training on the respiratory protective equipment is arranged through Employee Health Services at ext. 2395
- Limit transport of patients outside of the room to medically-necessary purposes
  - When transport is necessary, patient should wear a procedure mask and any infectious lesions should be covered
  - Never place an N-95 mask on a patient or visitor as they are not fitted to wear one
  - Healthcare personnel do not need to wear a mask or respirator during patient transport

Contact Precautions:

- To prevent the spread of infection from direct contact with an infected person or their environment
- Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission
  - Examples: scabies, *C. difficile*, certain multi-drug resistant organisms including ESBL *E. coli* (Extended-Spectrum Beta-Lactamases producing *E. coli*), CRE (Carbapenem-resistant *Enterobacteriaceae*)
- Patient should be placed in a private room, when possible, or cohorted by organism
- PPE: Gloves and gown should be worn when entering the patient's room and discarded upon exiting the room
- Limit transport of patients outside of the room to medically-necessary purposes
  - When transport is necessary, cover or contain the infected or colonized areas of the patient's body
  - Healthcare providers do not need to wear PPE during patient transport unless performing patient care

Droplet Precautions:

- To prevent the spread of infection from contact with droplets emitted by the patient when coughing, sneezing and talking
- Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that travel a short distance (about 3 to 6 feet)
  - Examples: influenza and meningococcal meningitis
- Patient should be placed in a private room, when possible, or cohorted
- PPE: Procedure mask should be worn when entering the patient's room and discarded upon exiting the room. PPE should be added for patient's that are coughing and sneezing under Standard Precautions (eye protection, gown and gloves)
- Limit transport of patients outside of the room to medically-necessary purposes
  - When transport is necessary, patient should wear a procedure mask
  - Healthcare personnel do not need to wear a mask or respirator during patient transport

A complete list of diseases in each category can be found in the Isolation Policies in the *Infection Prevention and Control Manual* (located on the hospital intranet).

Aerosol Transmissible Disease (ATD) Plan

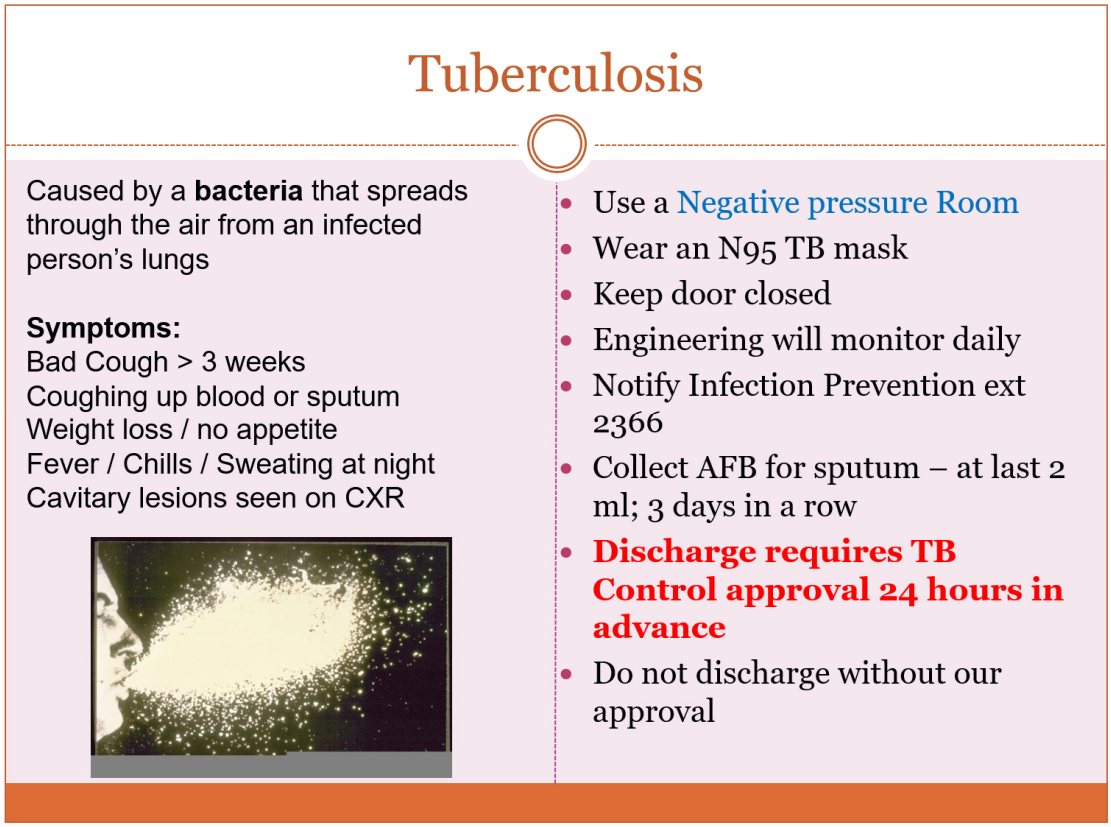
The Cal-OSHA Aerosol Transmissible Disease (ATD) standard is aimed at protecting workers at high-risk of droplet and airborne spread infectious diseases. Good Samaritan has a written plan including policies and procedures for protecting healthcare workers which is available in the *Infection Prevention and Control Manual* (located on the hospital intranet). This plan includes training protocols for PPE, including N-95 respirators for airborne pathogens, PAPRs (powered air purifying respirators), CAPRs (used only by Respiratory Therapists when performing an aerosol-generating procedure) for certain high hazard procedures.

Here is a sample of the PAPR (powered air purifying respirator) and CAPR (used by Respiratory). Contact Central Issue department at ext. 2297 if a unit is needed.

Used by Nursing

Used by Respiratory Therapists

Tuberculosis Exposure Control



Tuberculosis (also known as TB) is caused by the bacteria *Mycobacterium tuberculosis*. It belongs to a group of organisms called acid fast bacilli (AFB). The disease is spread by tiny airborne droplets when a person with active pulmonary TB expels the organisms into the air when coughing, sneezing or talking.

Symptoms of TB: cough > 3 weeks, coughing up blood, unexplained weight loss, night sweats, fever/chills, loss of appetite

Risk Factors for TB: recent immigrant; resident of a jail or prison, homeless shelter, known exposure or did not complete TB therapy

How is TB transmitted: droplets are inhaled by another person

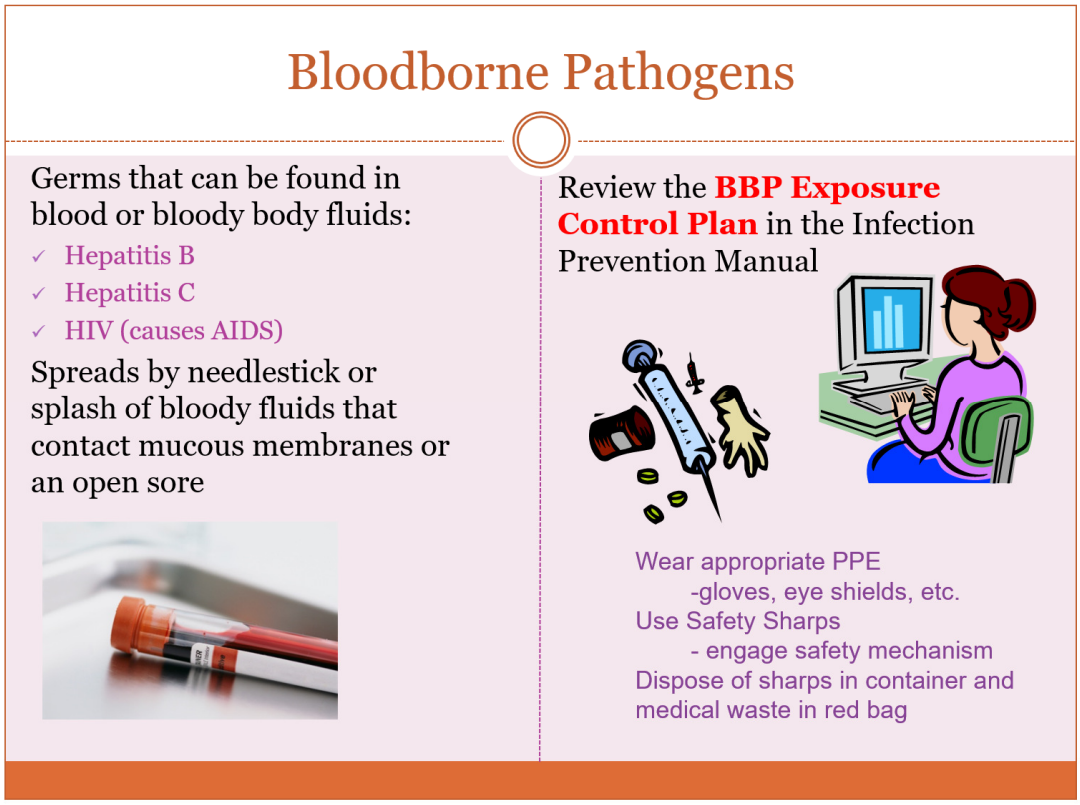
Managing a suspect TB patient:

- Notify Infection Prevention department at ext. 2366 when the following conditions are present:
  - Signs and symptoms of TB are present and/or,
  - The patient has an abnormal chest x-ray (cavitary lesions), or
  - The patient has a positive AFB smear/culture, or
  - The patient is placed on two or more anti-TB drugs (Isoniazid, Rifampin, Pyrazinamide and Ethambutol)
- Initiate Airborne Precautions in a negative pressure room and keep the door closed
- Obtain order for three AFB sputum specimens at least 8 hours apart with one early morning specimen.

- Collect a specimen of at least 2ml to send to the lab.
- Wear an N-95 respirator mask to enter the room or PAPR if unable to wear N-95 respirator mask
- If patient must be transported, put a regular procedure mask on the patient. The transporter does not need to wear a mask. Never place an N-95 mask on a patient or visitor as they are not fitted to wear one and it can cause respiratory issues in those with underlying respiratory disease such as COPD.

Protecting yourself from TB

- Be fit tested for the N95 mask (contact Employee Health at extension ext. 2395)
- Periodic TB screening
  - Your health screening is scheduled by department. A reminder notice will appear on your time clock with advanced notice that you are due for screening. Most departments are annually screened; but certain departments that are more likely to have contact with a TB patient are screened every six months.
  - Be sure to complete your required screening or your badge will be deactivated and you won't be able to clock in.



Blood Exposures – Reducing the Risks

The hospital's Bloodborne Pathogen Exposure Control Plan is located in the *Infection Prevention and Control Manual* (located on the hospital intranet). It outlines the special steps the facility has taken to reduce the risks healthcare workers face when caring for patients.

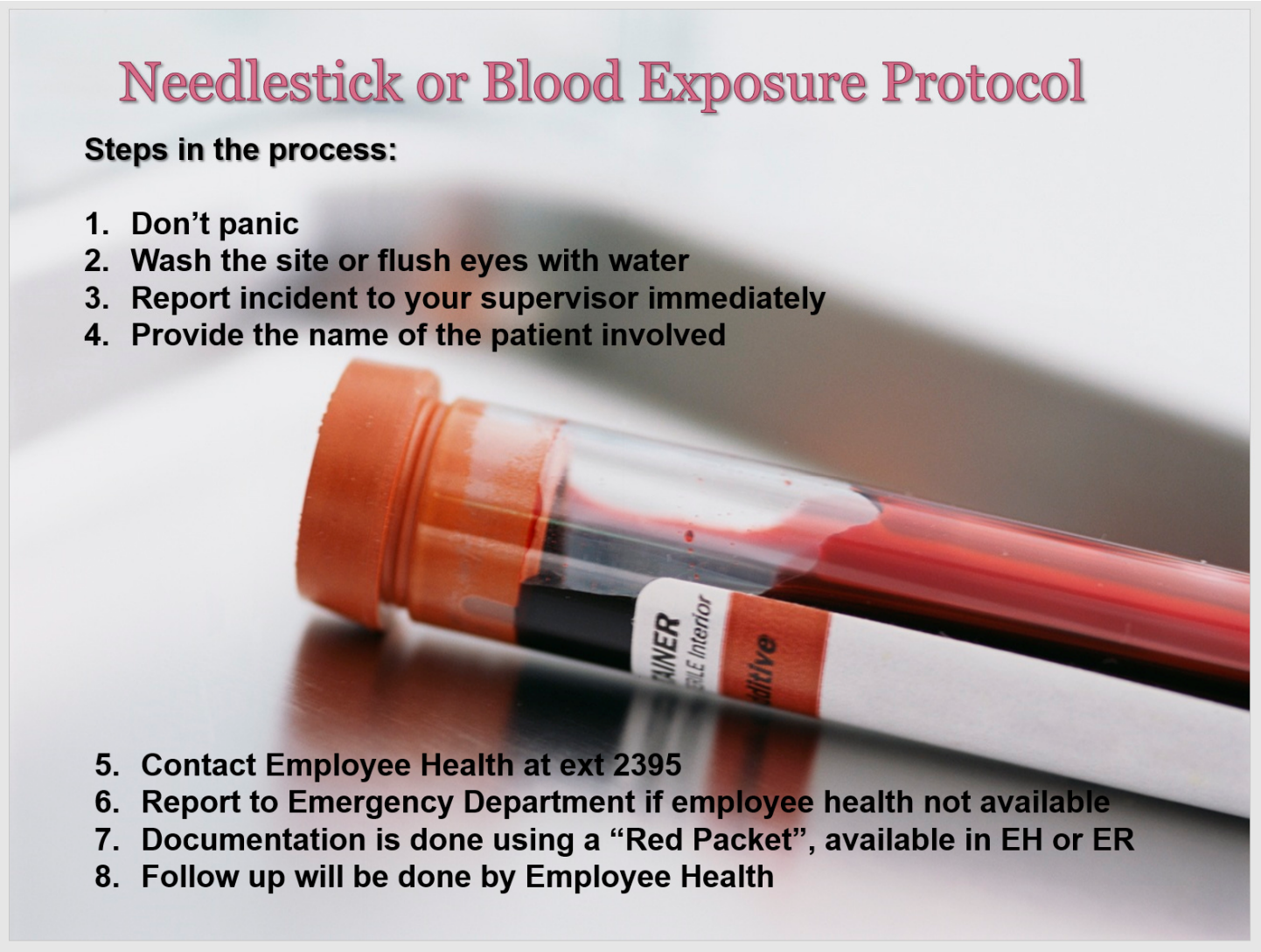
Use care when handling needles or sharp instruments. **Always** use devices with safety features and dispose of these items in the sharps disposal container; never in the regular trash. Wear personal protective equipment such as gloves, goggles, mask, and gown when contact with a patient's blood or body fluid is likely.

Eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in the patient care areas because of the risk of transmission of HIV, Hepatitis B and Hepatitis C.

Steps to take if you have a needlestick or blood splash:

- Wash the exposed area with soap and water (for eye exposure, irrigate with normal saline or water).
- Notify your supervisor of the incident.
- Complete a Red Exposure Packet to document the incident. Red Packets are available at the Emergency Room Security Desk and in the Employee Health Department.

- During working hours, complete the Red Packet in Employee Health; after hours, go to the Emergency Room to complete the red packet and for exposure follow-up.
- Testing of the source patient is done by the clinician ordering "SOURCE" in the Meditech lab module. This will order HIV (rapid), Hepatitis B surface antigen and Hepatitis C antibody.
- Consent from the patient is required for HIV testing.
- Testing of the exposed HCW will be ordered by the evaluating clinician and will consist of HIV (rapid) with consent, Hepatitis B surface antibody, and Hepatitis C antibody.
- Lab results will be reviewed by the Employee Health Office and follow-up care initiated.



Influenza Vaccination Program

- Annual seasonal flu vaccine is offered through Employee Health Services at no charge to HCWs
- ALL HCWs are expected to be vaccinated unless a medical contraindication is present
- The Los Angeles County Health Officer has ordered that all acute hospital HCWs be vaccinated or wear a mask in patient care areas during flu season (November 1 through April 30) each year.
- California State Law requires a signed "declination statement" if the vaccine is refused.

QUALITY MANAGEMENT, PATIENT SAFETY, & REPORTING OF UNANTICIPATED ADVERSE EVENTS

Our Quality and Patient Care Programs promote a culture of patient safety where care is delivered in a safe and reliable manner. We utilize performance improvement tools, aggregated data, and patient safety metrics to monitor our environment and make sure we achieve desired patient outcomes and meet established benchmarks/goals. In developing our culture of safety, we look at errors as an opportunity to learn and improve. We deal with errors in a non-punitive manner (unless behavior is truly intentional and/or egregious).

Good Samaritan Hospital's quality program and values promote the *"Tradition of Caring"* and include six key components:

- Improve patient care
- Improve patient outcomes
- Improve patient safety and reduce harm throughout the organization
- Meet our customer's needs and strive to exceed expectations
- Improve clinical, operational processes and services within the organization
- Fulfill the Mission of the hospital

Good Samaritan Hospital is committed to providing high quality care and services to the community we serve. In order to achieve our goals, we have a formal performance improvement plan and a physician led performance improvement council approved by the GSH Board of Trustees.

Performance Improvement and Patient Safety Committee

The Performance Improvement and Patient Safety Committee are chaired by a physician member of the Medical Staff. The committee serves as the oversight committee for all Performance Improvement/Patient Safety activities and approves and makes recommendation for improvement hospital-wide. The committee is multi-disciplinary and made up of physicians, hospital leaders and Governing Board members. The

committee meets on a regular basis and reviews Service Areas Performance Improvement Reports. The committee reviews publicly-released healthcare quality information, performance improvement activities, quality resources, and regulatory mandates recommended by our various external review agencies i.e., TJC, CMS, CDPH. Findings and recommendations are sent to the Medical Executive Committee and Governing Board for review and approval.

Employees Contribution to Quality

We encourage all employees to actively participate in our Quality Program and get involved with quality activities or studies being conducted in their areas and throughout the hospital. We value your ideas and process improvement suggestions. Most quality issues that occur within a medical setting are due to processes that need to be reviewed and improved and not as a result of an individual error. Process improvement serves to identify and resolve problems in order to achieve successful outcomes.

Any employee, physician, or patient who has a safety or quality of care concern is encouraged to discuss the matter with the immediate supervisor or contact the Quality Management Staff. No disciplinary action will be taken against an employee who makes a valid report.

The Joint Commission and Core Measures

In order for a hospital to receive reimbursement for a Medicare patient, they must be accredited by a deemed status organization (i.e. TJC, DNV, AOA, etc.). Good Samaritan Hospital is a Joint Commission accredited hospital. All Joint Commission accredited hospitals are required to have Core Measures (performance measures) in place.

To be in compliance with The Joint Commission, the hospital must meet standards of practice and are required to participate in performance or outcome measures also known as Core Measures. Currently, our Core Measures are:

Inpatient Measures:

- Sepsis
- ED turnaround time for Admitted Patients
- Prevention (Immunizations)
- VTE
- Perinatal Care (Exclusive Breast Feeding & Early Elective Delivery)

Outpatient Measures:

- Outpatient Chest Pain (ED Patients)
- Op Web
- ED Turnaround Times for Discharged Patients
- ED Pain Management
- ED Management of Stroke Patients

By continuously monitoring our Core Measures we standardize care provided, initiate national best practice guidelines, and implement changes which lead to improved patient outcomes.

Patient Safety Plan

Good Samaritan Hospital has a formal Patient Safety Program structured to oversee and improve patient safety throughout the medical center by preventing medical errors, adverse occurrences, and patient injuries during the course of medical treatment. Your active participation in the Patient Safety Program is important to assure our patients have a safe experience while in our hospital. The Patient Safety Goals should be used in your routine work as you interact with patients, visitors, physician and other healthcare providers.

Be aware of risk and hazards that can affect patients, physician, employees and visitors. As an employee, you play a critical role in Patient Safety. Here are some tips on how you can work with us to promote patient safety.

- Read and understand the current National Patient Safety Goals posted on bulletin boards throughout our facility.
- Identify potential hazards to patients in your department/service.
- Keep the environment in your area free of safety issues.
- If you are in a patient care area and you see a patient trying to get out of bed with a Fall emblem on their door, ask the patient to "wait until the nurse is present before you attempt to get out of bed."
- Follow hospital policies and procedures as they pertain to blood drawing, giving shots, specimen collection, labeling medicine on and off of the sterile field, and administering medications.
- Always **identify the patient by** using two hospital approved identifiers
    - Patients with wrist bands: use first and last name and "V#"- (visit number)
    - Patients without wrist bands: first and last name and birthday
    - Calling MD about a patient: use first and last name and diagnosis
    - Patient receiving blood or blood products: use first & last name and V# - visit number
- When using equipment, check to see if the preventive maintenance sticker is current and the equipment has the approved safety sticker affixed to the equipment.
- If a piece of equipment fails during a treatment, take the equipment out of service, mark it as defective, complete an Event Report and notify the Risk Manager.
- Never use a piece of equipment on a patient unless you have been trained and are competent to use the equipment.

- Notify your supervisor or the Director of Quality of safety concerns that are not corrected immediately and pose a threat to the safety of a patient.

The falls prevention program is part of our hospital wide patient safety program to keep our patients safe from injuries from falls. The goal is to reduce the number of falls with and without injury. The falls prevention program must be followed by every nursing unit and is comprised of the following:

- Daily Review Dashboard: filled out at the beginning of each shift by the department supervisor; form serves as a rounding tool to ensure correct interventions are in place (i.e., bed alarm, fall sign).
- Post Fall Assessment: if fall occurs, a post fall huddle must take place between the nurse involved, the department supervisor and if possible, a member from the Quality team. Post fall forms must be completed and a discussion around how the fall could have prevented is completed (Note: Always fill out an event report when a fall takes place).
- Brochure for Patients and Families: 'Fall Prevention Guidelines for Patient & Families' brochure serves as an education tool for patient and family members and must be given to any patient who is at high risk for falls; For more information about the Falls Prevention program, contact your department supervisor or the Quality Management Department.

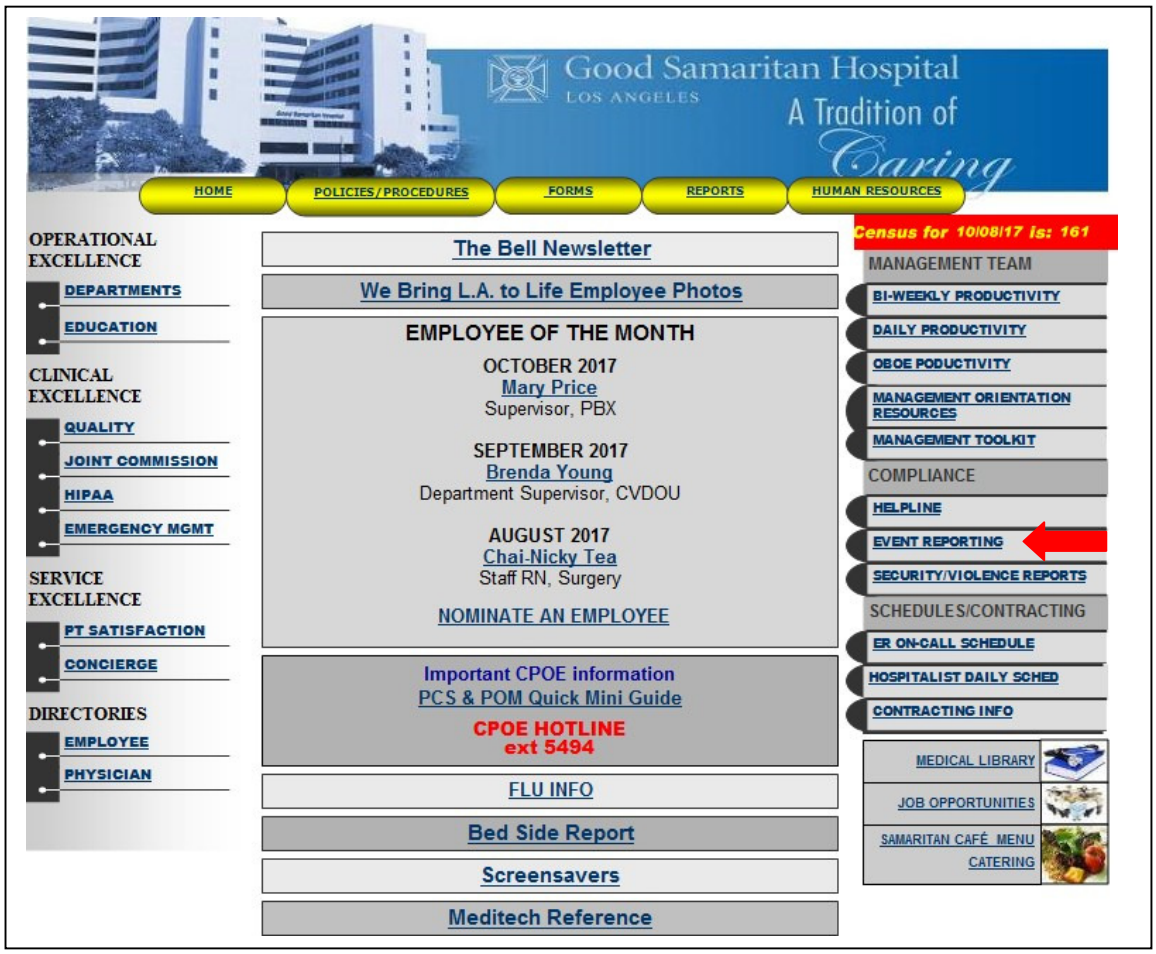
National Patient Safety Goals (NPSG)

Good Samaritan Hospital is committed to reducing and preventing adverse medical events while enhancing the care given to our patients. The NPSG posters are throughout the hospital to help remind staff of their importance. Additional copies are available from the Quality Improvement Department.

Reporting Patient Safety Risks and Events

If you become aware of a patient safety issue or risks of harm, go to the on-line event report system and enter the information requested. Once you have completed the on-line form please do the following:

- Notify your immediate unit supervisor or nursing house supervisor that an event has occurred.
- Enter the event into the **event reporting** system ASAP and no later than 24 hours.
- Do not make print copies of the event report. The information you submitted becomes a legal document maintained by the Quality Director and/or Risk Management Department.



Significant and Sentinel Events

If an unexpected event occurs resulting in a Significant (serious physical or mental injury with the potential of significant harm to a patient) or a Sentinel Event also called a *Serious Reportable Event or Adverse Event* (one that results in serious physical injury, death or the risk thereof) complete the on-line event report and contact the Risk Management and the Quality Director regarding the event. The Quality Director (who is also the Patient Safety Officer) should be contacted immediately.

Examples of Significant and Sentinel Events include but are not limited to the following:

Significant Events:

- Medication error with respiratory depression (but no arrest occurred)
- Unsterile instruments used causing infection
- Mislabeled x-ray identified just prior to the start of a procedure

Sentinel Events:

- Medication error requiring patient to move from the medical or surgical floor to ICU
- Patient in restraint dies
- An infant abduction occurs
- A suicide or homicide occurs in the hospital
- A healthcare associated infections (HAI) resulting in permanent loss of function
- Wrong site surgery
- Major injury in the MRI Suite, etc.
- Near misses which could have resulted in a bad outcome, etc.

Sentinel Event Review and Root Cause Analysis (RCA)

When a **Sentinel Event** occurs, the Quality department initiates a Root Cause Analysis (RCA) investigation and discloses the event to the patient and/or family. If required, the event will be reported to the California Department of Public Health (CDPH). The timeframe for reporting to the CDPH is within 5 days of the event being detected.

The RCA team reviews all information gathered about the adverse event. Staff who are directly involved, including physicians, nurses, technicians, will be asked to participate in the RCA review. The information discussed during the RCA is protected and confidential. A layman's explanation and an apology will be made to the patient and their significant others regarding the event. We will discuss the action plan we have put into place to assure that no future event of this type will occur in the hospital.

Informing Patients of Unanticipated Outcomes

Good Samaritan Hospital believes that patients/significant others have a right to be informed of unanticipated outcomes, Sentinel Events, adverse events or Serious Reportable Events. The patient/family will be notified by his/her physician (along with a representative from Nursing Administration or Quality Management) of what, when and how the event occurred. An explanation will also be given in regards to what the expected outcome is, what harmful effects the event had on the patient, what actions are being taken to prevent future occurrences of this type and what staff education and training is planned.

When an unanticipated event occurs our staff members are responsible for the following:

- Caring for the patient; doing whatever is necessary to make sure the patient is ok
- Notifying the patient's physician, immediate supervisor, or the house supervisor immediately
- Completing the appropriate on-line event reporting form and other required hospital forms
- Documenting in the patient's medical record only the actual activity surrounding the event e.g. "patient received aspirin but Advil was ordered; MD notified and patient transferred to ICU".

Rapid Response Team – Recognition and Response to Changes in Patient's Condition

The Joint Commission encourages hospitals to select a suitable method that enables health care staff members, patients, and family to request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.

A significant number of critical inpatient events are preceded by warning signs prior to the event. A majority of patients who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a patient's condition by a specially trained individual(s) may reduce cardiopulmonary arrests and patient mortality.

The Hospital has selected the **Rapid Response Team (RRT)** as a method for responding to a patients worsening condition in non-intensive care unit areas.

The RRT consists of a critical care nurse and respiratory therapist. The House physician on duty will be contacted if urgent medical care is needed in a timeframe that cannot be met by the patient's managing or consulting physicians.

RRT recommendations and interventions may include:

- Airway/Breathing: oral airway, suctioning, 0_2 mask/nasal, nebulizer treatment (if ordered), bag mask, ABG, or no interventions.
- Circulation: EKG, defibrillation, CPR, BMP, Hemogram or no intervention.

The criteria for calling additional assistance to respond to a change in the patient's condition or a perception of change by the staff, the patient, and/or family are:

ACUTE CHANGES IN:	PHYSIOLOGY
Airway	Respiratory Distress Threatened Airway
Breathing	Respiratory Rate >30/min. Respiratory Rate <6/min. SaO_2<90% on Oxygen
Circulation	Systolic Blood Pressure <90 mmHg despite treatment Pulse Rate >130 bpm
Neurology	Any unexplained decrease in level of consciousness New onset agitation or delirium Repeated or prolonged seizures Severe uncontrollable headache
Other	Nurse concerned about the patient New onset chest pain

Based on the presence of the above criteria, staff, patients or family may seek additional assistance when they have concerns about a patient's condition. The hospital encourages the patient and family to seek assistance when the patient's condition worsens.

Activation of the RRT

The licensed staff may activate the RRT by dialing "6" and notifying the operator to overhead page "Rapid Response Team to_____". The blank is filled in with the patient's location. Family or non-licensed staff may activate the RRT by notifying the nursing staff who will in turn call the operator as listed above if clinically indicated.

Education of Patient, Family, and Staff

The clinical staff will educate the patient and family on the patient's condition-specific criteria for notifying the nurse of a worsening status.

Formal education for urgent response policies and practices is conducted with the staff and licensed independent practitioners who may request assistance and those who may respond to those requests through competency based orientation, annual update and unit-based in-services as identified by the Quality Improvement Process.

FIRE LIFE SAFETY, GENERAL SAFETY, and EMERGENCY PREPAREDNESS

Fire Life Safety

Code Red:

A Code Red is announced through the overhead paging system by the hospital operator in the event of a fire. When a Code Red is announced, staff are to practice the following:

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1. ***Safety of Life:*** If fire or smoke is discovered in a patient room,
   Remove the occupant out of the fire room. Close the door.

2. ***Notification:*** Report the fire to your facility "Central Reporting Station" (CRS)

   Located at: PBX OFFICE and at the SECURITY CONTROL FRONT DESK at the HOSPITAL MAIN LOBBY

   By: DIALING "6"
   Pull the closest fire alarm

3. ***Extinguish the fire*:**

   If it can be done quickly and safely (within 5 seconds)
   Continue to close doors to resident's rooms and/or offices.

4. ***Relocate/Evacuate:***

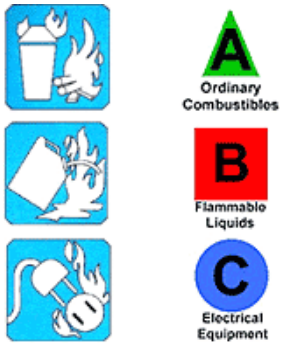
   Move everyone out of the fire area to a safe location within the facility, past at least one set of fire doors.

Use of Fire Extinguishers:

Fire extinguishers are located in strategic locations throughout the hospital. The location of extinguishers is typically identified by a sign placed above the extinguisher.

Fire extinguishers at Good Samaritan Hospital are typically ABC type.

Fire Extinguisher Types:



- **A –** A water based extinguisher is used on fires primarily fueled by wood, paper, cloth, etc. Type **A** extinguishers should not be used on grease or electrical fires. Use of a type **A** extinguisher on a grease or oil fire will usually cause the fire to spread. Use of a type **A** extinguisher on an electrical fire may lead to severe shock or electrocution.
- **B –** A chemical based extinguisher is used on fires primarily fueled by oil or grease. Type **B** extinguishers are to be used on fires where grease, oils, and plastics are involved. Type **B** extinguishers are not recommended for extinguishing fires involving wood, paper, or electrical components
- **C –** A chemical based extinguisher is used on electrical fires. Type **C** extinguishers are used on fires where electrical or electronic devices are involved. These fires may involve electrical wires or cables, computers, monitors, etc.
- **ABC –** A chemical based extinguisher that may be used to extinguish type **A**, **B**, or **C** fires. **This is the most common type of fire extinguisher in the hospital.**

When using a fire extinguisher, practice **PASS**:

PASS is an acronym for the following:

- **P – Pull the pin** on the fire extinguisher. Do not squeeze the handle while attempting to pull the pin out of the extinguisher as this may crimp the pin and prevent you from pulling the pin from the extinguisher.

A - Aim the hose or nozzle of the extinguisher at the base of the fire. Stand at a safe distance from the fire but close enough where the discharge from the extinguisher can reach the base of the fire.

S - Squeeze the handle, fully, to activate the fire extinguisher. Squeeze until fully engaged and extinguishing material is expelled from the nozzle or hose.

S - Sweep the extinguisher from side to side while aimed at the base of the fire and continue the sweeping motion until the fire is completely extinguished.

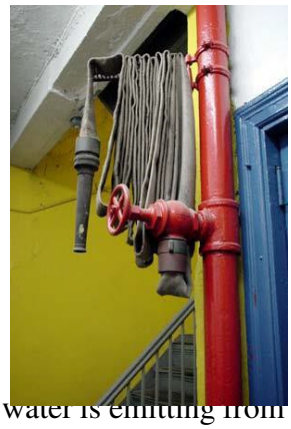
Interim Life Safety Measures

Interim Life Safety Measures are implemented when a fire life safety system is compromised or unable to fulfill the intent of its design. Interim life safety measures need to be implemented when any of the following are compromised:

1. Clear path of travel or exit paths
2. Fire extinguishing systems
3. Fire alarm systems
4. Fire and smoke partitions or barriers

Fire Hoses

Fire Hoses are located throughout the 27/53 building (Old Building) and at the Heliport on the main hospital building. Practice the following when using a fire hose:



1. A fire hose should be used when 2 individuals are available to use the hose.
2. Un-rack the hose by pulling on it until fully removed from the fire hose case. Fully extend the hose.
3. The first individual needs to grasp the hose and firmly hold it.
4. The 2nd individual should turn on the water at the fire hose cabinet.
5. The 2nd individual should then assist by standing approximately 3 to 4 feet behind the first individual and firmly grasping the hose.
6. Turn the hose nozzle while firmly holding the hose until the water is emitting from the hose. **DO NOT RELEASE THE HOSE AT ANY TIME. RELEASING THE HOSE MAY CAUSE SERIOUS INJURY OR DAMAGE.**
7. Upon extinguishing the fire or ceasing to use the hose; the 2nd individual should turn off the water at the water hose cabinet while the 1st individual continues to firmly hold on to the hose until all water flow ceases.
8. Re-rack the hose.

Smoking Policy:

Good Samaritan Hospital is a non-smoking campus. There is no smoking or use of tobacco products allowed anywhere on campus or in hospital vehicles. Nicotine-replacement options are available for patients during their stay. Patients who wish to smoke must sign out AMA and leave campus to do so. Visitors can purchase nicotine-replacement options from the Gift Shop.

Oxygen Safety

1. Labeling of areas using oxygen:

a. Signs must be posted where clearly visible at the entrance to the room and inside the room
b. Oxygen storage areas must be identified by posting a sign on the exterior of the room.

2. Smoking, open flames and fire prevention:

a. Smoking or open flames are not permitted where oxygen is in use.
b. Do not use grease or oil-based products (such as may be in some patient skin care lotions) where oxygen is being used. When enriched by oxygen, these may ignite a fire.
c. Do not use organic materials in an environment that may be enriched by oxygen. Materials such as rubber, cotton, etc. may ignite when used in oxygen-enriched environments.

3. Turning off oxygen in an emergency:

a. The unit Manager, Director, or person assuming overall responsibility for the unit or area shall make the decision to turn off oxygen to an area. The Director of Engineering, Manager of Engineering, or the Power Plant Engineer on duty may make the decision to turn off oxygen to the entire facility in a catastrophic event.
b. Implement emergency backup procedures for patients requiring oxygen therapy if oxygen must be turned off to an area.

4. Storage of oxygen and compressed gas cylinders:

a. Oxygen and compressed gas cylinders must be stored in a manner that will protect the cylinder and the cylinder's neck from damage.

b. Always store oxygen and compressed gas cylinders in a carrier or anchored to a secure location with 2 chains that support the upper and lower portions of the cylinder.
c. Tanks that may not be secured in a carrier or by chains must be temporarily laid down and secured to prevent rolling. The cylinder may not remain in this position and must be secured in a carrier or by 2 chains.

Emergency Codes:

The hospital Operator should be contacted by **dialing "6"** if a situation arises requiring that an Emergency Code be announced.

Disasters (Code Triage Internal/External)

There are many different types of disasters that could affect the hospital in a number of different ways. Some could be external like a large car crash; some could be internal like a loss of power; some could be both. Good Samaritan Hospital plans for all types of these potential scenarios and manages them through what is called the Hospital Incident Command System (HICS). The Administrator On-Call or a designee will assume the role of Incident Commander and set up an area of operations called the Hospital Command Center and manage the event from there.

To communicate to all departments in a disaster, Good Samaritan Hospital uses a web-based system called Everbridge. All incident information will be provided through this system assuming computers are operational.

Several times a year the hospital will hold drills to test the response plans we developed. Depending on the type of drill, you may be called on to participate. Your participation is critical to determining the effectiveness of our response capability.

Internal Triage

An Internal Triage means something has happened in the building that will affect our ability to perform patient care. This may be a loss of utilities, a fire, a bomb threat, an active shooter, or some other type of event. Your response and responsibilities will be based on the situation, so take some time to familiarize yourself with the response procedures for your area. Be sure you know where flashlights, fire extinguishers, evacuation equipment, and exits are located.

External Triage (Medical Surge)

An External Triage means something has happened that will cause us to receive a large number of patients in the ED. These patients may not be the type we normally service – they could be children, mentally ill, trauma patients, or burn victims, and we may have to treat these victims the best we can. This may include setting up an area outside the hospital to triage patients before they enter the ED or even providing mass decontamination to victims who have been exposed to hazardous chemicals or radioactive materials.

It is therefore critical that every department works to support the ED. Each department will be expected to respond and help in some way. Please refer to the hospital's Emergency Operations Plan to know the role of your department in a disaster.

Earthquakes:

Earthquakes are common in California and unleash forces of nature that have a tendency to cause severe destruction and injury. There is a good chance an earthquake will cause both an Internal and External Triage. Unfortunately earthquakes are unannounced and therefore we must be as prepared as possible to provide assistance to those requiring it during a time of emergency. The following should be considered:

Before the Earthquake**:**

- Ensure that **emergency supplies** are readily available in your area
- Verify that **flashlights and other emergency lighting is fully functional**
- **Secure or anchor equipment and supplies that may fall or come loose during the quake**
- Be sure to have **emergency supplies in your home,** including food, water, first aid kits, medications, copies of important documents, and cash
- **Have a plan to communicate with your family** in the event you are apart when disaster strikes

During the Earthquake**:**

- Remain calm and in control
- Get under a desk, table and hang on, or stand in the corner of a room
- Do not use elevators
- Do not run
- Do not attempt to exit the building as falling debris or glass may cause serious injury or death
- Stay away from glass or windows as glass may shatter during the earthquake and potentially cause serious injury

After the Earthquake**:**

- Check for injuries and administer care if required
- Notify the Hospital Command Center, or dial "6" if you smell natural gas or if there is an oxygen leak
- Check for cracks and damage and report any that are identified to the Hospital Command Center (HCC)
- Limit telephone use

Contingency Communications and Supply Plan

Good Samaritan Hospital's Communication's Contingency Plan includes backup telephone lines that allow communications in the event that the hospital's telephone system is nonfunctioning. These backup lines are referred to as CENTREX lines and are indicated by a **red telephone jack.**

The Emergency phones are now held in each unit and are to be plugged in when needed. CENTREX telephones use different extension numbers than those of the hospital telephone system. Refer to the list of extensions attached to each telephone for the CENTREX extension of areas served.

The Reddinet emergency communications system permits Good Samaritan Hospital to be connected to an emergency web of hospitals and to the County of Los Angeles. This system can be used as an emergency method of communications for obtaining emergency assistance from other facilities or governmental agencies.

Most internal communication will be posted on the communication system called Everbridge. This system allows broadcast messages and an email messaging system to request supplies or repairs. Internal Communication Radios (Walkie Talkies) may be distributed and utilized as an alternate method of communication if required.

Use of cellular telephones should be maintained to a minimum to reduce the possibility of interference with equipment and hospital system. Texting is commonly much more reliable in a disaster than calls.

Chemical Emergencies (Code Orange)

In the event of a chemical spill, ensure your safety as well as the safety of others and workplace by performing the following:

1. Remove people from danger
2. Obtain an Safety Data Sheet for the chemical or compound spilled

3. Use personal protective equipment (PPE) as recommended in the Safety Data Sheet
4. Cordon off (close off) the area
5. Notify the Hospital Operator by dialing "6". Give the operator the location of the spill, the type of chemical or compound spilled, and the approximate size of the spill
6. Ask the Hospital Operator to notify the Safety Officer.
7. If you are exposed, report the exposure to a supervisor and report to employee heath during weekdays or the emergency room on evenings and weekends.
8. If safe, clean up the spill

Safety Data Sheets (formerly called MSDS)

A Safety Data Sheet identifies a chemical product, its hazardous ingredients, its physical and chemical characteristics, physical hazards associated with using the product, its reactivity, potential health hazards associated with using the product, precautions for safe handling and use, and controls measures to be taken to contain the product. The Engineering, Security, and Emergency Room contain listings of **all** Safety Data Sheets for compounds known to be in the hospital. **Your department will have Safety Data Sheets that are specific to your work area.**

Right to Know

"radoat" means that you have knowledge of the hazards you face on the job and how you can protect yourself against them. Safety Data Sheets provide information on chemical products and hazards that they may pose.

Right to Know Notice

This facility contains chemicals known to the state of California to cause Cancer or birth defects or other reproductive harms.

Management of Medical Equipment:

Operating and Safety Procedures:

To reduce the possibility of injury from a defective medical devise, observe the following:

- Do not use equipment in a wet environment unless the device is designed to be used in this type of environment.
- Be aware of static electricity and do not touch equipment that may have a static charge on its surface.
- Use proper eye protection when using a laser. Ensure that you have the proper laser goggles for the specific device and wavelength that is being used.
- Practice safe procedures when handling high voltage equipment such as defibrillators and high frequency equipment such as electro surgery equipment to prevent injury to the patient and the user.

Product Recalls and Hazard Alerts:

From time to time a product manufacturer or the FDA may notify the Hospital of a product recall or of a potential hazard related to a specific device. If you receive a notification of this type, please forward it to the Hospital's Materials Management Department for assistance with processing; lend your assistance if needed.

Electrical Safety:

Certain precautions should be taken to ensure an electrically-safe environment for patients and equipment users. Observing the following will assist in maintaining an electrically-safe environment:

- **Do not use extension cords**. Extension cords are prone to damage and may be a source of electrical fires
- **Check the equipment's power cord, wires, and cables** and verify that they are not damaged, have cuts on the insulation, or have exposed wires. Do not use the equipment if any of these are present.
- **Do not use or drink liquids in the proximity of equipment**. Liquids such as coffee, soft drinks, water, etc. will damage equipment and may lead to electrical shock if spilled on the equipment.
- **Do not place items on top of or around equipment**. This may prevent proper ventilation leading to overheating and equipment failures, or malfunctions.

The Safe Medical Devices Act (SMDA)

The Safe Medical Devices Act was enacted in 1990 to enhance the safety and reliability of medical equipment. The Act places certain responsibilities upon the hospital through primarily two sections; these are as follows:

- **Medical Device Tracking:**

  - The FDA publishes a list of medical devices that require tracking. Receipt, implantation, and explanation of these devices require reporting to the manufacturer by the hospital. Please refer to your department-specific policies for your department's requirement under the act.

- **Medical Device Reporting:**

  - A report must be submitted to the FDA and the manufacturer within 10 working days in the event of a death associated with a medical device**.** A report must be submitted to the device manufacturer in the event of serious injury within 10 working days of the injury. Complete an online Event Review Form and Risk Management will be notified and will file the required report with the FDA or the equipment manufacturer.

Management of Utilities

Getting to know Hospital and Department utilities:

It's important for all staff to familiarize themselves with the location of emergency shut off controls and the procedures to shut off utilities under emergency or normal circumstances. Your department manager or director is a good resource for additional information on utilities that serve your department, the controls for these utilities, and emergency controls to use in the event of an emergency.

Electrical Grounding

Electrical grounding is a safety mechanism built into equipment and electrical distribution systems. **The main purpose of this mechanism is to prevent electrical shock to patients and users of equipment**.

Check the condition of the equipment's power plug and the electrical distribution system's receptacle and ensure that the plug's blades are straight and that the receptacle is not damaged prior to connecting equipment to the receptacle. Ensure that the round or semi-round blade of the receptacle is not bent or damaged. This will provide a good ground connection from the equipment to the electrical distribution system.

Plugs on medical equipment must be hospital grade plugs and receptacles in patient care areas must be hospital grade receptacles. A <u>green dot on a plug</u> or receptacle indicates that the device is rated as hospital grade.

Relocatable Power Taps (RPTs), commonly known as power strips and Special Purpose Relocatable Power Taps (SPRPTs), commonly known as special purpose power strips,

must be compliant with the requirements of the National Electrical Code (NEC). The introduction into the environment of RPTs and SRPTs requires evaluation by the Engineering Department prior to first use. Engineering will issue the appropriate device for the intended use if the environmental requirements are met and compliance with the (NEC).

Cheater plugs are not allowed for use on equipment anywhere in the hospital because these devices can defeat the equipment's electrical grounding system which may lead to electrical shock.

Emergency Power:

The hospital's electrical power is normally derived from the local electrical utility. This is commonly referred to as normal power. **In the event that normal power fails, an 8 to 10 second power outage condition will be experienced by all electrical systems in the hospital. It is important that you prioritize equipment and connect that which is most important to emergency receptacles prior to starting the use of the equipment in case of a power failure.** This will minimize the amount of equipment that may require switching of power sources during a normal power outage.

Microwave ovens, toasters, coffee makers, and other non-patient care devices are not critical during a power outage and shall not be connected to emergency power sources.

In the event of a power failure the following sequence of events takes place:

- The hospital's electrical distribution system senses the loss of power from the local utility and starts the emergency generators.
- The generators synchronize and supply power to fire life safety systems, red emergency receptacles, and emergency lighting systems within 8 to 10 seconds following the start of the power outage**. Only red receptacles will have power available. Other receptacles will not have power.**
- Only equipment and systems powered by the emergency power system will be functional during a normal power outage. Equipment and lighting not connected to the emergency power system will not have power available.

Reporting Medical Equipment and Utility Failures and User Errors

Reporting equipment problems, failures, and errors

In the event that a device fails or an error occurs while using the device, it shall be reported to the Engineering & Maintenance Department and your immediate supervisor.

Taking the following steps will assist in servicing the equipment and returning it to your department in a safe working manner as soon as possible:

- **Clearly identify** the equipment or utility that is defective**. Clearly describe the fault** with the device. "Defective" tags are available in your work area as well as from the Engineering & Maintenance Department. These tags should be completed and attached to the defective equipment.
- **Notify your department manager** or director of the failure.
- **Call the Engineering Hotline at ext 2473** and inform them of the failure or error. Providing a clear description of the failure or error, your name, the type of equipment or utility, your extension, and other pertinent information will assist in obtaining a quick resolution.
- In the event that a computer used for non-patient care purposes fails or requires software assistance, contact the Information Systems Department at ext 4029.
- If further assistance is required, you may contact the Director of Engineering & Maintenance at ext 2470.

RADIATION SAFETY

The GSH Radiation Safety Program is designed to insure that all persons within the hospital are protected from radiation exposure based on the concept of "as low as reasonably achievable" (ALARA), and as far as practicable below the limits set by the California Department of Health & Human Services.

The Radiation Safety Committee at GSH is responsible for all sources of ionizing radiation used in the hospital. The Radiation Safety Officer is responsible for the education of all staff in the ALARA concept, posting of radiation warning signs, and maintaining the records of each employee's work- related exposure to radiation.

Radiation Monitoring Badges

Radiation monitoring badges are important safety tools when worn during exposure to radiation. Badges are issued to employees who may receive a certain level of radiation when performing their job. It is absolutely essential that these badges are worn so that doses of radiation can be recorded and reported. Badges issued by Good Samaritan Hospital should only be used at GSH. The badges are collected at the end of each month and sent out to be read. This reading is sent back to the hospital in a report and this report is posted in the department. If the dose exceeds the permissible level, the employee will be contacted. Lost badges should be reported at once to your supervisor.

Posting of Radiation Areas

Radiation exposure to personnel is not to exceed the maximum permissible limits established by governmental regulations. The posting of the "radiation in use" sign serves to alert employees and visitors when there is a possibility of exposure to radiation.

Basic Principles of Radiation Protection

The basic methods for reducing exposure to radiation are as follows:

- Keep the length of **time** of the exposure to a minimum.
- Maintain a safe **distance** between yourself and the source of the radiation.
- Place a **shield** between you and the source of radiation

Check with the nurse in charge before you enter a controlled room to learn of any specific precautions.

Let your supervisor know if you are pregnant or think that you may be pregnant. More strict precautions are used for pregnant women, especially during the first trimester.

Emergency Code

CODE ORANGE– HAZARDOUS MATERIAL SPILL

DIAL ‘6’ to notify PBX of CODE ORANGE and give location. PBX will notify Security and the Radiation Safety Officer.

If you have questions about radiation safety or if a contamination is suspected, you should contact the Radiation Safety Officer at x2360.

MAGNETIC RESONANCE IMAGING (MRI) SAFETY

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For the safety of all, access to the MRI Suite is restricted. The American College of Radiology has identified four Safety Zones that restrict access to patients, staff and family members who have not been properly screened.

ZONING:

The MRI Suite is conceptually divided into four Zones as follows:

- **Zone I:** This includes all areas that are freely accessible to the general public. This area is typically outside the MRI environment itself and is the area through which patients, health care personnel, and other employees of the MRI Suite access the MRI environment.

- **Zone II:** This area is the interface between the publicly-accessible uncontrolled Zone I and the strictly controlled Zone III and IV. Typically patients are greeted in Zone II (waiting room and/or screen room) and are not free to move throughout Zone II at will, but are under the supervision of MRI Personnel. It is in Zone II that information is obtained on patient history and medical insurance as well as answers to questions pertaining to MRI screening.

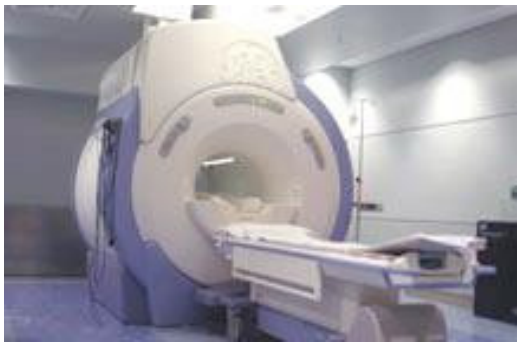
- **Zone III:** This area is the region in which free access by unscreened Non-MRI Personnel and/or ferromagnetic objects and equipment can result in serious injury or deaths as a consequence of interactions between the individuals/ equipment and the MRI scanner's particular environment. All access to Zone III is to be emphatically restricted, with access to regions within it (including Zone IV) controlled entirely under the supervision of MRI Personnel. **Only properly screened patients and staff should be permitted in Zone III.**

Patient dressing rooms are within this zone. Zone III regions should be physically restricted from general public access by key locks, pass-key locking systems, or other reliable physically restricting methods that can differentiate between MRI Personnel and Non-MRI Personnel.

There should be **NO** exceptions to this guideline. Specifically, this includes hospital/ site administration, physicians, security, and other Non-MRI Personnel. Non-MRI Personnel are **NOT** to be provided with independent Zone III access until such time as they undergo the proper education, training, and screening.

- **Zone IV:** This area is synonymous with the **MRI** Scanner Magnet **Room** itself- i.e., the physical confines of the room within which the MRI scanner itself is located.

In case of cardiac or respiratory arrest or other medical emergency within the MRI Room (Zone IV) for which emergent medical intervention and/or resuscitation is required, appropriately trained and certified MRI Personnel should immediately initiate basic life support and/or CPR as required by the situation **WHILE** the patient is being emergently removed from the MRI Magnet Room/Zone IV to a predetermined magnetically safe location. At **NO** time shall magnetic or unscreened equipment or personnel be permitted or taken into the MRI Room/Zone III or IV.



It is very important to remember that the **MRI MAGNET IS ALWAYS ON!** Therefore, there is **NEVER** a time when entry into the MRI Suite Zone III or IV is safe. Only patients and staff members who have been properly trained and screened should ever enter these areas.

While there is no guarantee that accidents will not occur, education is the best way to help prevent them. All hospital staff members should have annual MRI training. Screening is not only required for patients, but also any employee, Non-MRI or MRI Personnel, who may have cause to enter the MRI Suite Zones III or IV must undergo an MRI screening as part of their employment process to ensure their own safety in the MRI environment. For their own protection, any MRI trained and screened employee must immediately report to the Medical Imaging Medical Director any trauma, procedure, or surgery that they experience or undergo in which a ferromagnetic metallic object/device may have become introduced within or on them. This will permit an appropriate screening to be performed on the employee to determine the safety of permitting that employee into the Zone III/IV environment of the MRI Suite.

Cardiac pacemakers, aneurysm clips, electronic implants or devices, cochlear implants or implanted hearing aids are only a few of the implanted devices that can cause serious injury to patients and staff members in the MRI Suite. Individuals who have those devices should **NOT** enter the MRI Suite/Room. It is essential that every patient undergo extensive documented screening prior to having an MRI procedure.

Persons entering the MRI Suite must also remove ALL metallic objects including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, steel-toed boots/shoes, and tools. No one should enter the MRI environment or MRI System

Room if they have any question or concern regarding an implant, device, or object that may be on their person.

There are a number of injuries that can be caused by the MRI system to patient and staff. However, the "missile effect" can be the most life-threatening and, at the same time, the most preventable. Also referred to as the "projectile effect", the missile effect is the tendency of the extreme strength of contemporary MRI magnets to draw ferromagnetic materials into the center of the magnet. Iron-containing materials, including steel, can be drawn to an MRI with such force that they become airborne accelerating at speeds of up to 40 miles per hour.

The establishment of thorough and effective training and screening procedures for patients, staff and other individuals are the most critical components of a program that guards the safety of all those preparing to undergo MRI procedures or to enter the MRI environment. An important aspect of protecting patients, staff and other individuals from MRI system-related accidents and injuries involves an understanding of the risks associated with the various implants, devices, accessories, and other objects that may cause problems in this setting. This requires constant attention and diligence to obtain information and documentation about these objects in order to provide the safest MRI setting possible. In addition, because most MRI-related incidents have been due to deficiencies in screening methods and/or a lack of properly controlling access to the MRI environment (especially with regard to preventing personal items and other potentially problematic objects into the MRI System Room), it is crucial to set up procedures and guidelines to prevent such incidents from occurring.

Recommended Safety Precautions for MRI

- Always assume that the MRI system's static magnetic field is present, and treat the system accordingly.

- Don't allow equipment and devices containing magnetic (especially ferromagnetic) components in Zones III and IV, unless they have been tested by the device manufacturer and have been labeled "MRI safe" for your specific MRI environment. Also, adhere to any restrictions provided by suppliers regarding the use of MRI safe and MRI compatible equipment and devices in your MRI environment.
  ***NOTE**: "MRI safe" is defined as safe for individuals within the environment, but may cause interference with diagnostic information. "MRI compatible" is defined as safe for individuals within the environment with no significant effect on the quality of diagnostic information.*

- Don't make assumptions about devices or equipment (e.g., sandbags) being MRI safe. Err on the side of caution: Unless a device or piece of equipment has been proven to be MRI safe, do **NOT** bring it into the MRI environment.

- Test equipment or devices with a powerful handheld magnet to determine their potential to be attracted by the MRI system before allowing them into the MRI environment. This is important even for MRI safe and MRI compatible equipment. (i.e. attaching a plastic sign to an MRI compatible oxygen tank with a ferromagnetic wire renders the device incompatible).

- Bring non-ambulatory patients into the MRI environment using a non-magnetic wheelchair or wheeled stretcher. Ensure that no oxygen bottles, sandbags, or any magnetic objects are concealed under blankets or stowed away on the transport equipment.

- Ensure that IV poles accompanying the patient for the MRI procedure are not magnetic.

- Carefully screen all people entering the MRI environment for magnetic objects in their bodies (e.g., implants, bullets, shrapnel); on their bodies (e.g., hair pins, brassieres, buttons, zippers, jewelry); or attached to their bodies (e.g., body piercing). Magnetic objects on or attached to the body of a patient, family member, or staff member should be removed before the individuals enter the MRI Scan Room. Dental fillings are an example of a non-removable item. Patients with ferromagnetic materials in their bodies may not be candidates for MRI imaging, unless the physician has reviewed the case and approved scanning.

SECURITY

At GSH, we value the safety and security of every member of the team including staff, volunteers, physicians, patients, visitors and anyone else who walks through our doors.

Although the Security Department oversees many of the issues concerning the safety and welfare of each person at GSH, safety and security is EVERYONE'S responsibility.

Here are some important facts for you to remember-

Identification Badges

Identification badges are an important security tool because they mark you as an authorized member of the GSH team. **When you are entering the hospital at any time, it is required that you wear your ID badges above the waist, with your picture clearly visible.**

If you lose your badge, report it to Security immediately and go to Human Resources for a replacement.

Visitor Badges

All visitors should receive and display a visitor's pass when entering the hospital that identifies what area of the hospital they are visiting.

General visiting hours are 8:30 am – 8:30 pm. Please see complete ***Visitor Policy*** for specific guidelines.

Suspicious Persons

If you see anyone in the hospital that looks as if he or she does not belong, is found in an unauthorized area or looks suspicious for any reason**, dial "6"** (emergency code call number) **and tell the operator that there is a Mr. or Ms. Strange**.

Remember to state the location of the person and briefly describe the situation. Security will respond to the location immediately. Don't attempt to run after the person or hold them. This may put you in an unsafe situation.

EMERGENCY CODES (dial "6" for all)

Code	Meaning	Dial
Code Red	Fire Emergency	**6**
Code Blue	Medical Emergency	**6**
Code Pink	Suspected Infant Abduction	**6**
Code Orange	Hazardous Material Spill	**6**
Code Yellow	Bomb Threat	**6**
Code White	Pediatric Medical Emergency	**6**
Code Silver	Person with weapon (Dial 5555)	**6**
Code Sepsis	Sepsis Bundle Patient	**6**
Code Stroke	Stroke Patient	**6**
Code Gray	Security Emergency	**6**
Triage Internal	Internal Disaster	**6**
Triage External	External Disaster	**6**
MR / MS. Strange	Security Needed i.e. Unauthorized person in area	**6**

More detail on two of the codes:

CODE GRAY (DISTRESS CALL)

Sometimes a patient, visitor or even a co-worker could begin to act in a way that is threatening or combative. This can be in the form of either a verbal threat or someone "acting out" in an inappropriate manner. Employees involved in an emergency situation, requiring assistance from Security should dial "6" to notify the operator and call Security at x 5555. Help will arrive shortly.

CODE PINK – INFANT ABDUCTION

The safety and security of infants will be protected by the collaborative efforts of all employees. If an infant is discovered to be missing from the Perinatal center, the following action will be taken.

Action for Hospital Personnel to take:

1. Dial "(6)" to notify PBX "**CODE PINK**" – give location.
2. Call Security, extension 5555 (Give a description of the person, if seen)

Hospital Operator will announce through the overhead paging system "**CODE PINK"** followed by the location of the code pink.

IMMEDIATELY

Close doors and block ALL hospital stairwells and exits, including Concourse, Lucas Street exits, and Medical Office Building exits.

Stop ANYONE with an infant or carrying a backpack, large purse, box, etc. that could conceal an infant. Detain the individual and infant or inform the individual that you are searching for an important piece of equipment that is missing. Detain the individual and the infant until cleared to exit by security personnel or confirm that the package is not concealing an infant. Continue to block exits and stairwells until the **"CODE PINK" ALL CLEAR",** is announced by the operator over the overhead paging system.

Violence Prevention in the Workplace

PREVENTION PLAN: The safety and security of patients, visitors, and employees of GSH is very important. The hospital has a Violence Prevention Plan which is located on the GSH intranet under Security Policies. Therefore, acts or threats of physical violence, including intimidation, harassment, or coercion, which occur on any Good Samaritan Hospital property are investigated immediately.

This prohibition against threats and acts of violence applies to all persons involved including but not limited to, all patients, visitors, employees and independent contractors. Violations of this policy by an individual affiliated with Good Samaritan Hospital and affiliate organizations is considered misconduct and will lead to disciplinary and/or legal action as appropriate.

If you come in contact with a violent patient, visitor, or employee:

Dial "6" to notify PBX "**CODE GRAY**" Call Security, Ext 5555.

Workplace Violence - use these steps if faced with a violent person

- Project calmness; move and speak slowly, quietly, and confidently.
- Encourage the person to talk, listen patiently; be an empathetic listener.
- Focus your attention on the other person to let him/her know you are interested in what he/she has to say.
- Maintain a relaxed and attentive posture. Position yourself at a right angle to the person rather than directly in front of him/her.
- Acknowledge the person's feelings. Indicate that you can see he or she is upset.

- Ask for small, specific favors (such as asking him/her to move to a quieter area).
- Establish ground rules if unreasonable behavior continues. Calmly describe the consequences of any violent behavior.
- Use delaying tactics to give the person time to calm down. Suggest a drink of water (use a disposable cup).
- Point out choices and be reassuring. Break down big problems into more manageable smaller problems.
- Accept criticism in a positive way if the complaint might be true. Use statements like "You're probably right" or "It was my fault". If the criticism seems unwarranted, ask clarifying questions.
- Ask for his/her recommendations. Repeat back to him/her what you feel he/she is requesting.
- Arrange yourself so that your access to an exit is not blocked.

Theft of Personal Belongings

Preventing theft is every employee's responsibility. Having the *"it's not my problem*" attitude is not realistic or practical. Everyone must work together to become the eyes and ears that will help keep the work place crime free. When individuals leave their office(s), most "hide" their purses under their desks or in unlocked file drawers. Many men believe that leaving their wallets in their jacket pockets or briefcases is safe. That is the first place an "office creeper" looks and those few seconds can cause you grief.

- Keep your purse or wallet with you or locked in a secure drawer or cabinet. Position coat racks away from entrances or exits to minimize temptation.


Leaving the office unlocked is an invitation for the "*Office Creeper"* to enter.

- Lock the office or have someone sit in for you;
- Secure laptop computers with a security cable locking device; and
- Secure all valuables, money, credit cards, personal checkbooks, and travel documents in a locked-file cabinet or drawer.



Panhandling- Did you know?

As GSH is located in downtown Los Angeles, many employees are often approached by panhandlers near our facility entry points. Although as Good Samaritans our first instinct is to give, national statistics show most cash handouts given to panhandlers is often times used for drugs or other illicit behaviors. This could lead to safety and security concerns. Should you encounter panhandlers on or near our property-please **do not give them money**; contact Security immediately.

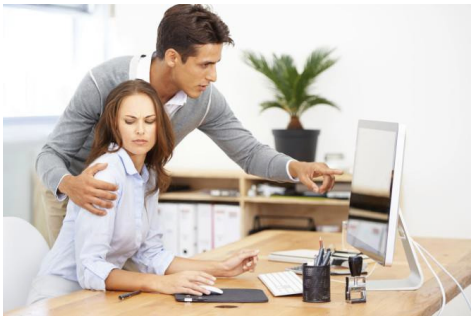
WORKPLACE HARASSMENT

The hospital has a policy to help prevent "*Bullying and Disrespectful Behavior*", located in the Human Resources Policy Manual on the intranet.

GSH is committed to provide a work environment that is free of harassment and discrimination. Furthermore, it prohibits unlawful harassment in any form, including verbal, physical, and visual harassment

In keeping with this commitment, GSH does not discriminate against employees or applicants because of race, color, national origin, ancestry, sex, sexual orientation, gender identify or gender expression, pregnancy, marital status, religion, creed, physical or mental disability, medical condition, age or any other protected category as defined by law. This policy applies to all employee agents and employees including supervisors, and non-supervisors.

Sexual harassment includes, but is not limited to, making unwanted sexual advances and requests for sexual favors where either:



- Submission to such conduct is made an explicit or implicit term or condition of employment.
- Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual.
- Such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment.

Employees who violate this policy are subject to disciplinary action up to and including termination.

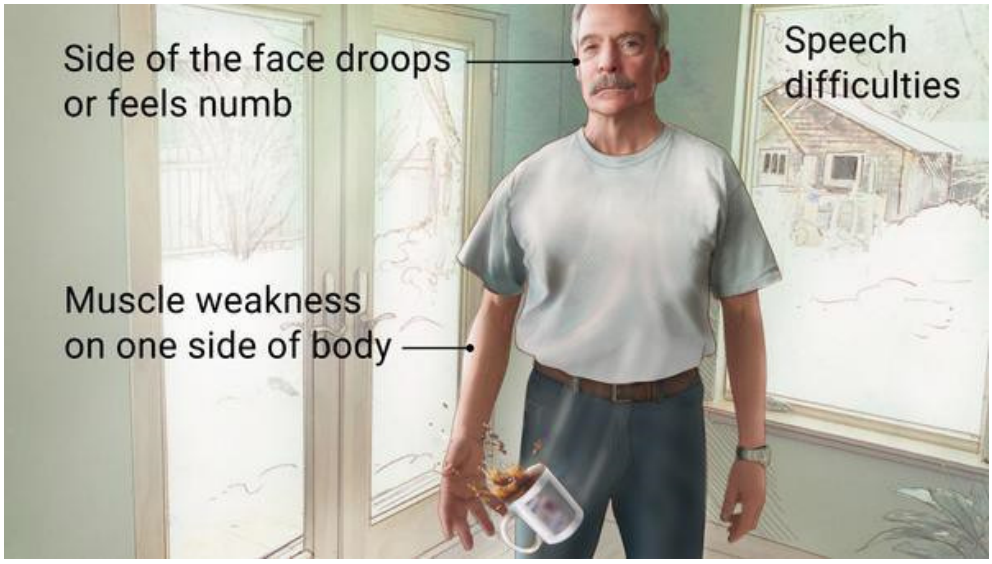
Any employee who believes that he or she has been harassed by a co-worker, supervisor, or agent of the employer should promptly report the facts of the incident or incidents to his or her supervisor and to the Human Resources department.

STROKE FACTS

Stroke Facts you need to know:

- Each year 750,000 people experience a new or recurrent stroke
- It is the **No. 5 cause of death** in the U.S
- Every 40 seconds someone in the US is having a stroke
- Every 4 minutes someone dies of a stroke
- Stroke is the leading cause of **long-term disability**

Can you recognize when a person is having a stroke?



- A stroke is also known as "cerebrovascular disease" and it occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts.
- When that happens, part of the brain cannot get the blood and oxygen it needs, so it starts to die.

Warning signs are:

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination.

Can you spot a stroke? Look for FAST…

F – Face droop
A – Arm weakness
S – Speech difficulty
T – Time to call for help

Risk factors for stroke are hypertension, smoking, diabetes, atrial fibrillation, high fat diet, heart disease, carotid artery disease, history of TIA, heavy alcohol use and obesity.

Prompt response is required when these symptoms are recognized. If a patient has these symptoms, Dial 6 and call a **CODE STROKE**. If a patient, visitor or co-worker collapses you would call a **CODE BLUE.**

Stroke Center

Good Samaritan Hospital is a primary stroke center. It is one of 45 in LA County. **Primary Stroke Center Certification** recognizes hospitals that meet standards to support better outcomes for stroke care.

STAFF RIGHTS

When an employee feels that a treatment or procedure is in conflict with their personal cultural values, ethics, or religious beliefs they may request not to participate. The procedures that may cause conflict to some staff may be administration of blood or blood products, sterilization procedures, termination of pregnancy, harvesting of organs for transplant, and withdrawing of life sustaining measures.

Caregivers should NOT request to be relieved of patient care solely based on the patient's race, religion, age, sex, sexual orientation or national origin.

When time permits, the employee should file a formal request with their Director and include the aspect of patient care or treatment from which the employee declines to participate.

AGE APPROPRIATE CARE

Growth and Development across the Life Span

The Joint Commission (TJC) requires that healthcare providers who have patient contact are educated, trained, and competent to provide care that is age appropriate.
We all have different needs at different ages. Understanding the developmental safety and care needs for the age groups we serve will assist us in providing excellent, safe care and service.

Infancy to Toddlerhood

Approximate age: Birth – 3 years
Cognitive stage: Sensorimotor
Psychosocial stage: Trust vs. mistrust (birth -12 mos.)
Autonomy vs. shame (1-3 yrs.)

Growth and Development

Physical	Mental	Social/Emotional
▪ Rapid growth rate especially the brain ▪ Responds to light and sound ▪ Crawls, progresses to walking	▪ Senses, explores, plays ▪ Facial expression ▪ Baby talk ▪ Simple sentences	▪ Trusting ▪ Dependent ▪ Begins to develop a sense of self

Key Care Issues

Communication	Safety	Health
▪ Security and physical closeness ▪ Encourage to communicate (smile, talk softly, laugh) ▪ Needs love and security	▪ Needs safe environment for exploring, playing, and sleeping	▪ Immunizations ▪ Proper nutrition ▪ Adequate sleep ▪ Oral health ▪ Regular check-ups

Preschoolers

Approximate age: 3-6 years
Cognitive stage: Preoperational
Psychosocial stage: Initiative vs. guilt

Growth and Development

Physical	Mental	Social/Emotional
▪ Grows at a slower rate ▪ Motor skills improve ▪ Dresses self ▪ Toilet trained	▪ Symbols become important ▪ Memory improves ▪ Active imagination	▪ Identifies with parents (s) ▪ More independent ▪ Exhibit fears ▪ Aloof to strangers ▪ Safeguard against drowning

Key Care Issues

Communication	Safety	Health
▪ Praise and give rewards ▪ State rules as necessary ▪ Learns by playing ▪ In hospital setting, reassure that procedures are not punishments	▪ Teach habits in swimming Pools, team sports and use of bike/skate helmets, and seat belts	▪ Immunizations ▪ Teach nutritional habits ▪ Teach good personal hygiene including hand hygiene

School Age

Approximate age: 6-12 years
Cognitive stage: Concrete operations
Psychosocial stage: Industry vs. inferiority

Growth and Development

Physical	Mental	Social/Emotional
▪ Grows slowly until that spurt of puberty	▪ Active, eager learner ▪ Understands cause and effect ▪ Can read, write, and do Math	▪ Focuses on school activities ▪ Negotiates for greater independence ▪ Learns to cope with peer pressure

Key Care Issues

Communication	Safety	Health
▪ Encourage and give opportunity to feel competent and useful ▪ Build their self-esteem ▪ Praise them when they help ▪ Give them tasks that they can do successfully	▪ Promote safety habits ▪ Encourage them to resolve conflicts peacefully	▪ Keep up immunizations and check-ups ▪ Teach healthy nutritional habits ▪ Teach good personal hygiene ▪ Give facts about smoking, drugs, alcohol, and sexuality

Adolescence

Approximate age: 12-18 years
Cognitive stage: Formal operation
Psychosocial stage: Identity vs. role confusion

Growth and Development

Physical	Mental	Social/Emotional
▪ Grows in spurts ▪ Matures physically ▪ Able to reproduce	▪ Thinks abstractly ▪ Can make independent decisions ▪ Idealistic and thinks of the future	▪ Identifies with parents (s) ▪ More independent ▪ Exhibit fears ▪ Aloof to strangers ▪ Safeguard against drowning

Key Care Issues

Communication	Safety	Health
▪ Needs privacy, respect and acceptance ▪ Needs to learn teamwork	▪ Promote safety habits such as safe driving, violence prevention, hazards of gangs	▪ Update immunizations ▪ Regular check-ups ▪ Promote sexual responsibility ▪ Advice against substance abuse

Young Adults

Approximate age: 18-40 years
Cognitive stage: Formal operation
Psychosocial stage: Intimacy vs. isolation

Growth and Development

Physical	Mental	Social/Emotional
▪ Physical and sexual maturity ▪ Nutritional needs are for maintenance not growth	▪ Acquires new skills and information and uses these to solve problems	▪ Seeks closeness with others ▪ Sets career goals lifestyle ▪ Starts own family ▪ Can be a stressful stage

Key Care Issues

Communication	Safety	Health
▪ Needs support and honesty ▪ Respect for personal values ▪ Respect for their choices	▪ Provide information for hazards at home and work ▪ Provide information on disaster Preparedness	▪ Regular check-ups ▪ Update immunizations ▪ Promote healthy lifestyle ▪ Provide information about health risks

Middle Adults

Approximate age: 40-65 years
Cognitive stage: Formal operation
Psychosocial stage: Generativity vs. self-absorption and stagnation

Growth and Development

Physical	Mental	Social/Emotional
▪ Begins to age ▪ May develop or manifest chronic problems ▪ Hormonal changes (menopause for women)	▪ Mentally active ▪ Builds on what he/she already knows ▪ Uses like experiences to continue to learn, creates, and solve problems	▪ Contributes to future generation ▪ Balances dreams with reality ▪ Plans for retirement ▪ Cares for children and parents (sandwich generation)

Key Care Issues

Communication	Safety	Health
▪ Keeps a hopeful attitude ▪ Concentrates on strengths and limitations	▪ Addresses age-related changes and the effects of senses, reflexes	▪ Regular check-ups ▪ Emphasize need for exercise ▪ Emphasize good nutrition habits ▪ Focus on prevention of illness

Older Adults

Approximate age: 65 years and older
Cognitive stage: Formal operation
Psychosocial stage: Ego integrity vs. despair

Growth and Development

Physical	Mental	Social/Emotional
▪ Gradual aging ▪ Decline in senses and physical abilities	▪ Active learner ▪ Decrease in memory ▪ Shares wisdom with others	▪ Retirement ▪ Death of spouse and friends ▪ Adapts to change of social roles ▪ Life review

Key Care Issues

Communication	Safety	Health
▪ Respect, avoid isolation ▪ Acceptance of aging limitations ▪ Driving equals independence	▪ Promote home safety ▪ Prevent falls and injury ▪ Guard against depression and suicide ▪ Help for physical impairment	▪ Monitor health closely ▪ Promote physical, mental, and social activities

Resources: Bastable, S.B. (2003). Nurse as Educator. *Principles of Teaching and Learning Practice*
https://www.quia.com/files/quia/users/juliehl2/Age-Specific-Competency.What are Age-Specific Competencies?

BODY MECHANICS

LIFTING

Lifting is the most common cause of back injury among health care workers. So always:

- Get close to the load before attempting to lift; keep the load close to your body when carrying.
- Spread your feet to shoulder width to achieve a broad base of support and increase your stability.
- Bend your knees and hips. Use the large muscles of the legs, hips and arms as they are the strongest in the body.
- Tighten your abdominal muscles when you lift; this will help support your back.
- Maintain the 3 natural curves of your spine.
- Test the load before beginning the lift. If it is too heavy for you to lift safely, **Get Help**.
- Make sure the area is safe; lock the brakes on beds and wheelchairs; clear out pathways for transfers or gait.
- Avoid twisting; move your feet not your back.
- Avoid lifting heavy objects above your waist; use a stool or ladder to reach higher levels.

BENDING

Cleaning under beds and other furniture calls for a lot of bending. To perform bends safely:

- Kneel down on one knee.
- Maintain the 3 natural curves of your spine.
- Bend hips and knees, not your back.
- When leaning forward, move your whole body, not just your arms.

TWISTING

Your work may sometimes require twisting your back, such as turning a valve. To safely perform a twisting motion you should:

- Kneel down on one knee.
- Maintain the 3 natural curves of your spine.
- Position yourself so that you have the best possible leverage
- Use your arms and legs to do the work, not your back.

REACHING

Reaching for supplies, especially in high places, can injure your back if you reach too far or lift too great a weight. Be sure to:

- Reach only as high as is comfortable but don't stretch; use a stool if you need it.
- Test the weight of the load before lifting by pushing up on one corner.
- Let your arms and legs do the work, not your back.
- Tighten your stomach muscles as you lift.

PUSHING AND PULLING

Pushing and pulling large objects such as trash bins can be hard on your back as heavy lifting. Remember to:

- Stay close to the load, don't lean forward.
- Whenever possible, push rather than pull (you can push twice as much as you can pull without strain).
- Use both arms.
- Tighten your stomach muscles when pushing.

REPETITIVE MOTIONS

When you use repetitive motions, such as stacking linens, remember your back is always working. Take care to:

- Keep the loads small.
- Turn your whole body instead of twisting.
- Get close to the load; don't reach and lift.
- Lift with your arms and legs, not your back.
- Tighten your stomach muscles to lift.
- Change positions frequently.

Ergonomics

- Ergonomics means designing your workplace to fit the worker. In other words, making your workplace worker friendly.
- Look around your facility for areas that make using correct body mechanics difficult.
- Take an active role in your well being by communicating any problems to your supervisor.
- Questions to ask
  - Do you have to stretch to reach the items with which you work?
  - Does the location of objects keep you from using proper lifting techniques?
  - Is this area safe: are the brakes locked on the bed, the wheelchair?
  - Is this area clean and free from clutter?
  - Are the tables you work at too high or low to comfortably fit your body?

CORRECT

INCORRECT

FACTS TO REMEMBER WHEN WORKING AT A COMPUTER

A Few Easy Tips

- Top of monitor placed at eye level for proper head and neck posture.
- Hard copy holder close to monitor to reduce eye movements and allow good neck posture.
- Proper eye glasses, if needed.
- Adjustable furniture with padded wrist rests and/or arms on the chair.
- Keyboard place at elbow height with slight incline (elbow bent at 90 degrees).
- Feet flat on the floor or adjustable foot rest.
- Don't forget to look at a far object (15-20 feet) every 15 – 30 minutes.
- Sit up straight in your seat; do not slump down in your seat.
- Perform stretching exercises (on following page) throughout the day.

POSITIONING AT THE KEYBOARD

- Use a wrist rest
- Do not lean on wrist rests, this isolates work to the hand/wrist muscles and tendons.
- Maintain arches of the hand.
- Use proximal shoulder muscles to move arm, forearm and hand as a unit.

USING THE MOUSE

- Do not rest the palm on the mouse
- Maintain arches of the hand.
- Move hand and wrist as a unit to navigate mouse and depress clicker.
- When feasible, select size of mouse according to hand size

POSTURE - STANDING

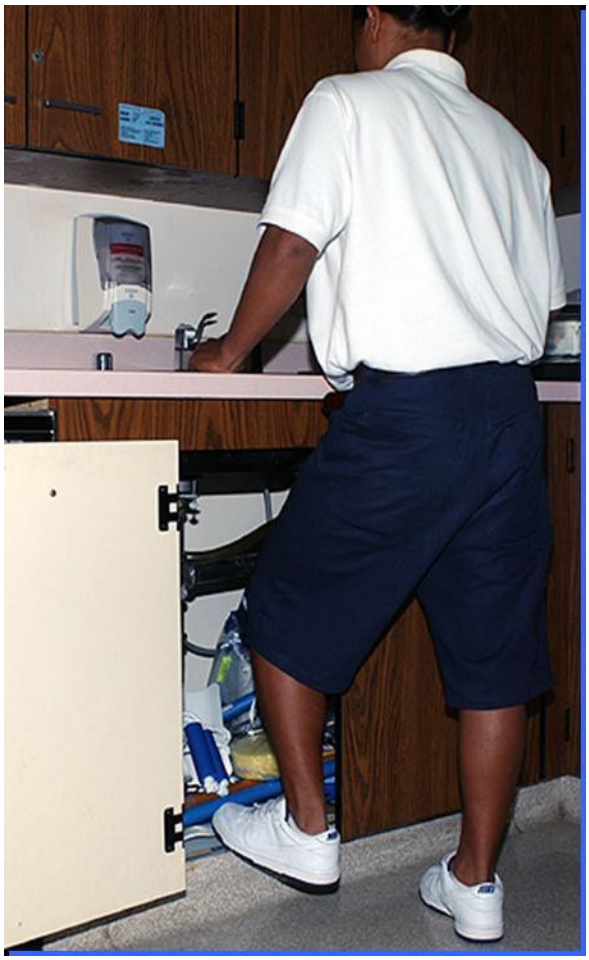
Good balance is the primary goal.

Don't:

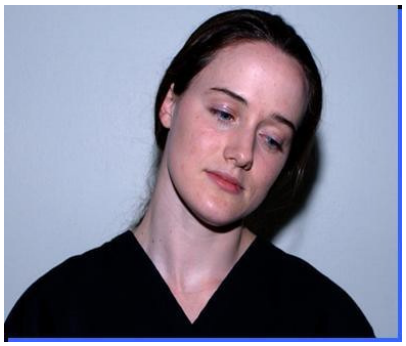
- Wear high-heeled, hard heeled or platform shoes for long periods of time.
- Stand in one position too long.
- Stand with knees locked, stomach muscles relaxed, and swayed back.
- Stand bent forward at the waist or neck with your work in a low position.

Do:

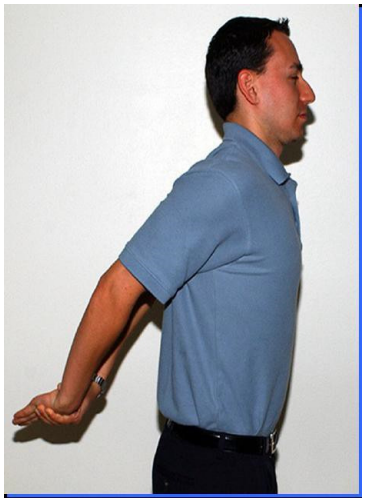
- Elevate or incline the work surface for precision work.
- Put one foot up and change positions often when standing for long periods of time.
- Keep work at a comfortable height.
- Change positions frequently.
- Stand on a cushioned mat.



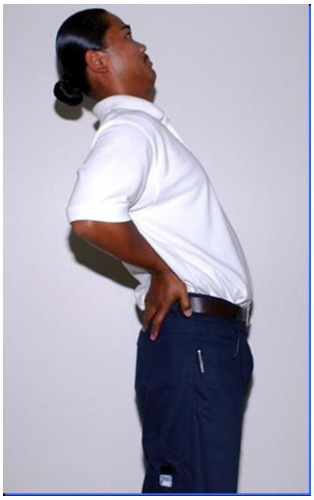
EXERCISES TO PERFORM AT YOUR DESK DURING THE DAY

	
Neck Flexion/Extension: Sit in a supportive chair with your back straight. Slowly bend your head forward as far as possible. Hold for 3 seconds, then slowly move your head up and backward, looking toward the ceiling. Hold for 3 seconds.	**Neck Side end:** Sit with your head facing forward and chin tucked. Bend head toward your shoulder, hold for 10 seconds, then return to midline. Repeat toward the other shoulder. Perform 5 repetitions.
	
Wrist Circles: Keeping wrist loose, slowly move wrist in circles. Repeat 10 times and then 10 times in the opposite direction.	**Finger Exercises:** Start with your fingers straight, then make a half-fist with first 2 knuckles bent, then make a fist with fingers curled into your palm, then make a fist with fingers straight towards your wrist.

EXERCISES TO PERFORM AT YOUR DESK DURING THE DAY

<table>
<tr><td>  </td><td>  </td></tr>
<tr><td>Shoulder Shrugs: Lift your shoulders up toward your ears, hold for 3 seconds then relax your shoulders completely. Repeat 10 times.</td><td>Scapular Retraction: Sit on the edge of a firm chair with your back unsupported, slowly squeeze your shoulder blades together, bringing elbows backward. Hold for 5 seconds, then relax completely. Repeat 5 times.</td></tr>
<tr><td>  </td><td>  </td></tr>
<tr><td>Arms Above Head: Raise your arms above your head (do not look up). Touch the backs of your hands together, and reach up towards the ceiling. Hold for 5 seconds.
Relax and return to the starting position. Repeat 10 times.</td><td>Shoulder Extension: Stand with your back straight, hands clasped behind your back. Lift your arms upward behind your back as far as possible without bending your body forward. Hold for 5 seconds. Repeat 5 times.</td></tr>
</table>

EXERCISES TO PERFORM AT YOUR DESK DURING THE DAY

	
Back Extension: Stand with feet comfortably apart, knees straight and hands placed against the back of the pelvis. Arch your shoulders backward as far as comfortably possible while pushing forward with your hands on the pelvis. Do not arch your neck backward. Repeat 10 times.	There are other things you can do to keep your back healthy. An important step to maintaining a healthy back is warming up before working, or other activities, by doing a few stretching exercises. Eat right, sleep on a firm mattress, and get some aerobic exercise three times per week, and you will be on your way to a healthy back.

Next Sections:
FOR PATIENT CARE PROVIDERS ONLY

1. Registered Nurses
2. Radiology Technologists
3. Physical Therapists
4. Occupational Therapists
5. Speech Language Therapists
6. Respiratory Therapists
7. Nursing Assistants
8. Surgical Techs
9. GI Lab Techs
10. Other employees who have direct patient care responsibilities.

RESTRAINTS

Definition

Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The purpose for using a restraint can either be for a Violent–Self-Destructive Behavior or Non-Violent–Non Self Destructive Behavior.

Violent – Self-destructive Restraints

- To prevent the individual from purposely injuring others or him/herself because of an emotional or behavioral disorder.
- Primarily used in the Emergency Department for the purpose of assessment, stabilization, or treatment.
- Can also be used in other units if the patient is waiting transfer to a psychiatric bed after receiving medical or surgical care.

Non Violent–Non Self Destructive Restraints

Application of restraints to patients who, because of confusion, behave in a way that directly interferes with their necessary medical treatment or healing (i.e. pulls out IV lines, feeding tubes or gets out of bed when physically unable to walk).

Types of Restraints

- Soft vest
- Waist belts
- 3rd and/or 4th Side rails
- Mitts
- Manual Hold
- Limb restraints

Alternative Measures that can be used:

- **Environmental manipulation-** such as soft lighting, reducing stimuli by use of a "quiet room,"
- **Diversionary activities-** such as recreational therapy, physical activities, art, and music.
- Try to identify and handle potentially aggressive situations proactively before a patient acts out verbally or physically.

Guidelines for Restraint Use

- Physical restraints may be used only when less restrictive measures prove inadequate to prevent an agitated or disoriented patient from injuring him/herself and/or others, and to prevent the patient from deleteriously interfering with medical treatment.
- Physical restraints should be used in a way that the safety and dignity of the patient is preserved.
- Restraints may not be used for convenience.
- The least restrictive type of restraint that will accomplish the intended purpose should be utilized.
- Leather restraints usually are used only in the **EMERGENCY DEPARTMENT.**
- There are no standing or as needed (PRN) orders for restraints.
- A trained RN will be present when restraint is initiated.
- Restraints shall be easily removable in the event of fire or other emergency.
- The nurse notifies the unit leader within 1 hour of restraint application.
- Notify patient's family as soon as possible upon application of restraints.

Physician's Order for Non-Violent – Non Self Destructive behavior

- According to federal guidelines, physical restraints may be ordered for a time period **not to exceed 24 hours.**
- When the order expires, the physician must evaluate the patient to see if there is still clinical justification for restraints.
- For continued need, a new time-limited order, **not to exceed 24 hours**, must be written.

Physician's Order for Violent – Self-destructive behavior

- Orders are limited to four hours for adults, two hours for children ages 9 to 17, and one hour for children younger than 9 years.
- MD must designate type of device, placement, and indicate purpose of restraints.
- A face-to-face assessment will be performed by the MD **within one hour** of the restraint.
- Verbal or telephone orders for emergency restraint use must be countersigned by the physician within 24 hours of implementation.

Nursing Responsibilities

- Continuous or frequent observation
- Monitoring vital signs, circulation, and skin integrity
- Offering nourishment, fluids, and bathroom breaks
- Range-of-motion exercises, if appropriate
- "Two-finger" checks for sleeping patients with limb restraint, which ensures that circulation is not compromised
- Inspection and massage of the restrained area when released, unless contraindicated

Documentation

- Alternative measures used
- Outcomes of alternative measures
- Rationale for restraint application
- Date/time
- Type of Restraint
- Pt/Family notification
- Risk/Benefits
- Visualization of the patient
- Patient repositioning, release and ROM
- Address patient basic needs, i.e. toileting, nutrition
- Assessment of the need to continue
- RN Initials/Signature

General Guideline: Application of Protective Restraints

- Restraint shall only be used as a measure to protect the patient from injury to self and other such as:
    - To protect a patient from falls
    - To protect patients during treatment or diagnostic procedures like intravenous therapy, tube feedings, catheterization, etc.
- Always approach the patient calmly and quietly even though his own behavior might not be calm or rational.
- Identify yourself to the patient and significant other(s), if present, and explain why restraints are necessary.
- Position the patient in proper body alignment.
- Apply restraint snugly without binding so that two fingers will fit between the patient and restraint. The patient must have room for movement.
- Restraints should be:
    - Tied out of patient's reach
    - Attached to the bed frame and not to side rails
- Restraints must never restrict the patient's circulation. Some signs of restricted circulation are:
    - Swelling
    - Change in skin color
    - Change in skin temperature
    - Sensation of numbness, tingling, or burning
- The patient's skin must always be protected from pressure, irritation from wrinkles, buckles and knots.
- Place call light within reach of the patient. This is an essential need of the patient and a state regulation.

- Some less-restrictive, alternative measures to consider:
  - Frequent observation
  - Encourage family visits
  - Keeping patient comfortable
  - Giving help when needed
  - Providing diversion
  - Verbal support and encouragement
  - Allow choice
  - Be calm and self-assured, Smile
  - Provide a structures, consistent and quiet environment

NOTE: Restraints should only be used for the protection of the patient, and others and restraints are **NEVER** used as a form of punishment.

Refer to GSH policy on *Restraints* for more information.

PAIN MANAGEMENT

Refer to Pain Management policy & procedure in the Patient Care Manual

Question	Answer	Evidence
Why do we record pain assessment with routine vital signs?	1. It is a Patient right 2. We want our patients to be comfortable 3. It is California Law	• Patient Care Record ("Flow sheet") • Vital sign graphic sheet
How is pain assessed and how often? • On admission • On an on-going basis	1. We use Universal Pain Scale (0-10) for pain rating scale – verbal adults; PAINAD – for cognitively impaired, Wong-Baker – for children 3 years and above, Neonatal Pain and Assessment Score Scale (NPASS) will be used in NICU, Neonatal Infant Pain Scale (NIPS) will be used in Nursery and Mother-Baby. 2. When pain is present (on admission) – assess location, intensity, character of pain, frequency and duration, what makes it worst, and what makes it better. 3. With each set of vital signs 4. Re-assessed one hour after intervention. 5. On transfer to another patient care area 6. Prior to and after an invasive procedure 7. Prior to walking (surgical patients) 8. With each new report of pain/intense pain 9. At time of discharge	• Pain rating scales are located in each patient care area • Patient Care Record ("Flowsheet") and scale used other than the Universal Pain Scale • Vital sign graphic sheet • Progress Note/Meditech (Pain Intervention) • Medical record that patient identified "at risk" (if pain level is above 3 at time of discharge) and measures taken for appropriate pain management and referrals.

Question	Answer	Evidence
Where do I document my assessment?	1. Patient Care Record next to vital signs 2. Multidisciplinary Plan of Care 3. Progress Notes, Meditech (Pain Intervention)	Medical Record documentation –response to pain interventions, along with information on the effectiveness of these interventions (pharmacologic/non-pharmacologic)
What is my responsibility about pain education?	1. Orient the patient to the pain tools. 2. Establish an accepted pain level for each patient (comfort goal); goal is 3 or less 3. Inform them of their right to pain management. 4. Encourage the patient to discuss pain status with physicians and nurses. 5. Patient/caregiver roles in managing pain and potential limitations and side-effect of pain treatment.	• Pain Rating Scale is posted in each patient room and in treatment and procedure rooms. • On admission the patient is given the brochure entitled "Understanding Your Pain" • Multidisciplinary Education Record.
Who is responsible for pain assessment?	1. All licensed care providers	• Medical Record documentation.
How do you know that the patients on your unit are receiving appropriate pain management?	1. Patient Satisfaction Survey (/HCAHPS) 2. We regularly monitor data on Pain Management	• Medical Record documentation audit

END-OF-LIFE CARE AND ORGAN PROCUREMENT

Although End-of-Life is an incurable and irreversible condition such that death is nearing, dying is a natural and inevitable part of living.

The patient's values, religious beliefs, and philosophy are key considerations in the development of a plan of care for them.

Purpose of End of Life Care

- To provide guidance to the physicians and hospital staffs who provide care at the end-of-life.
- To provide support to the patient, family members, and significant others during the end of life experience.

Ethical/Legal Issues:

- Ethical practice requires that particular care and consideration for respect and dignity be given to patients and their support system during the dying process. Under normal circumstances, the patient shall be the decision maker; but when the patient is unable to make decisions, the same respect should be accorded to surrogates.
- The Patient Self-Determination Act supports the patient's right to control future treatment in the event the individual cannot speak for him or herself.
- Consider if a palliative care consultation is appropriate.

The Nurse's Role:

For the Patient:

- Allow patient to participate in the end-of-life care.
- Manage symptoms and minimize discomfort.
- Provide emotional and spiritual support.
- Respect the patient's need for privacy.
- Recognize the grief process and provide support as the patient moves through it.
- Provide quiet time.

For the Family:

- Assure family that appropriate care is being given to the patient.
- Allow them to participate in the patient's care.
- Provide emotional support and foster realistic hope.
- Listen to family concerns, feelings and questions.

- Facilitate communication of concerns between the patient and the family or between family members.
- Accept family values in non-judgmental manner
- Provide flexibility in visitation
- Provide spiritual resources as appropriate
- Prepare them for what they may experience as death becomes imminent
- Advocate for family as appropriate
- Allow family to remain with the body for reasonable length of time after patient expires

Refer to Patient Care Policy: *"Care of the Dying Patient"* for more information.

Organ Procurement Organizations

- Are not-for-profit and federally designated and funded
- They were established to:
  - Educate the public about benefits of organ donation and transplantation
  - Recover, preserve, and distribute donated organs
  - Increase the availability of organs for transplantation

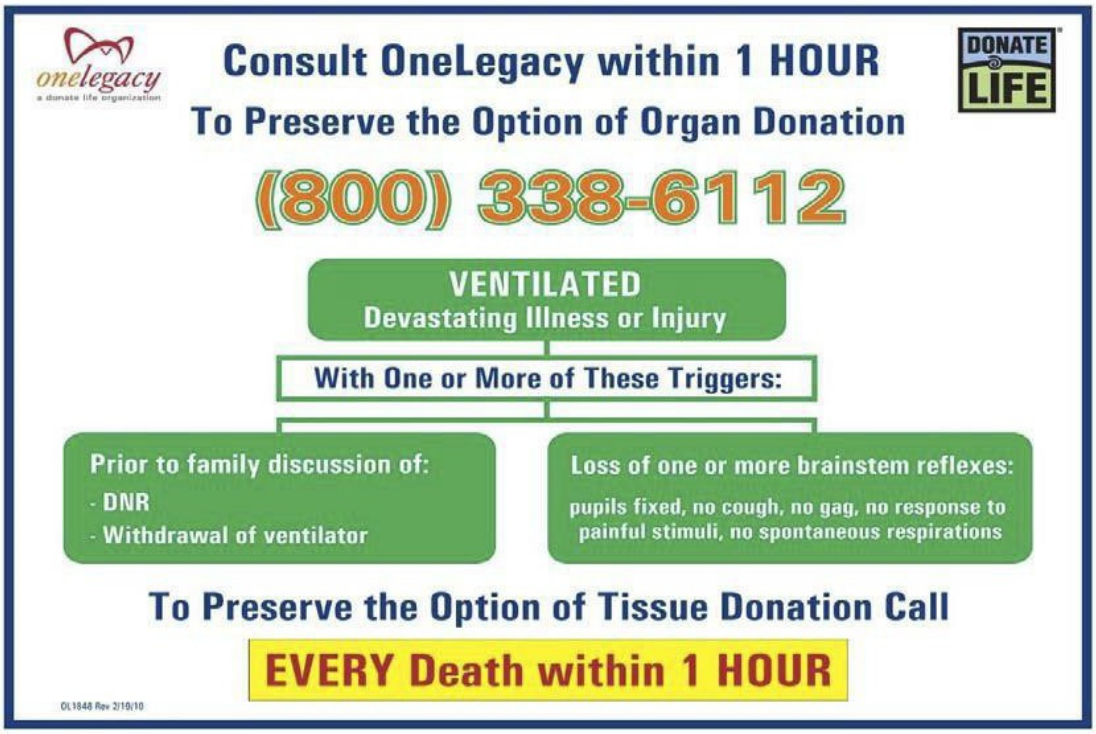
Medicare Conditions of Participation

CMS requires hospitals to refer all deaths and impending deaths to the local Organ Procurement Organization in a *timely manner.* Compliance with this requirement is reviewed and may affect Medicare reimbursements to hospitals.

We work together to:

- Educate hospital staff on the donation process
- Present family with organ and tissue donation options
- Maintain potential donor while testing and placement are performed
- Review death records

Early Referral is Critical and Required by CMS Regulations – follow these guidelines:



- Never rule out any patients for disease or age. Call One Legacy even if the patient will be a coroner's case; the organ procurement agency will work with the coroner's office.

- After the referral is made, the organ procurement agency will evaluate the patient for suitability. If the patient is suitable, they will follow the case until brain death is documented (according to our brain death declaration policy) or the decision to withdraw life-support is made.

- If the decision to withdraw life-support is made, there is still the possibility to donate after cardiac death.

Physician's Responsibilities:

Brain Death Determination

- Brain death documentation by 2 licensed physicians
- Notes should state "Patient is Brain Dead"
- Sign, date & time notes

Test(s) that may be performed to determine brain death:

- Clinical exam is required in the State of California
- EEG or CBF is not mandatory
- Discretion of the physician for confirmatory tests
- Review Hospital Policy and Procedure

Explanation to the Donor Family

- Physician explains brain death and tests
- Do not bring up organ donation to the family as the patient may not be suitable or it is too early for the family.
- Once the brain death declaration or decision to withdraw is made, use the bridging statement as follow:

"*Someone will be coming in to speak with you regarding some end-of-life decisions that you'll need to make at this time.*"

Organ Donation

- Once the decision/consent to donate is made, call and inform admitting and inform admitting that the patient is a One Legacy patient.
- One Legacy assumes financial responsibility after consent is obtained
- One Legacy is billed for all charges related to organ donation

Tissue Donation

- One Legacy supplies staff and surgical supplies for tissue recovery
- OR recovery: One Legacy ensures area is left clean
- Morgue recovery: One Legacy ensures area is left clean

The Gift of Life

For many families The Gift of Organ Donation is the only positive experience in the tragic chain of events surrounding the loss of their loved one. It can help give meaning to an otherwise senseless event that has occurred.

Refer to Patient Care Policy: *"Organ Donation or Procurement*" for more information.

MEDICAL STAFF FUNCTIONS

Disruptive Physician Behavior

The Medical Staff strictly prohibits practitioners from manifesting aberrant, disruptive, or unprofessional behavior, which may reasonably appear to lead to a compromise in patient care.

Such behavior can be classified in one of three categories:

- Disruptive behavior
- Discrimination
- Sexual harassment

The behavior should be reported via the Hospital event reporting system. All reports are held in strict confidence and processed by **the Professional Standards Committee**. An acknowledgement of receipt of a report will be sent to you.

Also note that a physician who is being intense, arrogant, or loud may not necessarily be considered "disruptive." California Law encourages physicians to advocate for medically-appropriate health care for their patients. However, such advocating is to be done in a professional manner and in writing.

For more information, please consult the Medical Staff policy "*Disruptive Physician Behavior.*"

Physician Wellbeing

The Wellbeing Committee's operating philosophy is public protection via promotion of practitioner wellbeing that will prevent conditions that lead to impairment. This Committee has a specific focus of issues relating to (a) mental clarity issues and/or (b) chemical dependency.

Suspicions relative to the Wellbeing Committee's focus can be reported via the Hospital event reporting system or conveyed to either the Director of Medical Staff Management or the Chair of the Wellbeing Committee. All reports are held in strict confidence and processed by **the Professional Standards Committee**. An acknowledgement of receipt of a report will be sent to you.

However, if a practitioner is suspected of impairment while on duty and requires immediate intervention, the Chair of the Wellbeing Committee, the Medical Staff Chairman, or the Director of Medical Staff Management need to be immediately called.