MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Powered by knowledge.
Inspired by caring.

Anne Arundel Medical Center

Agency Nursing Staff Orientation Packet

Updated 12/15

TABLE OF CONTENTS

I. WELCOME TO ANNE ARUNDEL MEDICAL CENTER

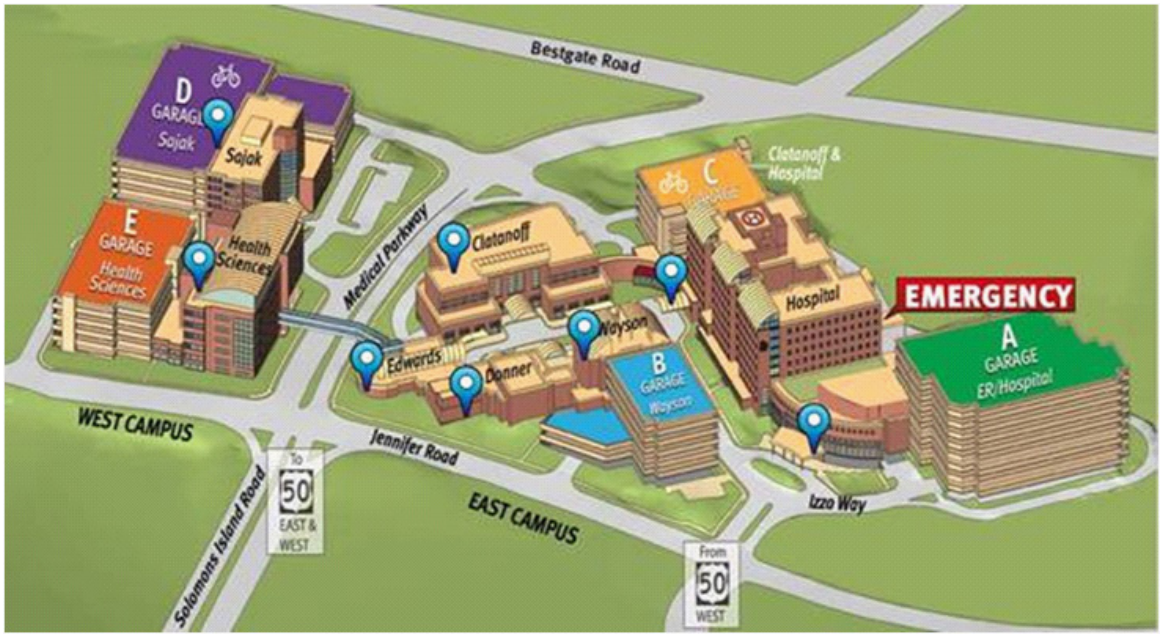
The information in this booklet is designed to help orient you to the standards and routines that apply to most of the nursing units at AAMC. Standards for specialty areas vary. Please consult the clinical educator or clinical director for questions. Nurses at AAMC maintain primary responsibly for the care of our patients and are expected to comply with AAMC's standards of care, policies and procedures.

A. Security and badges:

All agency nurses and must wear photo IDs provided from AAMC's Human Resource department. HR is located in the Wayson Pavilion, Suite 350. Call 443-481-1950 for more information.

B. Parking and Map

Park in Garage A, 4th level. Parking stickers are not distributed to agency staff.



C. Important phone numbers and web sites:

Central Staffing Office (staffing issues)	443-481-1760
Hospital Operator	443-481-1000
Administrative Coordinator (admin issues after hours)	443-481-5509
Human Resources	443-481-1950
AAMC Web site	**www.aahs.org**
AAMC Nursing web site	**www.aahs.org/aamcnursing**
AAMC Nursing Blog	**www.aahs.org/nursingblog**

D. AAMC Mission, Vision, Values and Philosophy

Mission: To enhance the health of the people we serve

Vision 2020: Living Healthier Together

Learn more here about our values and our organization here.

II. PRACTICE, JOB DESCRIPTION AND COMPETENCIES

A. Practice

- An evaluation must be completed at the end of the first shift.
- Agency nurses receive a skills checklist at the start of the first shift. Not all skills can be observed on initial orientation and agency personnel may be limited in patient care until skills are validated. Upon completion, return skills checklist to the Central Staffing Office.
- Orientation will consist of computer training and observation of unit-specific skills.
- Each unit has identified skills that cannot be performed by agency staff. These should be documented on the evaluation sheet.
- All Agency RN's will be required to use Time Call (see below).

B. Clocking in and out

1. Dial x5259
2. Enter Social Security number then press the # key
3. Enter PIN number then press the # key (a 4-digit number determined by you)
4. Press 1 to record your time In or Out
5. Press 3 to enter a Department change
6. Enter the cost center of the department
7. Press the # key
8. After pressing the # key, listen for a special tone. The tone verifies your entry. If you do not press the # key, the recording of your time will not be saved.
9. Hang up
10. This same procedure is used to record your time In and Out

C. Job description and competencies

Click the policy to review: **HR8.8.02 Process for orientation of agency and contractual staff**

Job Description Review:
POSITION TITLE: AGENCY/CONTRACT NURSE
FLSA STATUS: NONEXEMPT
DEPARTMENT TITLE: GENERIC JOB GRADE: 00
SUPERVISOR'S TITLE: NURSE MANAGER/DIRECTOR POSITION: 504

POSITION OBJECTIVE: Contributes to the provision of high-quality, cost-effective health care as a provider of direct and indirect patient care and by effective collaboration with other members of the health care team. Functions as a competent member of the health care team.

Within the scope of this job the individual will be exposed to blood-borne pathogens and hazardous materials. The individual will be required to utilize personal protective equipment in accordance with universal precautions.

KNOWLEDGE/EXPERIENCE: Current licensure as a registered nurse by the Maryland Board of Nursing.

WORKING CONDITIONS/PHYSICAL REQUIREMENTS: Medium work: Exerting up to 50 pounds of force occasionally, and/or up to 20 pounds of force frequently, and/or up to 20 pounds of force constantly to move objects. The above is intended to describe the general content of and requirements for the performance of this job. It is not to be construed as an exhaustive statement of duties, responsibilities or requirements. (Date reviewed: 01/06/04)

BEHAVIORAL COMPETENCIES (Performance Key: 3 = Excellent, 2 = Good, 1 = Fair)

___ 1. Communication
The ability to present ideas and information in a timely, concise, effective and interpersonally appropriate man ner through both written and oral forms. This competency is further demonstrated by the ability to receive and effectively process information through appropriate listening skills.

___ 2. Commitment to Change
The demonstrated commitment to contribute to and support effective change in order to enhance organizational performance. This competency is demonstrated by continuously identifying and acting on opportunities to improve AAHS processes and services

___ 3. Continuous Self-Improvement
The demonstrated commitment to identify opportunities, invest time, and participate in activities resulting in a personal and professional development.

___ 4. Customer Relations
The demonstrated ability to develop and cultivate mutually beneficial relationships with both internal and external customers. Customer relations behavior is demonstrated by continually striving to meet or exceed customer expectations, enhancing trust and respect for others.

___ 5. Problem Solving/Decision Making
The demonstrated ability to identify issues and opportunities, collect appropriate information, effectively process information and make timely and effective decisions to improve outcomes.

___ 6. Role Model
The demonstrated ability to be trusting, trustworthy and respectful of myself and others by insuring confidentiality and appreciation for others' time, resources and respect for the dignity of each person.

___ 7. Teamwork
The demonstrated ability to establish and maintain effective relationships with others. Teamwork is characterized by working toward a shared purpose or goals or through cooperating, collaborating and partnering with others.

___ 8. Accountability
The demonstrated ability to take responsibility and ownership for the outcome of all actions and decisions in fulfilling job requirements with special emphasis on customer satisfaction.

PROFESSIONAL/TECHNICAL COMPETENCIES /ESSENTIAL FUNCTIONS (Performance Key: 3 = Excellent, 2 = Good, 1 = Fair)
Clinical Decision Making/Judgment

___ 1. Demonstrates clinical nursing knowledge and skill in the specialization of the unit.
___ 2. Demonstrates the ability to apply the nursing process effectively in the care of culturally diverse patients and families.
___ 3. Demonstrates the ability to utilize all applicable laws, policies, standards, guidelines and evidence-based practice in provision of patient/family care.
___ 4. Organizes and reprioritizes patient care activities based on subtle and overt and/or environmental changes.
___ 5. Consistently and thoroughly assesses patients to collect data and identify learning needs according to established standards and policies.
___ 6. Utilizes a systematic, continuous and complete analysis of assessment data to develop individualized problem lists for assigned patients.
___ 7. Develops and individualizes a plan of care for each patient in accordance with established standards, appropriate prioritization of problems/needs, and mutually agreed upon goals.
___ 8. Efficiently implements the patient's plan of care in accordance with applicable standards, policies, procedures and guidelines.
___ 9. Demonstrates proficiency in medication administration, pain management and other unit or initiative specific skills.
___ 10. Continuously evaluates the effectiveness of the plan(s) of care, making revisions and recommendations based on analysis of patient responses to interventions.

Nurse-Patient Family Relationships

___ 1. Demonstrates the ability to assess the patient's/family's learning needs, readiness to learn, learning style, and presence of barriers to learning. Demonstrates the ability to develop, implement and evaluate teaching plans for patient populations in unit specialty in accordance with applicable standards.
___ 2. Demonstrates the ability to apply knowledge of growth and development across the life span to the care of patients.
___ 3. Provides direct patient care to patients and families in a culturally, developmentally and ethically appropriate manner.
___ 4. Plans of care address the physical, psychosocial, spiritual and learning needs of the patient/family.

D. Documented competencies

Agency nurses working at AAMC must have demonstrated and documented competency before they are able to care for patients with the following health care needs:

Critical Care Unit

- ❒ Epidural/Intrathecal Catheters
- ❒ Ventriculostomy
- ❒ Neuromuscular Blocking Agents
- ❒ Peripheral Nerve Stimulator
- ❒ Transcutaneous or Transvenous Pacemakers
- ❒ PA Catheters
- ❒ Femostops
- ❒ IABP Therapy
- ❒ Esophagogastric Tramponade Tube
- ❒ Peritoneal Dialysis
- ❒ Moderate Sedation
- ❒ Management of Ventilated Patient
- ❒ Intraabdominal Pressure Monitoring

Oncology Unit

- ☐ Chemotherapy infusion
- ☐ Epidural/Intrathecal Catheters

Progressive Care Unit

- ☐ Vascular patient population
- ☐ Peritoneal Dialysis

Mother/Baby Unit

- ❒ Infant Security
- ❒ Neonatal Infant Pain Scale

Pediatric Unit

- ❒ Pediatric – Blood Administration
- ❒ Infant Infusion Pump
- ❒ IVIG Administration

III. GENERAL ORIENTATION

A. Confidentiality and patient rights

In 2002, a national program was launched to urge patients to take a role in preventing health care errors by becoming active, involved, and informed participants on the health care team. All inpatients receive a "Speak Up" brochure and can report concerns via the hotline, Web site, or by writing in the brochure. If a patient gives you a concern in writing, send it via interoffice mail to "Speak Up". Staff should try to address any patient concerns as soon as possible with the patient, manager, physician, or patient advocate.

Teach your patients to speak up if they have questions or concerns; Pay attention to the care you are receiving; Educate yourself about diagnosis, medications, treatment and plan; Ask family or friend to be your advocate; Know your meds – what and why; Use a health care facility that is evaluated against current patient safety standards; Participate in all decisions about your treatment.

Click the policy to review:
HR 8.2.05 - Confidentiality Agreement
ERR3.1.03 - Patients rights and responsibilities

B. Patient Safety

Click the policies to review:
GNP14.6.04 - Double identifiers of patient information
GNP14.6.01 - Pre-procedure verification process for preventing wrong site, wrong protocol, wrong person surgery
MED16.1.25 - Medication reconciliation
NAP12.1.13 - Verbal orders from privileged medical staff
NAP12.1.15 - Handoff Report

C. Incident Reporting/4PTS Hotline

All reportable incidents should be reported to the 4PTS hotline (x4787). Examples include but are not limited to: patient falls; medication errors or near misses; specimen labeling errors; missed order for treatment, medication; narcotic discrepancy; removal of a patient's ID bracelet; significant delays in treatments or disposition.

Click policy to review:
ADM1.1.62 - AAMC Incident reports

D. Patient and Family Centered Care

What is Patient and Family Centered Care (PFCC)? Working with patients and families—instead of doing to and for them. That is Patient- and Family-Centered care. Why is collaborating with patients and families so important? Health care providers are the "experts" in the medical field, while our patients and their families are "experts" on the patient. PFCC defines caregivers as everyone and anyone that has the ability to affect the patient care experience.

What does PFCC look like at AAMC? It is everyone across the hospital caring in a manner that incorporates the four core concepts of PFCC: Dignity and Respect, Information Sharing, Participation and Collaboration. Every patient and family member is treated in a manner that maintains their dignity and respects their preferences. Every patient and family is given timely, useful and accurate information in order to make decisions about their care and level of participation. Every patient and family is welcome to participate with the health care team on a level that is comfortable for them. Patients and families work in collaboration with the health care team to make decisions locally about the care of their loved or globally to help create hospital wide policies, practices and programs.

Our visiting policy welcomes families 24 hours a day, as the patient and/or family wishes. We are also working to bring patients and families as advisors to workgroups, committees and taskforces to add their unique perspective and aid in the decision making process. Collaboration at the hospital-wide level is one of the core concepts of PFCC and we are seeking patient and family advisors.

E. Behavior Restraints/Seclusion

Click to review: **GNP14.6.17 - Restraints/Seclusion**

F: Safe Patient Handling and Lifting

Click to review: **GNP14.6.16 - Safe patient handling and lifting**

G: Fall Prevention

Click to review: **NAP12.1.21 - Adult inpatient fall prevention and management program**

H: Cultural Sensitivity

The goal of the health care system is to provide optimal care for all patients. Culture and ethnicity are strong determinants in an individual's interpretation or perception of health and illness. Religion, ethnicity, and culture interweave into the fabric of each response of a particular individual to treatment and healing.

Culture - the behaviors and beliefs characteristic of a particular social, ethnic, or age group. Includes the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Diversity - differences in race, ethnicity,culture, language, age, gender, sexual orientation

Cultural Competence

- The ability to understand, appreciate and interact with persons from cultures and/or belief systems other than one's own
- Understanding one's own views and those of the patient while putting aside any biases, stereotypes, and/or judgments
- Having a basic knowledge of cultures, beliefs, customs other than your own

Barriers to Cultural Competence

- Equal Treatment Model
- Cultural conflict
- Ethnocentrism

Have I 'ASKED' Myself The Right Questions?

- Awareness: Am I aware of my biases and prejudices towards other cultural groups, as well as racism and other "isms" in healthcare?
- Skill: Do I have the skill of conducting a cultural assessment in a sensitive manner?
- Knowledge: Am I knowledgeable about the worldviews of different cultural and ethnic groups, as well as knowledge in the field of biocultural ecology?
- Encounters: Do I seek out face-to-face and other types of interactions with individuals who are different from myself?
- Desire: Do I really "want to" become culturally competent?

The **ANA Position Statement is summarized here:**

- Knowledge of cultural diversity is vital at all levels of nursing
- Cultural groups often utilize traditional health care providers, identified and respected within the group.
- Concepts of illness, wellness, and treatment modalities evolve from a cultural perspective or world view and are part

of the total cultural belief system.
- Recognizing cultural diversity, integrating cultural knowledge, and acting, when possible, in a culturally appropriate manner enables nurses to be more effective in initiating nursing assessments and serving as client advocates.

Resources at AAMC to communicate with non-English speaking clients:
- MARTII unit - this mobile unit with TV works like Skyle, hundreds of languages are available. Some languages have visual and audio while some only have audio -- the company will tell you when you call.
- Spanish-speaking interpreters - Clatanoff and ACP have interpreters from 8a-10p, 7 days a week.
- Sign-language interpreters available by request. Notify HOC or CPOC.
- Language Line - telephone with two receivers provides instant interpretation in hundreds of languages. Available on every unit. Follow instructions on the telephone to access.
- AAMC is committed to ensuring all staff has the knowledge and training necessary to care for culturally diverse patients (Healthstream assignments annually, educational offerings through Cultural Diversity Initiative Group). Cultural assessment is performed on admission, including dietary preferences, medications taken at home (herbal or vitamins), tests/procedures prohibited by culture, religious preference, primary language/language spoke at home, etc.
- Cultural Competence is emphasized. Nurses must have the knowledge and skills necessary to care for persons of all backgrounds/cultures and must have the desire to do so, while also being able to set aside any stereotypes or biases. Be respectful at all times, even if you do not agree with the patients beliefs or practices

Language Assistant (Interpreter Services) - It is a fundamental standard of care that all patients and their families are able to fully participate in their plan of care by providing them with culturally and linguistically appropriate services. A need to improve upon how we identify and support patients and families who need interpretation services has been recognized. New processes have been developed to help up serve patients who need interpreter services.

Key updates to the Interpreter policy:

1. When notified that language assistance is needed Staff member must call Patient Advocacy Department/Interpreter Services at ext. 3801,
2. The In-Person Interpreter will now document interactions in the medical record
3. The following communication tools are NO LONGER to be used: Telecommunications Device for the Deaf, Interpretation by family and friends.

A Communication Barrier care plan and a Teaching plan have been added to ALEC.

- Patient will be identified as needing interpretation services at the time of pre-registration.
- If a patient requires some form of interpretation service, a BPA will fire alerting the care team and a Communication Barrier Care plan and Teaching plan will automatically be added in ALEC.
- The nurse will need to individualize the goals and intervention for the patient, implement the interventions in the care plan and document on the goals.

I. SBAR/Bedside Handoff

SBAR (Situation, Background, Assessment, Recommendation) is the report communication tool used at AAMC during bedside shift report. Click here to see the video.

Critical elements of bedside shift report:

1. Open the patient's medical record with the computer/WOW in the room
2. Introduction
3. Verbal SBAR report with family
4. Focused physical assessment
5. Patient goal for the day

Benefits for Patients: Acknowledges patients as partners, builds trust in the care process, increases teamwork and reassures patient, actively encourages patient and family engagement, gives patient and family an opportunity to ask questions, information shared helps with transitions to home

Benefits for Nurses: Improved: accuracy about the patient's condition, accountability, time management, patient safety

Addressing HIPAA concerns: Health information can be disclosed for treatment and payment. HIPAA acknowledges incidental disclosures may occur. Not a HIPAA violation as long as the nurse takes reasonable safeguards to protect privacy and only discloses or uses the minimum necessary information.

J: Infant Security

AAMC delivers more than 5,000 newborns per year. We are the second largest in the state.

Code Pink

- Suspected or actual infant/child abduction
- Clatanoff Pavilion is secured – access into/out of building is restricted
- Security Personnel and County Police provide direction
- All staff in the Clatanoff Pavilion are to remain on site until cleared by county police
- Staff in hospital are expected to stop and question all individuals with infants, children and bags
- Carefully plans the abduction, visits site several times before event
- Asks detailed questions about procedures and layout
- Obtains uniform, lab coat or other staff attire
- Waits for an opportunity: visible in hallway for as little as 4 seconds
- May be known to parents (Abductor of older child is often an estranged parent/family member)
- Race/skin color of abductor almost always matches the infants

Abductor profile:

- Almost always female, usually early 20's, typically overweight
- Gainfully employed
- Recent pregnancy loss not revealed to partner
- Fakes one or more pregnancies
- Relies on manipulation and lying as coping mechanisms
- Nesting behavior consistent with expectant parent (announces the pregnancy)

Safety Measures: All staff must be aware of the risk and prevention measures and be alert to visitor behaviors. Women's & Children's staff receive additional training

Staff Education: All hospital personnel are required to wear color photo ID badges. Women's & Children's hospital and medical staff wear color coded (red stripe)"Authorized Baby Care Giver"

Transportation: Mother always escorted by a Women's & Children's RN or Tech when discharged

- Infants are transported: by bassinet; carried by mother while she is riding in a wheelchair/stretcher; in car seat carrier; NEVER carried in arms outside of patient's room
- Children are transported by: wheelchair or stretcher; Jeep or Wagon

Prevention

- Educate families and staff
- Know abductor profile
- Know acceptable modes of transportation
- Identify unusual behaviors
- Know your role in a Code Pink

- Control access to restricted areas: Do not allow unauthorized personnel to ride restricted elevators or enter restricted doors when you pass through; escort people to their destination
- ASK QUESTIONS : "Excuse me, I'm_____ from the_____Department. We are very concerned about Patient Security at AAMC. Do you have a Visitor Pass? Who are you visiting, please? Please walk with me to Security to get the proper identification."

K: Abuse and Domestic Violence

Domestic Violence (DV) is a pattern of behavior used by one person in a relationship to gain power and control over another, usually an intimate partner. It can include physical, psychological, emotional, verbal, sexual, and/or economic abuse.

Why doesn't the victim leave? Fear, economic dependency, no one to help, shame, language and/or cultural barriers, poor self confidence.

Why does the victim stay? Commitment, no place to go, children, religious beliefs, medical problems, immigration status.

What to say: "What you are experiencing is abuse," "It is not your fault," "Help is available."

Referrals to the AAMC Abuse & DV Program
- Page A/DV through the Hospital Operator 443-481-1000, after paging A/DV send a consult;
- For noncritical issues contact A/DV at 443-481-1209.

Domestic Violence (Adult Partner Abuse)
- 30% of female homicides are committed by intimate partners
- DV is leading cause of death of both pregnant women and women who are 1 year post delivery or pregnancy termination
- 25-45% of battered women were battered while pregnant
- **Reporting Laws:** In MD, there is no mandatory reporting unless assault is with a deadly weapon or moving vessel.

Child Abuse
- Abuse of a minor child (under 18 years)
- Mandated report to Department of Social Services Child Protective Services (CPS)
- Abuse may be physical or neglect
- A person does not have to be "certain" of abuse in order to report; it is the responsibility of CPS to investigate
- **Reporting Laws:** mandatory report to Department of Social Services, Child Protective Services

Vulnerable Adult/Elder Abuse
- Older adults may be subjected to a pattern of abusive behavior
- Abuse may be committed by a family member or by someone with whom they have an intimate relationship (may also be caregiver).
- Vulnerable adults (such as physically or mentally disabled individuals) may be at risk for abuse.
- **Reporting Laws:** Mandatory report to Department of Social Services, Adult Protective Services

L: Age Specific Care

Each age group has different communication, comfort, and safety needs. How these needs are met depends, in part, on the age of the patient and your understanding of their needs.

	Communication	Comfort	Safety
Infant	• Introduce self to caregiver and explain procedures • Smile and speak slowly, calmly to infant • Use soft sounds, such as music, to comfort • Try to initiate eye contact, but do not force.	• Keep warm & dry, avoid bright lights • Allow for usual feeding schedule • Allow caregiver nearby • Allow patient to keep comfort objects • Meet physical needs promptly	• Pt may feel safer when cuddled • Provide non-flammable toys and safe environment • Avoid choking hazards • Transport using size-appropriate means
Toddler	• Introduce self to pt and caregiver, involve caregiver in plan • Expect self-centered thinking from child • Do not rush patient. May need time to think about what has been asked of him/her • Use simple words to explain things	• Provide warmth • Allow pt to keep favorite comfort objects • Establish routine of care and keep continuity • Consolidate care to provide rest • Encourage use of playroom	• Do not leave unsupervised. Pt often does not recognize danger. • Keep side rails up • Provide non-flammable toys • Avoid choking hazards • Limit separation from caregiver
Pre-school	• Introduce self to patient and caregiver • Get down to eye level to talk to child • Do not rush patient • Offer choices when possible • Allow pt to touch equipment • Include parents in explanations • Use familiar characters to assist in communication. • Expect regressive behaviors	• Allow pt to talk and verbalize fears • Do not separate from comfort objects • If frightened, may accept explanations/exams given on “teddy” or favorite toy • Praise attempts to cooperate	• Limit separation from caregiver. • Usually able to obey simple commands and recognize danger • Set limits. Often cannot understand why something is acceptable vs. unacceptable. • Provide close supervision • Provide safe environment • Watch for hazards
School-Aged	• Introduce yourself • Provide explanations appropriate to age. • Talk to child directly • Allow time for repeated questions • Allow to explore equipment before use • Involve in planning and decisions	• Allow security objects. • Be subtle in encouraging child to take comfort object with him • May need parent • Use calm, unhurried approach • Allow child some input on decisions • Reassure that it is okay to cry	• Curious • Able to accept limits • Review rules and parameters of safety • Provide safe environment • May transport in wheelchair
Adolescents	• Introduce yourself • Use adult vocabulary. Do not “talk down” to • Very curious- take time for explanations and questions • Needs privacy • Provide choices.	• Maintain privacy. May be very modest • Allow patient to choose whether or not caretaker is present • Take time for explanations	• Can recognize danger • Inform pt of hospital/department rules • Transport as an adult • Provide safe environment
Young Adult/ Early Middle Age	• Introduce yourself • Call pt by title and last name • Do not use endearment terms, such as “honey” • Explain procedures using details • Allow time for questions • Be respectful	• Maintain adult privileges- decision making, privacy, routine of personal habits • Offer assistance with personal care • Inform of available amenities/services • Inform of hospital/department policies (ex. smoking, visitors)	• Keep needed items within reach- including walking and hearing aids • Fall precautions, if appropriate
Late Middle Age/ Late Adult	• Same as “Young Adult/Early Middle Age” • Ensure assistive devices are in working order • Speak slowly, clearly, looking at patient. Do not shout at the hearing impaired patient. • Put objects where patient can see them • Keep room well lit, use night- lighting	• Same as “Young Adult/Early Middle Age” • Do not rush pt • Ask family to bring in familiar items from home • Tell confused pt who you are, where they are, and what time of day it is every time you meet them. • May need repeated offers of assistance for personal care needs • Keep pt warm • Follow home routine as closely as possible	• Fall precautions, if appropriate • Keep needed items within reach, including walking aids • Weak or confused pts may need special safety measures • Do not rush pt. Reaction time is slower • Help pt to and from bathroom if necessary

M: Infection Control

Healthcare-associated infections affect 2 million patients in the US each year and are responsible for 80,000 deaths per year. Transmission of health care-associated pathogens most often occurs via the contaminated hands of health care workers. The Centers for Disease Control and Prevention (CDC) and other health care-related organizations believe that cleaning your hands before and after having contact with patients is one of the most important measures for preventing the spread of bacteria in health care settings.

Wash hands with soap and water if:

- your hands are visibly soiled (dirty)
- hands are visibly contaminated with blood or body fluids
- before eating
- after using the rest room

When washing hands with plain or antimicrobial soap:

- wet hands first with water (avoid HOT water)
- apply 3-5 ml of soap to hands
- rub hands together for at least 15 seconds
- cover all surfaces of the hands and fingers
- rinse hands with water and dry thoroughly
- dry with a paper towel

When should you use an alcohol-based handrub? If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based handrub for routinely cleaning your hands**:**

- before having direct contact with patients
- after having direct contact with a patient's skin
- after touching equipment or furniture near the patient
- after removing gloves

ISOLATION GUIDELINES AND STANDARD PRECAUTIONS

Isolation Type	Examples of Organisms/Diseases in this isolation category	Personal Protective Equipment (PPE) for ALL HCWs, visitors, and family members	Housekeeping Requirements
Contact Isolation B = Basic	• MRSA, VRE, ESBL, Multidrug-resistant organisms (MDRO) • Uncontrollable draining wounds • RSV =Respiratory syncytial virus (+Droplet) • Shingles (+Airborne **only** if **disseminated zoster**) • Impetigo/ Scabies/ Head Lice	• **Gloves** • **Gown** for contact with patient and direct patient environment	**Basic Isolation Cleaning B:** • Quaternary ammonium disinfectant 1 bucket, 1 mop for single room • Change privacy curtains after **each** isolation patient. • Single use cloths with disinfectant to all surfaces, including equipment in room; spot clean walls/ceiling
Contact Isolation A = Advanced	• Multidrug-resistant (MDR) *Acinetobacter sp.*; other significantly resistant organisms (Infection Control will assign **"A"** as needed)	• **Gloves** • **Gown use EVERY time** in isolation area/room • **Mask with face shield** as needed (respiratory secretions, splashes, trache patient, etc.)	**Advanced Isolation Cleaning A:** • Basic Isolation Clean (see above) **Plus** • Wash all walls and spray ceiling with disinfectant.
Contact Isolation C = Complex	• *Clostridium difficile* (Cdiff) and other spore producing pathogens • Rotavirus, Norovirus	• **Gloves** • **Gown** for contact with patient and direct patient environment	**Complex Isolation Cleaning C:** • Basic Isolation Clean **Except** • Use **1:10 diluted BLEACH** instead of the usual disinfectant.
Droplet Isolation B	• Seasonal influenza • RSV (+Contact B) • Pertussis (whooping cough) • Suspected or confirmed **bacterial** meningitis (d/c after 24 hours of antibiotic treatment)	• HCWs and visitors: **Mask with face shield** • Patient: **surgical mask** used **only** while transporting patient	**Basic Isolation Cleaning B:** (see above)
Airborne Isolation B	• Suspected or confirmed **pulmonary** *M. tuberculosis* • Chickenpox (+Contact B) • **Disseminated** Shingles/zoster (+Contact B) • Measles (rubeola)	• Healthcare workers (HCWs): **N95 respirator**- choose size and brand you have been fit-tested to wear • Visitors: **surgical mask** • Patient: **surgical mask** used **only** while transporting patient	**Basic Isolation Cleaning B:** (see above)
Standard Precautions	• **ALL patients require Standard Precautions.** (Examples of those infections/ conditions that do **not** require **transmission-based** isolation include: HIV, AIDS, Malaria, Hepatitis B&C, **viral** meningitis, etc.)	• **No** isolation sign required. • PPE (gloves, gown, mask) is used as needed to prevent contact with blood and body fluids • No transmission-based isolation needed	**Standard room clean:** • Quaternary ammonium disinfectant bucket/mop changed per routine + when visibly soiled • Change privacy curtains per schedule + when visibly soiled; change after every CCU pt • Single use cloths with disinfectant to all surfaces, including equipment in room; spot clean walls/ ceiling.

Using Alcohol-based Handrub Effectively: Apply 1.5 to 3 ml of an alcohol gel or rinse to the palm of one hand and rub hands together. Cover all surfaces of your hands and fingers. Include areas around/under fingernails. Continue rubbing hands together until alcohol dries. If you have applied a sufficient amount of alcohol hand rub, it should take at least 10 -15 seconds of rubbing before your hands feel dry.

Artificial Nails Policy: Nails need to be intact and short, no more than ¼" in length. Polished nails are acceptable only if nail polish is clear and intact. Artificial nails are not allowed for those administering patient care or patient-related care.

N: Sound-Alike-Look-Alike (SALA) Medications

JCAHO National patient Safety Goal #3 Requires AAMC to develop and maintain a list of medications that can be confused and potentially leading to errors. Our list is developed from both JCAHO's suggestions AND medication error reports from 4PTS calls. In addition, the corresponding actions taken by AAMC to prevent these errors are listed. The detailed AAMC list of SALA medications is available as an attachment to the policy on the Intranet.

Joint Commission-required Intranet policies to guide use and interpretation for standing orders and multiple narcotic orders

Standing Medication Order:

- PRN Orders–Need indication for "as needed"
- Hold Orders–Either hold indefinitely OR hold for a clinical parameter
- Automatic Stop Orders– Orders are stopped automatically post-op, on transfer, narcotics at 4 days, and ketorolac (toradol) at 5 days
- Resume Orders–"Blanket"resume orders are not allowed (e.g. resume all pre-op meds). Each medication must be written out completely.
- Titrate Orders– Must have clinical parameters for titration. Narcotic titration also requires initial dose, increment of titration, interval of titration, and maximum allowable dose.
- Taper Orders–Must have goal indicated; either off or down to a certain dose
- **Range Orders:** Range orders are permitted when deemed essential to the care of the patient by the MD–
- Both "time"and "dose"ranges are allowed, however time ranges are redundant and should be discouraged. Interpretation of range orders is outlined as follows:

  The first dose must be administered using the lowest dose and the longest interval in the specified range(s). For example:

  1. Dose 2-4 mg would be given as 2 mg initially
  2. Time 3–4 hours would be given at 4 hours

  If the initial, or subsequent, dose is inadequate the time the peak effect is anticipated, one additional dose may be given.

- The additional dose cannot exceed the difference between the first dose given and the largest dose in the interval AND the time before giving another dose begins at the administration of the additional dose

  For example: "Morphine 1-2 mg IV q 3 hours PRN pain" would be given as 1 mg for the first dose. If the patient still rates pain unacceptable within 30 minutes of the first dose, an additional dose of 1 mg may be given. The next dose may be given 3 hours after the additional dose. Since 1 mg was shown to be ineffective initially, the next dose could be 2 mg.

Multiple Narcotic Orders: In place to prevent excessive multiple narcotic administration which may lead to an adverse drug reaction

- States that only one short-acting narcotic may used at a time.

  MD orders must give specific directions to the nurse as to when to choose one drug over another. For example:
  Morphine 2 mg q 3 hours PRN pain, may give percocet-5 2 tabs po q 4 hours PRN pain when taking PO Morphine 2 mg q 3 hours for severe pain, Percocet -5 1 tab q 4 hours for moderate pain)

  A narcotic option may not be given until the end of the time span for the last short-acting narcotic given (e.g. in the examples above, the patient cannot get Percocet until 3 hours following the last morphine dose)

- Short-acting narcotics may be given for breakthrough pain when patient is on a long-acting narcotic

  Multiple short-acting meds may be ordered with a long acting narcotic if done according to the previous guideline

- Long-acting narcotics should be limited to only one medication which should be adjusted by the MD for optimal pain control. Multiple long-acting narcotics may only be used on patients who are admitted already on multiple long-acting narcotics.

O: Medication Administration/Double Identifiers

The identification wristband will include the patient's name, assigned account number and bar code. The patient's name and account number will serve as the double identifiers when providing care, treatment and services by all caregivers.
Click policy to review: MED16.1.01 - Medication administration.

P: Pain Management

In an effort to increase safety of opioid analgesia, AAMC does not usually allow more than one long acting or more than one short acting opioid to be ordered/active at one time unless there are clear instructions as to which medication to administer under which circumstances.

Acceptable examples: Morphine 2mg IV q2hrs prn pain while NPO
Percocet 5mg 1-2 tabs po q4hrs prn pain when tolerating PO
Percocet 10/325 1-2 tabs po q4hrs prn pain
Dilaudid 6mg po q3hrs prn pain if Percocet ineffective and discontinue Percocet thereafter.

Unacceptable examples Morphine 2mg IV q2hrs for pain
Dilaudid 2-4mg po q3hrs for pain
Percocet 5mg 1-2 tabs po q4hrs prn pain

If a patient is admitted with an analgesic regimen that *already* consists of more than one long-acting or more than one short acting opioid, it is allowable to continue the patient on their pre-existing regimen.

Reassessment & Documentation of Pain

- When a prn analgesic is administered, you are required to reassess and document your reassessment within 1 hour.
- Consideration of the onset, duration and peak effectiveness should be considered when timing your reassessment of pain.
- Make every effort to reassess and document pain within 30 minutes for IV analgesics and within 60 minutes for PO analgesics.
- The documentation of the reassessment of pain is audited every month and reported to the unit directors.

Dilaudid

- The administration of IVP and IM Dilaudid here at AAMC are only approved for staff in the ED, OR, PACU, CCU and Interventional Radiology.
- Dilaudid PCA can only be ordered by those physicians who have completed the Dilaudid prescribing competency through the Medical Staff Office. This can be verified via the pharmacy or via Meditech. All of the PharmD's are competencied to prescribe Dilaudid. If a non-competencied physician wishes to have a patient on a Dilaudid PCA, obtain a PharmD consult for Dilaudid PCA management.

PCA by Proxy

- PCA by Proxy means that someone *other than* the patient pushes the bolus button.
- AAMC does NOT allow PCA by Proxy per our PCA Policy. Please educate family members, friends and significant others about the increased risk of respiratory depression when anyone but the patient pushes the bolus button.
- AAMC does not allow nurse proxy dosing either. If the patient is unable to initiate a bolus dose on their own, they are not an appropriate candidate for PCA management!

Patient / Family / SO Education

- Pain management education must be documented in the Interdisciplinary Patient Education Record (IPER).
- The following documentation is REQUIRED for *every* patient:
    - The "risks for pain" – this is now a look up option in the IPER in the pain management section
    - Pain scale
    - Pain management plan

Q: Code Carts

Defibrillator/ pacer check is performed and documented daily. Code cart checklist is checked daily. All outer locks on the adult code carts, broselow carts and NICU carts should be the same color. A cart that has different colored locks on the outside or has a lock missing or broken may not contain all the needed supplies.

R: Emergency Response, Code Blue and Rapid Response

As part of our commitment to a culture of safety, anyone (patients, family, employees, visitors and volunteers) can call the Rapid Response Team for help. The team can be activated by dialing 1111.

Emergency Response by campus location on campus is as follows:

- Code Blue and Rapid Response Team (Both teams -1111): Hospital, Clatanoff, Edwards Pavilions and Donner Pavilion Radiation Oncology Inpatients only
- EMS (911) and Security (6911): Wayson, Donner, Health Sciences and Sajak Pavilions, including all outpatient regulated space and all campus parking areas. Outpatient regulated space can still call the Hospital Operations Coordinator at 5909 if they need additional assistance to bridge the gap waiting for EMS arrival

There are still special situations for neonates in the Bay Area Midwifery and Outpatient Infusion Center – **Click policy to review: GNP14.6.15 - Emergency response teams (code blue, rapid response, and 911 calls)**

AEDs are located at the elevators in our office buildings and garages.

Patients who have a DNR or "do not resuscitate" designation and are undergoing a procedure will have an opportunity to discuss with their provider whether they wish this designation to remain intact during and after the procedure.

If the Rapid Response Team or the Code Blue Team is activated, the Unit Clinical Director, Hospital Operations Coordinator or Clatanoff Pavilion Administrative Coordinator will follow-up with the patient and/or family within 24 hours of the event. This will give the patient and/or family an opportunity to ask questions or voice concerns.

Both Code Blue and Rapid Response require MD/ RN signature and an evaluation of the event on the back of the yellow Resuscitation Form. This copy goes to Critical Care Committee for monthly review.

	Code Blue	Rapid Response
Criteria for Activation	Immediate response – goal to defibrillate as needed within 2 minutes of call for: • Respiratory or cardiac arrest	Responds within 10 minutes to adults for these reasons: • Any worrisome signs or symptoms • ACUTE change in heart rate (<40 or >130 beats/min) • ACUTE change in systolic BP (<90 mmHg) • ACUTE change in respiratory rate (<8 or >28 breaths/min) • ACUTE change in oxygen saturation (<90% despite O2) • ACUTE change in LOC • ACUTE Bleeding • ACUTE Neurological Change/ Stroke • Dysrhythmias • Rapid Deterioration • Seizures
Primary Responders	• Physician: intensivist, ED physician, Pediatric Hospitalist, Neonatologist, NNP • Critical Care RN, ED RN • Respiratory Therapist • Administrative Coordinator • Primary RN/LPN/CTC/PC • Unit based tech / escort	• CCU's Care Team Coordinator (CTC) • Respiratory Therapist

S: Advance Directives **Click policy to review: ERR3.1.02 - Advance directives**

T: Peak Census **Click policy to review: NAP12.1.12 - Peak census**

U. Corporate Compliance

What is Compliance?

- "The willingness to follow or consent to another's wishes" - Webster
- Not a new concept
- Who do we comply with at AAHS?
  - Federal Government
  - State Government
  - Other Regulatory Agencies

Identify

- Issues of non-compliance
  - Breach of Confidentiality and/or Security
  - Fraudulent or Abusive Billing Practices
  - Conflicts of Interest
  - Kickbacks/Bribes
  - Employee Theft or Embezzlement

Report

- Chain of Command Reporting
  - Prefer that you discuss with your supervisor or manager first
- Compliance and Ethics Hotline
  - 443-481-1338 24 hour voicemail
  - 443-481-1313 fax
  - compliance@aahs.org
  - US Postal Mail/Interoffice Mail

Reports can be made anonymously!

Your Role in Compliance

- Identify
  - Know what a compliance issue looks and feels like
- Summarize
  - Know the facts
  - Be able to summarize them for a better review
- Report
  - Know who to contact to discuss the issue so it may be resolved

Summarize

- Get the Facts
  - Who, What, When, Where, How??
  - Why are you concerned?
    - Violation of law or regulation
    - Violation of AAHS policy
    - "It just doesn't feel right"
  - Has the issue been brought up before?

IV. ENVIRONMENT OF CARE/SAFETY MANAGEMENT/ EMERGENCY OPERATIONS PLAN

AAMC MEDICAL PARK
SYSTEM FAILURE & BASIC STAFF RESPONSE
(See department policies & procedures for additional details)

Failure of:	What to Expect:	Who to Contact:	Responsibility of User:
Computer Systems	System down.	Information Systems	Use backup manual/paper system
Normal Electrical Power Failure - Emergency Generators Come on Line	Many lights are out. Only RED plug or RED face plate outlets work on emergency power.	Engineering Respiratory Care Services	Ensures that life support systems are on emergency power (red outlets). Ventilate patients by hand as necessary. Don't start new cases. Use flashlights. Manually regulate IV's as necessary.
Security Breach/Problem	Unauthorized access. Disruptive individual. Life threatening situation	Security Office (DAY) Officer STAT response (ANYTIME)	Immediately contact Security for problem. Activate silent alarm.
Elevators Out of Service	All vertical movement will have to be by stairwells.	Engineering	Review fire & evacuation plans.
Elevator stopped between floors	Elevator alarm bell sounding.	Engineering Security	Keep verbal contact with personnel still in elevator and let them know help is on the way.
Fire Alarm System	No fire alarms or sprinklers.	Engineering	Institute Fire Watch, minimize fire hazards, use phone or runners to report fire.
Medical Gasses	Gas alarms, O_2, Nitrous Oxide (NO_2); Medical air; Nitrogen	Engineering Storeroom, Respiratory Care and Security	Hand ventilate patients; transfer patients if necessary, use portable O_2 and other gases, call for additional portable cylinders.
Medical Vacuum	No Vacuum, vacuum system fails & in alarm.	Engineering Respiratory Care	Call Central Service for portable vacuum, obtain portable vacuum from crash cart, finish cases in progress, don't start new cases.
Natural Gas; Failure or Leak	Odor no flames on burners, etc.	Engineering	Contact Engineering to assist in opening windows to ventilate, turn off gas equipment, don't use any spark producing devices, electric motors, switches etc.
Nurse Call System (Attended Mode)	No patient contact. Room light over door not working; Nurses Station console not working	Biomedical Engineering Nursing Supervisor	Use bedside patient telephone if available; move patients, use bells, assign a rover to check patients.
Nurse Call System (Unattended Mode)	Not receiving patient calls on cordless phone, not receiving code alerts on pager	Biomedical Engineering Nursing Supervisor	Inform staff to switch to Attended Mode assign staff member to monitor master console at nurse's station.
Patient Care Equipment/Systems	Equipment/system does not function properly.	Biomedical Engineering	Replace & tag defective equipment.
Sewer Stoppage	Drains backing up.	Engineering	Do not flush toilets, do not use sinks. Install plastic bags in toilets.
Steam Failure	Sterilizers inoperative	Engineering	Conserve sterile materials. Call Central Sterile Processing at main campus (x1635) to coordinate sterile supply requirements.
Telephones	No phone service.	Communications	Use overhead paging, pay phones, emergency trunk lines, cell phones, use runners as needed.
Water	Sinks & toilets inoperative.	Engineering	Institute Fire Watch; conserve water, use bottled water for drinking, be sure to turn off water in sinks, use RED bags in toilet.
Water Non-Potable	Tap water unsafe to drink.	Engineering Dietary, and all Mangers	Place "Non Potable Water - Do Not Drink" signs at all drinking fountains and wash basins.
Ventilation	No ventilation; no heating or cooling.	Engineering	Contact Engineering to assist in opening windows (institute Fire Watch) or obtain blankets if needed, restrict use of odorous/hazardous materials.

Phone Numbers

Biomed	4750	Information Systems	5202	Security	1430	Oncology Center	5800
Environmental Svc.	5150	Engineering	4777	Security STAT	6911	Edwards Surgical Ctr.	5700
Dietary	6830	Materials Mgmt	4951	Communications	1111	Mr. Firestone	6911
						Off-Site Emergency	911

SYSTEM FAILURE SHEET

FIRE OR SMOKE IN YOUR AREA
(CODE RED: MR. FIRESTONE)

1. Do not shout "FIRE!" Adhere to the following procedure:

2. R-A-C-E

   R - Remove all individuals from the vicinity of fire. Close door to room.

   A - Activate the alarm:

   1. Pull the lever on the nearest red fire alarm box. **Know the location of all pull boxes in your area.**

   2. Pick up the telephone and dial Security at 6911. State "CODE RED: Mr. Firestone", location of fire, your name and type of fire. (trash, electrical, chemical)

   3. Ask security to repeat back what you told them.

   C - Confine - Close all doors and check to see that fire exits are clear.

   E - Extinguish - Obtain a fire extinguisher and attempt to extinguish the fire. **Know the location of the fire extinguishers in your work area.**

3. Assist fire response team and fire department.

4. Department Evacuation Plan:

   A. Exit building via fire exits. Know the location of fire stairway exits and the proper direction of evacuation from your work locations. See EOC 4.5.02 on the Intranet.

   B. Elevators may be used to evacuate non-ambulatory patients if elevator or elevator lobby is not the scene of the fire.

CARDIAC/RESP ARREST (CODE BLUE)

1. ACTIVATE THE CODE BLUE EMERGENCY RESPONSE SYSTEM.

A. <u>For In-Patients</u>

1. Push Emergency Call Button (if available on unit)

THEN

2. Pick up phone and dial 1111 and announce "Code Blue, patient, location, patient's name & physician's name".
3. If room has two-way intercom unit, you may speak directly with hospital operator – hands free

2. BEGIN CPR - only if you have been trained. Use ambu bag or open emergency air way kit located on wall in room. **(NO MOUTH TO MOUTH RESUSCITATION.)**

A. Send for crash cart and monitor/defibrillator.
B. Flatten bed.
C. Put a backboard under the patient.
D. CPR (2 man CPR: 2 ventilations to 15 compressions)

3. WHEN CRASH CART AND MONITOR/DEFIBRILLATOR ARRIVES:

A. Attach cardiac monitor to patient. Turn on recorder.
B. Assure a patient IV is in progress.

4. WHEN CODE TEAM ARRIVES:

A. Have the patient's chart available.
B. Assist code team.

ENGINEERING DEPARTMENT REPAIR
POWER FAILURE AND TELEPHONE OUTAGES

1. Maintenance Repairs and Utility Outages

A. Call ext. 4777

B. After hours, weekends and holidays, call Plant Operations on ext. 4777, Manager of Engineering 443-223-3674.

C. Insure you know locations of all emergency power outlets (RED OUTLETS) in your work area. Ask your supervisor to identify source of emergency power.

2. Biomedical Repairs

A. 6:00 a.m. to 5:00 p.m. Call ext. 4758

B. Emergency calls for Biomed after normal working hours are for life support equipment only and should be approved by the Nursing Supervisor prior to calling. Once the call has been approved by the Nursing Supervisor, call the hospital operator to call the On-Call Biomed.

3. Power Failure/Emergency Telephone System

A. In the event of a power failure in the telephone system, certain telephone extensions in the Edwards, Clatanoff, and Donner are equipped for making emergency calls to the outside. These extensions have emergency trunk numbers associated with them. If someone is trying to reach one of these departments during a telephone power failure, you must dial the emergency trunk number associated with that extension. **NOTE:** There is no power failure emergency call capacity in the ACP because the ACP lines are digital.

B. The following extensions have the emergency call capability:

Extension	Emergency Trunk #	Location	Department:	Emergency Cell Phone Number:
5722	410-224-5620	ESP PACU	Lab	240-319-1248
6082	410-224-5621	Engineering Admin Office	OBS Charge	240-565-3636
6799	410-224-5622	Tele Rm Woman's	ED Charge	443-758-6192
3381	410-224-5623	ESP OR#1	ED Physician	410-991-5950
3386	410-224-5624	ESP OR#6	HOC	240-581-3518
6961	410-573-2511	Clatanoff PACU	Escorts	443-758-0152
6966	410-573-2512	Clatanoff NICU	ACP Hospitalist	443-758-3309
6905	410-573-2513	Clatanoff 2nd Fl Main LDRP	Bed Board	443-758-0072
6213	410-573-2514	Clatanoff Pediatrics	PACU/OR Charge	443-223-2691
6925	410-573-2515	Clatanoff 2nd Fl LDRP	Pharmacy	443-758-0073
6936	410-573-2516	Clatanoff Security	Respiratory Charge	240-565-3996
5887	410-573-2517	Clatanoff Radiology	ICU Charge	240-565-2673
6910	410-573-2518	Clatanoff 2nd Fl West LDRP	PCU/ONC Charge	240-565-2505
6109	410-573-2519	Clatanoff 3rd Fl Nursing	Telecom Tech	240-581-3064
5816	410-573-2520	Oncology Dictation	JSC/GSU Charge	240-565-1693
8502	410-224-5625	ACP 6th Pod 4	MSU/SCU Charge	240-565-1279
8503	410-224-5626	ACP 6th Pod 2	L/D Anesthesiologist	443-758-6269
8504	410-224-5627	ACP 5th Main	CPAC	240-581-4128
8505	410-224-5628	ACP 5th Pod 2	WSU Charge	240-581-4799
8506	410-224-5629	ACP 4th Main	L/D Charge	240-786-8500
8507	410-573-2521	ACP 4th Pod 2	M/B Charge	240-786-8507
8508	410-573-2522	ACP 3rd Main	NICU Charge	410-991-1586
8509	410-573-2523	ACP 3rd Pod 2	OB Physician	410-991-8171
8510	410-573-2524	ACP OR @ Nurses Station	Peds Charge	443-758-3286
8511	410-573-2525	ED Nurses Station		
8512	410-224-0702	ED Admitting		
8513	410-224-2640	Observation		
8514	410-224-3033	Pediatrics PF Line 1		
8515	410-224-3177	Women's Surgery		
8516	410-224-3438	Main Lab – ACP LL		
8517	410-224-3587	PACU – ACP 2nd FL		
8518	410-224-6527	Radiology – CT Scan		
8519	410-224-7081	Radiology – Main Core		
8520	410-224-7082	Communications Ln 2		
8521	410-224-7083	Pharmacy – Clatanoff 2nd Fl		
8522	410-224-7084	NICU – PF Ln 2		
8523	410-224-7085	Endoscopy		
8524	410-224-7086	Cath Lab 5		
8525	410-224-9841	Temp to PBX Room		

C. To activate the use of the emergency phone line during a power failure, lift the telephone handset (this will give you dial tone from the Central Verizon Office). Then dial the desired 443 + 7-digit number you are trying to reach.

D. You will **NOT** need to dial 9 before dialing 443 + 7-digit number. You must also begin dialing immediately or you will lose dial tone after four (4) seconds.

EMERGENCY INCIDENT PLAN

Upon hearing **CODE YELLOW** "Emergency Incident Plan now in effect" over the overhead paging system, employees will:

1. Immediately report to their department manager/supervisor.
2. Incident Commander and HICS Section Chiefs (Logistics, Planning, Finance and Operations) report to Command Center, located in the Rotary Room, 1st floor Clatanoff Pavilion, and carryout appropriate incident response.
3. All directors or designees will report their departmental status, including staff availability, to the HICS (Hospital Incident Command System).
4. See Hospital Emergency Operations Plan, policy EOC4.4.01 found on the Intranet for department specific instructions and duties.
5. Limit use of telephones.
6. All questions from the media should be directed to the HICS on ext. 1414 or Public Relations on ext. 4700.

RIGHT-TO-KNOW LAW/MATERIAL SAFETY DATA SHEETS (SDS)

1. The purpose of the law is to create a safer and healthier workplace by providing employees with information about the chemicals that they use in their work areas.

2. The SDS sheets describe the hazards and technical information of the chemicals that an employee uses on the job.

3. To obtain a SDS, call the 3E Company at 1-800-451-8346 to get the SDS faxed to you. In the event the telephone land line is down, the alternate way to receive the SDS would be by using a cellular phone to call 3E and request the information be emailed to you. Please look for the yellow and black stickers on your phone or the yellow and black poster that is posted in your area. Information needed by 3E when requesting a SDS is:

   A. Product name or chemical description
   B. Manufacturer name
   C. UPC code (if available)
   D. Tell them the nearest fax number to you

4. Employees have these basic rights under the RIGHT-TO-KNOW LAW:

   A. The right to know information about the chemicals they work with in their work areas.

   B. Access to the chemical list and SDS within five working days of request by employee (Immediately if an emergency).

   C. One copy of the requested information about a chemical (the SDS) or the means to make a copy.

   D. If the SDS is not provided, an employee may refuse to work with the chemical.

5. If more information is needed, check with your supervisor or manager and Administrative Policy EOC 4.3.01

6. Department heads are responsible to ensure that all chemicals in use in their departments are added and subtracted from the facility's computerized chemical list.

BOMB THREAT

Notification of Threat

A. If a bomb threat is received via telephone call:

1. Get bomb threat checklist from the Emergency Flip Chart and get as much information about the caller as possible.
2. Keep the caller on the telephone as long as possible - DELAY - ask caller to repeat.
3. If a co-worker is nearby, they should contact Security immediately by dialing 6911, and give all pertinent data.
4. The Security Office will contact the Anne Arundel County Police Department, the Fire Department, and Administration.

B. See Bomb Threat Policy EOC 4.2.02 on the Intranet.

BOMB THREAT CHECKLIST

Date of Call _____Exact time of call _____

Exact words of caller _____

_____

QUESTIONS TO ASK:

1. When is bomb going to explode? _____
2. Where is the bomb? _____
3. What does it look like? _____
4. What kind of bomb is it? _____
5. What will cause it to explode? _____
6. Did you place the bomb? _____
7. Why? _____
8. Where are you calling from? _____
9. What is your address? _____
10. What is your name? _____

CALLER'S VOICE (please circle)

Calm	Disguised	Nasal	Angry	Broken
Stutter	Slow	Sincere	Lisp	Rapid
Giggling	Deep	Crying	Squeaky	Excited
Stressed	Accent	Loud	Slurred	Normal

If voice is familiar, whom did it sound like? _____

Were there any background noises? _____

Remarks: _____

_____

Person receiving call: _____Date: _____

Report call immediately to:_____(Refer to bomb incident plan)

OSHA/BIOHAZARDOUS WASTE MANAGEMENT/ INFECTION CONTROL

1. **Standard Precautions** will be consistently practiced by employees when dealing with patients. All patients are potentially infectious. Use appropriate personal protective equipment (gloves, gown, and mask) to prevent skin and mucous membrane exposure to blood and other body fluids. Wear masks and protective eye wear or face shields during procedures that are likely to generate droplets or aerosolization of body fluids. **All PPE must be removed** upon exiting a patient room or procedural area.

2. Utilize transmission-based isolation precautions (airborne, droplet, contact isolation) for presence or suspicion of those organisms that require enhanced protection. Appropriate signage must be posted on the patient's door and left posted until environmental services removes the sign following isolation cleaning at discharge.

3. Call engineering at ext. 4777 to conduct a "smoke test" prior to use of any negative pressure room for **airborne** isolation patients.

4. N-95 respirators are to be worn while caring for airborne isolation patients and may be worn only by those fit tested to wear them (employees). Fit testing is conducted annually per OSHA guidelines for those likely to enter airborne isolation.

5. Perform hand hygiene --washing hands and/or use of alcohol-based handrub-- thoroughly before and after contact with patients and body fluids, as well as the patient environment. Soap and water should be used when hands are visibly soiled, before eating, after using the restroom and for handrub patients in Contact C (e.g., *Clostridium difficile*) isolation.

6. Take care to prevent injuries when using needles, scalpels, and other sharp instruments. Dispose of all SHARPS in appropriate containers.

8. Impervious protective garb must be worn when working with biohazard materials or chemicals.

9. Biohazardous waste is to be placed into a leak-proof BIOHAZARD bag.

10. Employee exposures must be reported to the employee's supervisor and Employee Health (x1965) and treated immediately as directed.

11. NO EATING OR DRINKING in areas where potential exposure to blood and other infectious material takes place or where potential contamination of surfaces may occur (OSHA Bloodborne Pathogen Standard).

12. For detailed information, refer to the Infection Control intranet policies. For replacement isolation signage, refer to the Infection Control intranet site.

SPILL RESPONSE CATEGORIES:
(CODE ORANGE)

Category "A" Outside Assistance Required – Highly Toxic, Volatile, Large Volume (1 liter or greater), Unidentified or High Risk Chemical		
High Risk Chemicals		
Acetic Acid	Benzoic Acid	Hydrochloric Acid
Acetone	Calcium gluconate	Oxalic Acid
Ammonium Hydroxide	Carbon Tetrachloride	Perchloric Acid
Ammonium Molybdate	Citric Acid	Potassium Thiocyanate
Ammonium Sulfate	Formaldehyde	Sodium Nitroprusside
Evacuate/isolate spill area; warn others; assist those who may need help.		
Provide medical treatment for those exposed, if necessary.		
Requests **SDS** to be faxed from **3E Company, 1-800-451-8346.** Provide SDS to fire department spill team upon arrival.		
Contact Communications by calling 1111 for **Code Orange**. Provide the following information: Location of spill/release and chemical name, if known. Communications will contact the fire department for spills in this category.		

Category "B" No Outside Assistance Required – Non-volatile, Low Toxicity, Small Volume (under 500 ml.)
Evacuate/isolate spill area; warn others; assist those who may need help.
Provide medical treatment for those exposed, if necessary.
Request **SDS** to be faxed (email if fax is not working) from **3E Company 1-800-451-8346.**
Wear appropriate personal protection as defined by the SDS.
Perform cleanup according to SDS or departmental spill procedures.
Place all materials and waste from cleanup into yellow spill bucket; secure lid and label as to contents.
Attach copy of SDS to yellow bucket with scotch tape and contact the Hazmat Officer (ext 4274) to arrange disposal.

Category "C" No Outside Assistance Required – Infectious Waste
Evacuate/isolate spill area; warn others; assist those who may need help.
Provide medical treatment for those exposed, if necessary.
Do not ventilate area.
Wear protective clothing, eye protection, and gloves.
Cover spill with a paper towel/absorbent material to avoid splashing and to contain spill.
Pour solution of Virex 256 (available from environmental services) on covered spill and let stand for 10 minutes contact time.
Wipe up with paper towels or other absorbent material and dispose in regular trash.

Category "D" No Outside Assistance Required – Radioactive Material Release
Radiology or Nuclear Medicine technicians utilizing this material have been trained to respond to this type of spill/release.

Category "E" No Outside Assistance Required – Chemotherapy Material Release
Cleanup of chemotherapy material release will be the responsibility of the department where the material is utilized.

EMPLOYEE INJURIES

1. Complete the Employee Incident/Injury Report (commonly called "Green Sheet")

2. Notify department manager or area supervisor immediately after event, to complete the Supervisor's Investigation Report.

3. Go to the Employee Health Office for treatment or the Emergency Room if the health office is closed and the injury is serious enough to require immediate treatment. (Let your supervisor help you make the decision).

4. Always notify the Employee Health Office, ext. 1965, of injuries and report to the office as soon as possible,(next business day if EHO is closed), for assessment and to complete additional necessary worker's compensation forms.

5. EXPOSURE TO BLOOD/BODY FLUIDS (Includes needle sticks or splashes to open skin, mucous membranes or eyes.

   A. Wash area of splash immediately and/or flush eyes well.

   B. Follow the above procedures (steps 1 through 4) for reporting employee injuries.

   C. Always record the name and medical record number of source patient.

   D. Contact supervisor immediately so testing of the source patient can be done before discharge. Four Gold Top tubes are to be collected from the source and brought to EHO or, if after hours or on the weekend, to the blood bank.

6. If seen in the Emergency Room after any type or severity of injury, always follow up by reporting to the Employee Health Office on the next business day.

7. Supervisors should complete Supervisor's Investigation Report at time of accident and forward it immediately to the Employee Health Office.

SECURITY MANAGEMENT PROGRAM
SECURITY RESPONSE

1. **S**ecurity Notification: Dial ext. 6999.

2. **E**mergency Response: Dial 6911 for Security "STAT"; give location and circumstances requiring an emergency response.

3. **C**ustomer Service: Contact Security on ext. 1430 or 6999 for customer service needs.

4. **U**nauthorized Access: Report unauthorized individuals in your area to Security. Security is everyone's job; report suspicious activities, unsafe equipment, unsecured offices, and vandalism to Security.

5. **R**epository of Patient Valuables: To provide secure, temporary storage for patient valuables.

6. **I**nvestigation Reports: Safety and Security will document situations on AAMC premises which involve property loss, trespassing, assault or unusual circumstances.

7. **T**ransportation: Should a patient require the need for emergency transportation, Security will coordinate and arrange transportation by the most economical taxi available.

8. **Y**ou are the first to activate the silent alarms to alert Medical Center Security staff that a life threatening situation exists in the Gift Shop, Emergency Department, Pharmacy, Cashier or other sensitive areas.

INFANT ABDUCTION

The staff member discovering the missing child will:

1. Contact Security by calling 6911, and
2. Inform the C.P.A.C. (Clatanoff Pavilion Administrative Coordinator) and the A.C. (Administrative Coordinator)
3. All staff must be on high alert. Monitor the exit doors, stop and question individuals with children, infants or carrying bags capable of concealing an infant.
4. Report any suspicious activity immediately to Security by calling 6911.

Security will:

1. Overhead page **"CODE PINK"**
2. Notify the Anne Arundel County Police Department
3. Report STAT to the units
4. Lock down the unit, and
5. Direct the operator to activate the Code Pink contact procedure.

RAPID RESPONSE ACTIVATION PROCEDURES

Criteria for Activating the Rapid Response Team

- You are worried about your patient
- Call even if you are not sure!
- Acute change in heart rate ‹40 or ›130 beats/minute
- Acute change is systolic BP ‹90 mmHg
- Acute change in RR ‹8 or ›28 breaths/minute
- Acute change in saturation ‹90% despite o_2
- Acute change in LOC

How to Activate the Team:

- The nurse caring for the patient dials extension 1111 and informs the hospital operation to activate the RRT (except in NICU and Peds)
- The patient's attending physician may be paged at this time
- NICU and Peds patients are managed within their own units

EMERGENCY RESPONSE ACTIVATION PROCEDURES

The Emergency Response Team is activated in the event of a sudden illness involving an outpatient, visitor, and/or employee of or to AAMC.

How to Activate the Team:

- The ERT is activated by dialing the Operator at ext. 1111 (your are required to provide the specific location of the incident)
- The Operator will activate either the Rapid Response Team or the ERT depending on the circumstances.
- The responding ERT personnel will make an initial determination of the clinical condition of the subject, and recommend and/or administer the appropriate level of treatment.
- The ED is responsible for the maintenance of the ERT Bag. The ERT Bag is to be stored in a central location within the ED.
- Restocking – The ERT Bag is to be restocked immediately following an incident.

COPING WITH - AN ACTIVE SHOOTER SITUATION

- Be aware of your environment and any possible dangers
- Take note of the two nearest exits in any facility you visit
- If you are in an office, stay there and secure the door
- Attempt to take the active shooter down as a last resort

PROFILE - OF AN ACTIVE SHOOTER

An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area, typically through the use of firearms.

CHARACTERISTICS - OF AN ACTIVE SHOOTER SITUATION

- Victims are selected at random
- The event is unpredictable and evolves quickly
- Law enforcement is usually required to end an active shooter situation

Contact your building management or human resources department for more information and training on active shooter response in your workplace.

HOW TO RESPOND - WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

1. EVACUATE

- Have an escape route and plan in mind
- Leave your belongings behind
- Keep your hands visible

2. HIDE OUT

- Hide in an area out of the shooter's view
- Block entry to your hiding place and lock the doors
- Silence your cell phone and/or pager

3. TAKE ACTION

- As a last resort and only when your life is in imminent danger
- Attempt to incapacitate the shooter
- Act with physical aggression and throwitems at the active shooter

HOW TO RESPOND - WHEN LAW ENFORCEMENT ARRIVES

- Remain calm and follow instructions
- Put down any items in your hands (i.e., bags, jackets)
- Raise hands and spread fingers
- Keep hands visible at all times
- Avoid quick movements toward officers such as holding on to them for safety
- Avoid pointing, screaming or yelling
- Do not stop to ask officers

INFORMATION - YOU SHOULD PROVIDE TO LAW ENFORCEMET OR 6911 OPERATOR

- Location of the active shooter
- Number of shooters
- Physical description of shooters
- Number and type of weapons held by shooters
- Number of potential victims at the location

Call 6911 when it safe to do so

You have reached the end of the agency nurse orientation packet. Please complete the orientation checklist and return to appropriate personnel.

"Access to the policies is for the sole purpose of fulfilling the clinical work assignment at AAMC. The policies are the sole property of Anne Arundel Health System and may not be released, forwarded, shared, viewed or re-disclosed to any other individual without written permission from the hospital administration risk management office."