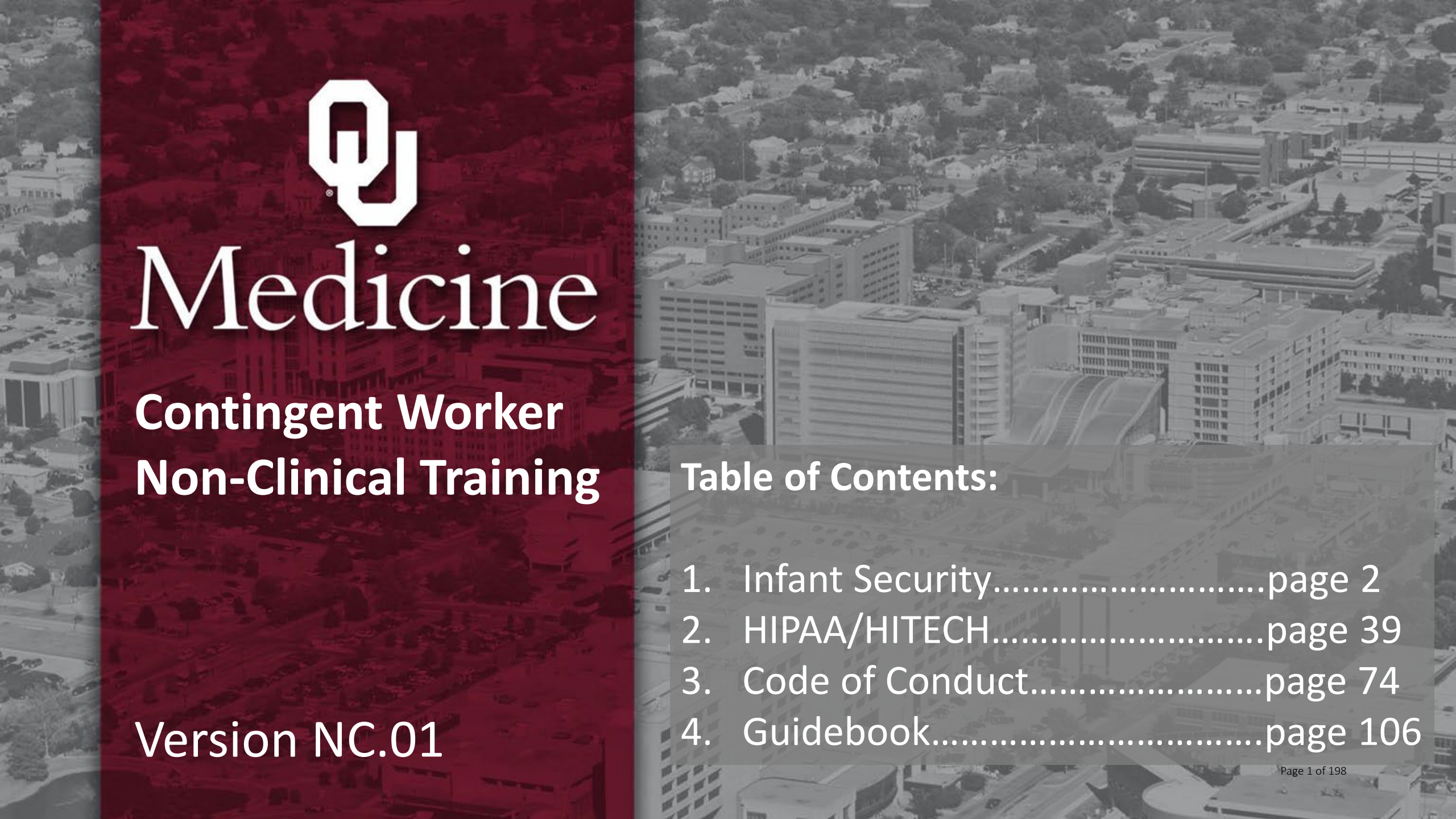


Medicine

Contingent Worker Non-Clinical Training

Version NC.01

Table of Contents:

Infant Security

OU Medicine

Policy Review

In addition to completing this Healthstream module you will also need to review the following policies:

- OU Medicine Policy: Infant Security
- OU Medicine Policy: Infant/Pediatric Abduction

I. PURPOSE:
To promote the security of newborns.

II. DEFINITIONS:

Perinatal Units: Labor and Delivery, OB Special Care, Mom Baby and Baby Care Area, My Birth Center
Neonatal Units: NICU East, West, North, and South
***Parent:** Biological mother and father of the infant. Father as indicated on the birth certificate or identified by the mother.
Guardian: Person(s) with court appointed custody of the infant.
Guest: Person(s) over the age of 18 identified on the Guest Form by the parent(s).
Visitor: Person(s) over the age of 16 accompanied by a parent.
Sibling: Brother(s) or sister(s) of the infant under the age of 16. Must present an up to date immunization record (upon entrance to the Neonatal Units).
*Adoptive parents are considered guests (if named on the guest list) or visitors (accompanied by the mother or the custodial agency) until court ordered guardianship is obtained.

III. POLICY:
To promote the security of newborns within inpatient Perinatal and Neonatal services. Infant abduction deterrence is a campus wide approach. Physical security, written protocols, policies, and procedures, as well as staff education and training are to be seamlessly interfaced with campus, facility, and unit security as well as the local community law enforcement to provide total security integration.

IV. PROCEDURE:

Gap Assessment
Annually or when significant changes occur to Perinatal and Neonatal units, all hospitals must complete a self-assessment provided by the National Center for Missing and Exploited Children[2, 3] and develop a gap analysis (current to compliant state) with an action plan based on findings. (This assessment activity will also support compliance with The Joint Commission Standard EC. 02.01.01 for hospital identification and management of its security risks.)[4]

Hospital and Unit Security Procedures
1. Training for all hospital employees is completed within the first seven days of hire. Additional training for employees involved in the care of newborns is completed prior to or during the employee's first shift in the patient care area.

2. Access to Perinatal and Neonatal care units is limited.
   a. Proximity locks with badge or card swipe access is recommended.
   b. Staff that resign from the unit will have their access revoked immediately after their last shift and key pad access codes are changed.

c. Access codes to units where neonates and/or infants are located are changed at irregular intervals and at a least annually.
d. Perinatal and Neonatal unit access doors have "door ajar" alarms.
e. Educate staff regarding tailgating/piggy-backing onto secured units.

3. Perinatal and Neonatal Unit ID Badges
   a. All hospital staff, including administrative and ancillary staff, presenting on the Perinatal and Neonatal unit(s), must wear a hospital- issued photo ID badge.
   b. Perinatal and Neonatal unit staff providing patient care which may involve transporting infants (including agency and traveling nurses) will have a distinctive, hospital-issued Perinatal and Neonatal unit badge to identify them as a member of that unit and having the authority to transport neonates and/or infants.
   c. Perinatal and Neonatal Medical Staff and Advanced Practice Clinicians providing patient care will have a distinctive, hospital-issued ID badge.
   d. Ancillary and support staff to Perinatal/Neonatal units will be expected to wear a hospital-issued ID badge and are required to notify unit staff of purpose for presence on the unit.
   e. Students and Contracted Staff (i.e., audiology services, photography services, etc.) providing additional healthcare services will be expected to wear accompanying school/company ID badge and provided a temporary unit-issued badge with **agreeing facility logo** indicating unit access permission per hospital policy.
   f. Non-healthcare service providers (i.e., vendors, consultants, construction workers, etc.) will be expected to wear accompanying company ID badge and provided a temporary hospital-issued badge with **agreeing facility logo** indicating hospital access permission per hospital policy.
   g. All ID badges are worn visibly on the chest area to ensure picture, name, and facility logo are facing outward and unobstructed by pins, decals, or other devices (i.e., double sided badges or a stationary badge may be used).
   h. ID Badge compliance will be strictly enforced.

4. Perinatal and Neonatal ID Badge Control and Inventory
   a. There will be a control and inventory process for issuance, tracking, and subsequent retrieval of hospital-issued, unit-issued, permanent and/or temporary distinctive ID badges, patches, etc. for Perinatal and Neonatal units.
   b. Perinatal and Neonatal distinctive ID badges, patches, etc. will be turned in upon termination, resignation or, when the individual is no longer associated with the facility.
   c. Temporary-issued ID badges issued to students, contractors, etc. are returned to a designated individual on the Perinatal/Neonatal Unit at the end of shift, contracted work hours, etc.

5. Perinatal and Neonatal Unit-Specific Uniforms
   a. Perinatal and Neonatal unit staff should be required to wear unit or hospital-specific attire limited to current employees.
   b. Attire is unique to perinatal/neonatal unit or hospital by magnet, patches, embroidery, stamps, or watermark which are easy to identify by staff and patients.
   c. There will be a control and inventory process for issuance, tracking, and subsequent retrieval of hospital-issued, unit-issued permanent and/or temporary distinctive uniforms, patches, etc. for the Perinatal and Neonatal units.
6. Hospital-owned perinatal specific scrubs that are stored on site are kept in a secured environment, with access limited to unit employees and other essential personnel with processes to manage

inventory. Visitor and vendor scrubs are distinctive and are disposed of or returned at the end of each visit.

7. Newborn identification of well born neonates must include:
   a. Application of mother-father-baby identification bands (four-part) in the delivery room where newborn condition allows.
   b. If the facility has an electronic infant security system, **application** of the electronic infant security device in the delivery room must take place, where newborn condition allows.
   c. If the facility has an electronic infant security system, **activation** of the electronic infant security device takes place at the moment the infant is within the security zone (i.e., at delivery, upon transitioning from OR to Perinatal and Neonatal Unit, etc.), where newborn condition allows.
   d. If the facility does not have an electronic infant security system, or application and/or activation of the electronic security system device is delayed due to physical plant or system default, the infant will transported by an authorized staff member wearing the authorized Perinatal and Neonatal distinctive badges and uniform using direct, line-of sight supervision.
   e. If the facility has an electronic infant security system, and removal and/or deactivation of the electronic security system device is required at time of discharge, the infant will remain supervised while on the unit by authorized staff members wearing the authorized Perinatal and Neonatal distinctive badges and uniform using direct, line-of sight supervision until physically discharged from the hospital. Upon discharge, electronic security devices should be removed immediately prior to exiting the perinatal/neonatal unit.
   f. Obtaining of newborn foot prints in the delivery room, where newborn condition allows. The newborn foot prints become a part of the medical record.
   g. Documentation of the initial newborn assessment in the delivery room, followed by a more detailed assessment within two hours of birth.
   h. Facilities that obtain a photograph or video/digital image of the newborn as part of their security process will obtain image within twenty-four (24) hours of birth, after obtaining parental consent.
   i. Newborn cord blood specimen and any other blood specimen is placed on hold in the hospital laboratory until the day after the newborn/infant's discharge.

8. Identification of premature or compromised neonates should mirror the processes of the well-born once the baby has been stabilized.

9. Bassinettes and cribs on Perinatal and Neonatal units should be placed on the side of mother's bed and away from the doors for added security. The same applies for NICU infants undergoing care-by-parent(s) or rooming-in.

10. Perinatal and Neonatal units should minimize the number of times the newborn or infant is removed from the mother's room or a staff supervised unit (Nursery, NICU, Post-Partum, etc.).

11. Perinatal and Neonatal unit staff should perform random security checks throughout the shift (i.e., checking empty rooms, badges, security of doors, etc.).

12. Empty or unoccupied patient room doors should be left open at all times unless the fire marshal or Authority Having Jurisdiction (AHJ) requires otherwise. If doors are equipped with a self-closing mechanism, their operation must not be impeded with devices such as manual hold open devices, furniture, wedges, etc. Self-closing doors should be equipped with automatic hold open devices that

are of appropriate design and connected to the fire alarm system, which ensures closure upon activation of the fire alarm. In the event of a fire, empty or unoccupied patient room doors should be closed.

13. Vendor access will be restricted and allowed only for necessary patient care and safety. Vendor credentials will be verified, and vendor access will be renewed each day.

14. Upon entrance to Perinatal and Neonatal units, all visitors shall be greeted and validated. Hospitals should restrict and monitor visitor entrance, especially within restricted areas on the Perinatal and Neonatal units, such as ORs, Well-Nurseries and NICUs.

15. External vendors and/or agency representatives who are required to interact with the infant and or parents must be appropriately identified upon arrival to unit, and introduced to parents/primary caregivers by the primary care nurse.

16. The Hospital does not support the placement of birth announcements in the newspaper, and provides information warning parents of the danger, including an explanation of the risks of birth announcements in the form of yard signs or outside decorations, or of placement of birth announcements with complete names and addresses in a newspaper.

Parent Education

1. Parent Education- Parents will be educated on security awareness, identification of hospital personnel, primary care staff for the shift, and communication regarding unit activities and any procedures involving the newborn or infant. Parents/primary caregivers will sign a form acknowledging an understanding of infant security education provided and shared responsibility for maintaining infant security during hospital stay. Documentation will be included in the patient's medical record (Attachment A). Language and cultural barriers may interfere with the understanding of, or compliance with, infant security education. Therefore, efforts should be made to achieve optimal understanding by the parent and documented in the medical record.

2. Perinatal Units should have a process for visitor check-in (i.e. visitor log book, visitor ID validation, visitors receive a distinctive visitor wrist band, or name tag allowing entry to the unit, etc.). The wrist band will be a cut away, non- transferable disposable band.

3. Based upon home-care needs of the infant at the time of discharge, parents/primary caregivers will be educated regarding in-home care vendors and other out-patient clinical services. Home Care education will include:
   a. Vendor/agency name
   b. Purpose of visit
   c. Anticipated arrival
   d. Expected vendor/agency representative identification
   e. Advisory to parents to remain present with the infant in the home during the vendor/agency representative's visit.

Infant Abduction-Drills, Potential and Actual

1. Infant abduction drills will involve the entire campus and will be conducted at a minimum of once per quarter. The drills will involve each shift, as well as during shift change. The goal is to provide each employee an opportunity to participate in a drill on an annual basis.

2. Hospital staff should be alert to any unusual behavior they encounter from individuals. The alert process should include the recommendations provided by the National Center for Missing and Exploited Children[1] and generate a communication and action plan based on observation and findings.

3. To assist in the timely identification of an abducted infant and/or an abductor, the hospital response for infant abduction includes :
   a. activating a designated code referencing the abduction of a newborn or infant
   b. performing a hospital-wide overhead page notification, which should include the unit from which the infant was abducted, gender and age of the infant, and a description of abductor, if available
   c. having a designated representative responsible for communicating with Law Enforcement agencies, relaying and updating information, as well as receives communication from Law Enforcement for further instructions.

Technology

OUM maintains a list of preferred vendors and negotiated agreements that meet the following requirements. If the facility chooses to purchase a non-preferred product, or initiate its own agreement, then the security product and agreement must meet the minimum requirements listed below.

1. High volume/high traffic units with multiple exits or blind areas should have an electronic infant security system. Appropriate staff should receive formal system training during orientation. The system should be linked to the hospital security team.

2. For Perinatal and Neonatal units, the device must be attached to the newborn and activated in the delivery room as clinically acceptable.

3. Security system must support a device that can only be removed by cutting the band or requires a special removal apparatus, or use skin sensor technology.

4. Infant security band should be adjustable to accommodate weight loss of newborn.

5. Any adjustments to or replacement of security devices required to accommodate weight loss/gain, care requirements, etc. should be done in the presence of the mother or primary caregiver, as clinically acceptable.

6. Security system must integrate with electromagnetic locks, elevators and paging systems, video close-caption cameras, and hospital security.

7. Security system should have the capability to identify infant or child by name, mother/primary caregiver, assigned room and device/tag I.D. number, as well as log date and time of events, archive activities, and create reports.

8. Receiving antenna should not be affected by antenna orientation.

9. Battery backup system in event of power outage.

10. System should have the capability of self-supervision and the ability to visually identify any problems with the system through trouble alarms. Computers supporting running the system should have the "mute" function disabled from the desktop and keyboard. Audible alarms should be located throughout the unit, and not rely on only the computer speakers.

11. One year active transmitter; must be waterproof; expiration date permanently engraved; pulse rate at least 1 time every 10-16 seconds and minimally affected by the application of aluminum to interrupt transmission of security signals.

12. Computer interface with programmable entry codes. Staff that resign from the unit should have their access code revoked immediately after their last shift.

13. Anti-tailgate feature with auto re-arm capability when door closes.

14. Delayed egress capability; continuous door status; perimeter alarm and elevator lockout capability.

15. Security system must be installed and maintained by manufacturer or their representative.

16. Service agreements should support maintenance and updates.

17. Company should have track record of strong customer support.

18. Contracts with the supplier shall require the supplier and the manufacturer to have general liability insurance for bodily injury, death and property loss and damage (including coverage for product liability, completed operations, contractual liability and personal injury liability) in amounts of $5 million per occurrence and $10 million in the aggregate with OUM listed as an additional insured.

19. At least quarterly, technology must be evaluated for propensity of false alarms and dead spaces. The evaluations should occur through a collaborative effort involving facility plant operations, security, information technology, nursing management and security system vendor.

20. In the event electronic security systems (i.e., badge access, electronic infant tags, remote door releases, etc.) experience downtime or temporary malfunction, application of physical controls and safeguards (i.e., Security Officer placed at the entrance of the perinatal/neonatal unit) should be implemented immediately.

ATTACHMENTS:

Attachment A: Parent Infant Security Competency Validation
Attachment B: Infant Security Downtime Procedures

REFERENCES:

1. National Center for Missing and Exploited Children (2014). For Healthcare Professionals: *Guidelines on Prevention of and Response to Infant Abductions, 10th ed.* @ http://www.missingkids.com/en_US/publications/NC05.pdf
2. National Center for Missing and Exploited Children (2009). For Healthcare Professionals: *Guidelines on Prevention of and Response to Infant Abductions, 9th ed.* @ www.missingkids.com/InfantAbduction
3. National Center for Missing and Exploited Children (2009). *Self Assessment for Healthcare Facilities* @ http://www.missingkids.com/en_US/publications/NC05assessment.pdf
4. The Joint Commission (January 1, 2012). Comprehensive Manual for Hospitals (CAMH). EC.02.01.01

APPROVED BY:

OUM Policy & Procedure Committee: 1/22/2016
OUM Board of Directors: 1/23/2018

ATTACHMENT A
Parent Infant Security Competency Validation

Patient instructions given (Check appropriate data)	Explained to: Patient	Explained to: Family	Understands: Patient	Understands: Family	Comments:
Only give your baby to hospital staff wearing a hospital photo, unit-specific ID badge clearly showing the hospital logo, the caregiver's name, and any unique identifier showing they are authorized to transport infants.					
Always keep your baby in sight. Never leave your baby unattended, even for a moment. Have family members or friends watch the baby while you shower or use the restroom. If they are not available, please call your nurse to transport your baby to the nursery.					
Infants are always transported by bassinet.					
Your baby's identification will be checked with yours each time the baby is brought to your room and each time that you pick up the baby from the nursery.					
Know your nurse on each shift.					
Know when tests for your baby are scheduled. Call the nurse's station if someone you don't know wants to take your baby for an unscheduled test. You have the right to ask to accompany the baby for tests.					
Only give information about you or your baby to people who you know well and trust.					
Consider the risk you may be taking when permitting your infant's birth to be publicized, either through newspaper announcements or by using outdoor decorations such as balloons, door wreaths, or lawn ornaments.					
Do not take your baby off of the _____unit/floor until you are leaving at discharge.					
Report any unfamiliar people who enter your room and ask questions about your baby by pushing the nurse call button or calling the nursery extension _____.					
When your baby is in the room with you, keep the bassinet beside your bed away from the door.					

ATTACHMENT B
Infant Security- Downtime Procedures

Employees

Will notify:

- Department Supervisor, Director, and/or Clinical Coordinator Immediately.
- Increase awareness and surveillance of anyone in question with a large bag, purse, coat, jacket, etc. While questioning an individual use the following phrase: "We are involved in a Code Pink. May I look inside your bag, purse, coat, jacket, etc.?" If they decline search or exhibit suspicious behavior, do not detain, call OUHSC Police Services and be prepared to provide a detailed description.

Facilities Dispatch

Will notify:

- Firetrol
- OUPD
- Safety Director and/or Manager

Other Nurses/Employees

- Increase awareness and surveillance of anyone in question with a large bag, purse, coat, jacket, etc. While questioning an individual use the following phrase: "We are involved in a Code Pink. May I look inside your bag, purse, coat, jacket, etc." If they decline search or exhibit suspicious behavior, do not detain, call OUHSC Police Services and be prepared to provide a detailed description.

Facilities/Maintenance

- Contact and/or Assist Firetrol
- Increase awareness and surveillance of anyone in question with a large bag, purse, coat, jacket, etc. While questioning an individual use the following phrase: "We are involved in a Code Pink. May I look inside your bag, purse, coat, jacket, etc.?" If they decline search or exhibit suspicious behavior, do not detain, call OUHSC Police Services and be prepared to provide a detailed description.

Charge Nurse, Supervisor, and/or Director

Will notify:

- Facilities Dispatch
- Clinical Coordinator, if they have not yet been notified
- Unit Director, if they have not yet been notified

All Staff:

Increase awareness and surveillance of anyone in question with a large bag, purse, coat, jacket, etc. While questioning an individual use the following phrase: "We are involved in a Code Pink. May I look inside your bag, purse, coat, jacket, etc.?" If they decline search or exhibit suspicious behavior, do not detain, call OUHSC Police Services and be prepared to provide a detailed description.

Remember, you must familiarize yourself with OUM Policy SS.006 Infant/Pediatric Abduction.

OU Medicine OU Medical Center | The Children's Hospital | OU Medical Center Edmond | Breast Health Network	POLICIES AND PROCEDURES PAGE 1 OF 5
	POLICY #: SS.006
TITLE: INFANT/PEDIATRIC ABDUCTION	
REPLACES: 15-08	EFFECTIVE DATE: 4/2001, 4/2002, 5/2007, 2/2009, 5/2010, 8/2012, 9/2016, 2/2018

I. PURPOSE: The purpose of this policy is to establish/describe a prevention system that limits the opportunities for an infant/pediatric abduction, increases the probability of recovery in case of abduction, and describes the actions to be taken in the event of an actual abduction. The system includes 1) staff and parent education regarding the safety of their child and prevention of abduction, and 2) a description of a physical environment that limits the possibility of abduction. This policy further defines specific procedures for employees, Campus Police/Security, Communications, and other hospital personnel to follow in the event of a "Code Pink."

II. POLICY: It shall be the policy of OU Medical System (OUM) that any actual or attempted abduction shall be referred to as "Code Pink."

Quarterly Code Pink drills will be conducted by the OUM Safety Officer/Safety and Security Subcommittee of the Environment of Care Committee. Drills will serve to increase staff risk alertness and probability of recovery in the case of an actual abduction.

The scope of this policy includes all neonates/infants and children who may be at risk for abduction.

Following an actual or attempted abduction, all involved employees will attend a mandatory debriefing.

Prevention of Infant/Pediatric Abduction:

A. All employees and OU Health Science Center (OUHSC) Police/Security will be oriented on processes to prevent abduction.
B. In infant and pediatric areas:
    1. All employees will be on the alert of any suspicious behavior and will immediately notify OUHSC Police/Security of concerns.
    2. The policy will be reviewed by all staff.
C. Education on abduction risk will be provided on admission to parents of hospitalized neonates/infants and pediatric patients. This information provides guidelines on parental participation in safeguarding their child.
    1. Parents will be advised to always identify staff by hospital badge and picture identification. Parents are advised to never relinquish their child to staff or anyone without proper identification.
    2. Parent education will be documented in the patient chart.

<u>Identification of Infants:</u>

A. All infants will be identified with a hospital armband on admission.
B. OU Medical System will not publish birth announcements in public newspapers.

<u>Transport of Infants:</u>

A. Infants will be transported by a parent or properly identified hospital personnel.
B. Infants will be transported one at a time.

C. Newborns will be transported in a bassinet, isolettes, cribs, or infant warming beds only.
D. During maternal and newborn transports, the infant will be transported in mother's arms with the mother in a wheelchair or carrier.

Environment:
A. Nurseries or units occupied by critically ill infants will have access controlled entries.
B. The Women's and Newborn Services will provide additional security surveillance.
C. Neonates will not be left unsupervised. Holding nurseries will be attended at all times.

Areas with Infant Abduction Security Systems
A. Each unit equipped with an infant abduction security system will perform routine equipment checks to include transponders and audible alarms according to unit/service policy.
B. Facilities/Maintenance will perform semi-annual preventative maintenance of all infant abduction security systems.
C. When a system or component of a system fails, the following departments will be contacted:
For OUM Downtown Campus:
1. OUHSC Police Services at 271-4911.
2. Facility Management at 271-4190.
3. Downtown Safety Officer at 271-5808.
4. Unit personnel of the affected unit until the system is properly functioning.

For OUM – Edmond Campus:
1. Edmond Security Dial 0 for the Operator
2. Plant Operations at 5527.
3. Edmond Safety Officer at 650-4990.
4. Unit personnel of the affected unit until the system is properly functioning.

III. PROCEDURE:

Responsible Party:	**Action:**
Suspected or Actual Abduction:	
Any employee	1. If a patient is found missing or suspected as abducted, activates the alarm system and/or immediately notifies: OUM Downtown Campus hospital operator at 271-4190 and the OUM Edmond Campus hospital dial 444. Gives the following descriptive information about the child to the operator. a. Age b. Sex c. The location last seen d. Any additional description to help searchers recognize the child…clothing, hair color, etc. 2. In the nursing care areas, notifies the Charge Nurse. 3. If the description involves an infant or small child, questions anyone with a large bag, purse, coat, jacket, etc. While questioning an individual use the following phrase: "*We are involved in a Code Pink. May I please look into your bag, purse,*

	coat, jacket, etc." If they decline this search or exhibit suspicious behavior, do not detain, call the OUHSC Police/Security and be prepared to provide a detailed description. 4. Immediately checks all adjacent stairwells and exits. 5. Immediately reports any suspicious individuals to the OUHSC Police/Security.
Hospital Operator	1. Announces "Code Pink" and provides any descriptions given by the staff (example: "Code Pink. This 4-year-old male child was last seen on the 8th floor of Children's Hospital. He has blond hair and is wearing crimson OU pajamas".) NOTE: Due to Health Insurance Portability and Accountability Act (HIPAA) requirements, patient names can never be use for announcements. 2. Transfers the caller to the OUM Downtown Campus Police at 271-4911 and OUM Edmond Campus Security at 5527 during normal hours or 921-6959 after hours.
Other Nurses/Employees	1. Immediately checks all adjacent stairwells and exits for the child and/or suspicious individuals and reports concerns to the OUHSC Police/Security as soon as possible.
OUHSC Police/Security	1. Notifies, not necessarily in this order, the following as deemed appropriate: a. Oklahoma City Police Department/Edmond Police Department. b. Capitol Patrol. c. Facilities/Maintenance at Downtown Campus: 271-4190. Plant Operations at Edmond Campus: 5590 d. Federal Bureau of Investigation (FBI) – 290-7770. e. Center for National Missing and Exploited Children – (800) 843-5678. f. Public Relations - 271-7900. Edmond 359-5580 g. Risk Manager at Downtown Campus: 271-8050 or through the page operator and 6318 for the Edmond Campus. 2. Assists in the investigation and search. 3. Responds to inquiries of other patients, providing minimal information and alleviating stress of the other patients; respect the confidentiality of the involved.
OUHSC Police Dispatcher for OUMC- Downtown	1. Sends officers to the scene. 2. Notifies the OUHSC Police supervisor on duty. 3. Notifies the OUHSC Police Director.
Security/OUHSC Police Director/Shift Supervisor	1. Conducts a search of the hospital(s), both interior and exterior. 2. Secures exits, including parking facilities.

OUHSC Chief, Major or Captain, Edmond Police Department	1. Assumes command of the investigation. 2. Identifies a law enforcement commander
Facilities/Maintenance Director/Employees	1. Stations day shift staff in exterior zones as designated by the Director of Facilities/Maintenance. 2. After hours, on-duty personnel reports to the affected unit to assist.
Supervisor/Charge Nurse or Designee	1. If code Pink is activated notifies: a. Unit Director and/or Clinical Manager b. Clinical Coordinator c. Chaplain d. Social Services
Director of Unit Involved	1. Notifies: a. Chief Nursing Officer/Associate Chief Nursing Officer b. Administrator On-Call c. Physician of patient.
Physician	1. Informs the parent(s) of the possible abduction.
Nurse Caring for Mother/ Infant/Child	1. Remains with the parents until the Chaplain and/or Social Service staff arrives.
All Staff	1. Continues to search the area. 2. Remains on the unit until released by Nursing Administration and the Police Department.
Chaplain/Social Services	1. Provides comfort and reassurance to the parents. 2. Assists in debriefing staff after incident.

To Cancel a Code Pink if the Child is Found

Supervisor/Charge Nurse	1. At OUM Downtown: Notifies Police Dispatch at 14911 to cancel the Code Pink. 2. At OUM Downtown: Notifies Communications at 11911 to cancel the Code Pink. 3. At OUM Edmond: notify the Operator by dialing "0" to cancel the Code Pink

To Cancel a Code Pink

Oklahoma City Police Officer/FBI/Edmond Police Department	1. Instructs the nurse in charge and/or the OUHSC officer and/or the hospital administrator to cancel code pink (as above)

APPROVED BY:

Nursing Policy & Procedure Committee: 8/3/2016
OUM Policy & Procedure Committee: 9/22/2016
OUM Board of Directors: 1/23/2018

Objectives

After completion of this module staff should be able to:

- Identify safety measures in place to secure infants within perinatal and neonatal services.
- Demonstrate appropriate safety measures
- “every patient, every time.”
- Recognize individuals exhibiting characteristics of an abductor.

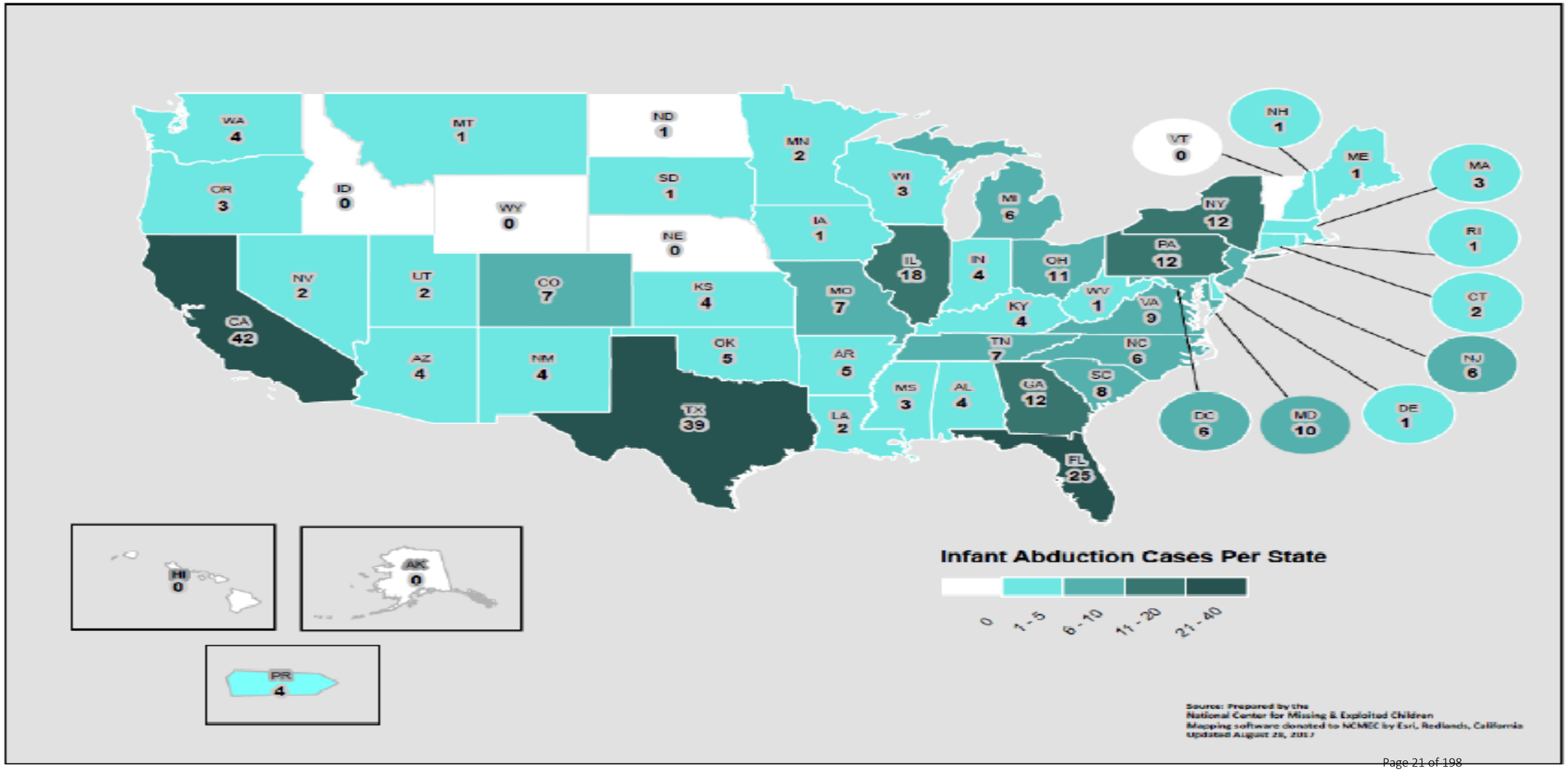
The birth of a baby is a joyous occasion for parents and families. To ensure the joyous event is not disrupted, infant security is of utmost importance at OU Medicine.

Infant abduction deterrence requires a whole system approach including not only
training/education for staff, families and visitors, but also includes many facility and equipment measures.

Since 1991, the National Center of Missing & Exploited Children reports there are on average 11 infant abductions each year.

Oklahoma reports 5 infant abduction between 1983-2017

Infant Abduction Cases per State



One infant abduction is too many.

An infant abduction is a tragedy for everyone – the infant, parents, staff and medical center.

In order to prevent such an occurrence, security measures must be in place and staff must be ever vigilant.

Definitions

<u>Perinatal Units:</u>

- Labor and Delivery
- OB Special Care
- Mother/Baby
- OB ED

<u>Neonatal Units</u>

- NICU East
- NICU West
- NICU North
- NICU South

Definitions

Parent:

Biological mother and father of the infant; father as indicated on the birth certificate or identified by the mother.

Guardian:

Person(s) with court appointed custody of the infant.

Adoptive parents are considered guests (if named on the guest list) or visitors accompanied by the mother or the custodial agency) until court ordered guardianship is obtained.

Definitions

Guest:

Person(s) over the age of 18 identified on the guest form by the parent(s)

Visitor:

Person(s) over the age of 16 not on the guest form (must be accompanied by a parent)

Sibling:

- Brother(s) or sister(s) of the infant under the age of 16

Safety Measures

- Staff education
- Staff identification
- Limited access
- “Code Pink”

Staff Education

- Training for all hospital employees is completed within the first seven days of hire.
- Additional training for employees involved in the care of newborns is completed prior to or during the employees first shift in the patient care area.

Identification of Staff

- All perinatal and neonatal employees must wear the following:
  - Pink hospital-issued photo ID badge
  - Black Scrubs attire to be worn only by Perinatal and Neonatal employees
- Students, contracted staff and non-healthcare service providers will wear accompanying school/company ID badge and a temporary hospital-issued badge

Limited Access

- All hospital staff, including administrative and ancillary staff, presenting on the Perinatal and Neonatal unit(s), must wear a hospital- issued photo ID badge. **Visible on the chest area.**
- Access to perinatal and neonatal care areas are limited to swipe access for essential personnel.
- All parents/guardians, guests and visitors must check in upon arrival to the unit.
- Do not allow “drafting”, piggybacking”, or “tailgating” (allowing individuals to follow into the unit) of visitors at secured entrances of locked units.

Abductor Profile

According to the National Center for Missing and Exploited Children, the following are common characteristics of abductors:

- Female of “childbearing” age (12-53)
- Overweight
- Compulsive
- Manipulative/Deceptive
- Frequently indicates she has just lost a baby or is incapable of having children
- Often married or cohabitating-the desire to provide the companion with a child is often motivation for the act
- Usually lives in the community where the abduction takes place
- Frequently visits nursery/maternity unit at more than one healthcare facility prior to the abduction

Abductor Profile

- Asks detailed questions about the procedures and the maternity/neonatal floor layout
- Frequently uses a fire-exit stairwell to escape
- May abduct from home setting
- Usually plans the abduction, but does not necessarily target a specific infant
- Frequently seizes any opportunity present
- Frequently impersonates a nurse or other allied healthcare personnel
- Often becomes familiar with healthcare staff members, staff members work routines, and victims parents
- Demonstrates a capability to take “good” care of the baby once the abduction occurs

Abductor Profile

- ✓ There is no guarantee an infant abductor will fit this description.
- ✓ This is only a profile.
- ✓ An infant abductor can be of **ANY** age, sex, or description. INCLUDING a **<u>hospital employee</u>**!

“Code Pink”

- Any actual or attempted abduction is referred to as “Code Pink”
- All employees should be on alert for suspicious behavior

“Code Pink”

- If a patient is missing or suspected as abducted activate the alarm system and/or immediately notify:
  - OU Medcine Downtown Campus at 1-1911 OR OU Medicine Edmond Campus at 444

- Give a description of the child:
  - Age
  - Sex
  - Last location
  - Any additional description (clothing, hair color, etc.)
- Unit charge nurse

“Code Pink”

- Question anyone with a large bag, purse, coat, jacket, etc.
  - Use the following phrase: “We are involved in a Code Pink. May I please look into your bag, purse, coat, jacket, etc.?”
  - If they decline this search or exhibit suspicious behavior, do not detain them, call the OUHSC Police/OU Medicine Edmond Security and be prepared to provide a detailed description of the person.

“Code Pink”

- Immediately check all adjacent stairwells and exits
- Immediately report any suspicious individuals to the OUHSC Police/OU Medicine Edmond Security
- Continue to search the area
- Remain on the unit until released by nursing Administration or Police/Security

“Code Pink”

- If you hear a Code Pink announced, **not in your unit**:
  - Immediately check all adjacent stairwells and exits for the infant and/or suspicious individuals
  - Report concerns to OUHCS Police/OU Medicine Edmond Security
  - Stay on your unit and remain near stairwells and exits until Code Pink is cleared

Medicine

HIPAA/HITECH Training

Administrative Staff

Objectives

Participants will be able to:

- Describe an overview of HIPAA and HITECH privacy key definitions and principles
- Describe how HIPAA and HITECH affect job duties
- List tips and guidance for applying privacy requirements

HIPAA Terminology

- BAA: Business Associate Agreement
- HIPAA: Health Insurance Portability and Accountability Act
- HITECH: Health Information Technology for Economic and Clinical Health Act
- PHI: Protected Health Information
- CE: Covered Entity (Hospital, physician practice, surgery center)
- ACE: Affiliated Covered Entity (Common ownership)
- OHCA: Organized Health Care Arrangement (The hospital and medical staff will be considered an Organized Health Care Arrangement)
- DRS: Designated Record Set (medical record and billing record)
- AOD: Accounting of Disclosures (patient's right to receive)
- Directory: Hospital census list used by volunteers and operators with name and room

Hospitals are required by law to maintain the privacy of patients' health information.

It is everyone's responsibility to ensure patient information is properly protected and safeguarded!

Facility Privacy Official (FPO)

What is a FPO?

- The FPO is the “go-to” person for any
  - Potential patient privacy issues
  - Questions on patient privacy matters
  - Patient privacy questions and complaints
- The FPO oversees and facilitates the privacy program including all training and compliance
- FPO for OU Medicine is Amber Simpson

HIPAA Definition & Purpose

What is HIPAA?

- The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information.
- Mandatory federal law.

What is the purpose of the law?

- Protect health insurance coverage, improve access to healthcare
- Reduce fraud, abuse and administrative health care costs
- Improve quality of healthcare in general

How does HIPAA affect you?

- Business Associate Agreements must be obtained on all contracts where they are performing a service on the facility behalf and PHI is exchanged.

- Patient information should only be accessed if there is a need to know (e.g., the information is required for the treatment of a patient, to carry out health care operations or for payment purposes). Only the minimum necessary amount of information may be used.

- All workforce members must have privacy job specific training.

How does HIPAA affect you? Cont.

- Reasonable safeguards must be put into place for patient privacy protection.
- Patients are provided with their privacy rights at the time of admission/registration via a Notice of Privacy Practices.
- Written patient authorization is required for disclosures that are not related to treatment, payment, or healthcare operations (TPO).

What is Protected by HIPAA?

PHI is the information pertaining to healthcare that contains any of these identifiers. People often believe that if the patient's name is removed then the information is not PHI. That is not true. There are many types of patient identifying information.

- Name
- Address including street, county, zip code and equivalent geocodes
- Name of relatives
- Name of employers
- All elements of dates except year (DOB, admission/ discharge, expiration, etc.)
- Telephone numbers
- Fax numbers
- Email addresses
- Social Security number
- Any vehicle or other device serial number
- Medical Record number
- Health plan beneficiary number
- Account number
- Certificate/license number
- Any other unique identifying number, characteristic or code
- Web universal resource locator (URL)
- Internet protocol address (IP)
- Finger or voice prints
- Photographic images

HITECH Definition & Purpose

What is HITECH?

- The Health Information Technology for Economic and Clinical Health Act (HITECH) was signed into law by the President on February 17, 2009. It is the part of the American Recovery and Reinvestment Act(ARRA) of 2009.
- It is a federal law.
- HITECH Act strengthens those patient privacy protections of HIPAA and places additional requirements on the healthcare community.

What is the purpose of the law?

- Makes massive changes to existing privacy and security laws
- Applies to covered entities and business associates
- Increases penalties for privacy and security violations
- Creates a nationwide electronic health record

Key HITECH Changes

While there are many changes as a result of HITECH, some of the more substantial changes include:

- Breach Notification
- Penalties
- Criminal provisions
- Accounting of Disclosure for treatment, and health care operations in electronic health record (EHR)environment
- Business Associate Agreements
- Right to Access
- Restrictions
- OCR Privacy Audits
- Copy charges for providing copies from EHR
- Sharing of civil monetary penalties with harmed individuals
- Private cause of action
- HIPAA preemption applies to new provisions

Let's look at some of the details of these changes.

Breach Notification

A breach is any impermissible acquisition, access, use, or disclosure of unsecured protected health information which compromises the security or privacy of such information.

HITECH provisions requires the following notifications when breaches (as defined in PHI.006) occur:

- To the patient
- To the Department of Health and Human Services
- To the media when the breach involves more than 500 Individuals in the same state or jurisdiction

Civil Monetary Penalties for Non-Compliance*

Violation Category	Each Violation	All such violations of an identical provision in a calendar year
Did not know	$110 - $55,010	$1,650,300
Reasonable Cause	$1,100 - $55,010	$1,650,300
Willful Neglect – Corrected	$11,002 - $55,010	$1,650,300
Willful Neglect – Not Corrected	$55,010	$1,650,300

*As of 9/06/2016

Criminal Penalties for Non-Compliance

- For health plans, providers, employees, clearinghouses and business associates that knowingly and improperly disclose information or obtain information under false pretenses can be assess penalties. These penalties can also apply to any "person".

  up to $50,000 and one year in prison for obtaining or disclosing protected health information (PHI)
  up to $100,000 and up to five years in prison for obtaining protected health information under "false pretenses"
  up to $250,000 and up to 10 years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm

- Penalties are higher for actions designed to generate monetary gain.

What is a Covered Entity (CE)?

- A Covered Entity is any entity that is subject to HIPAA and HITECH

- Health plans, health care clearing houses, and health care providers that transmit electronically for billing:
  - Hospitals
  - Physician Practices
  - Insurance Companies
  - Ambulance transportation services
  - Home Health Agencies
  - Hospice

What is a Business Associate (BA)?

- A person, company, corporation or any other legal entity that creates, receives or uses PHI to perform a function or activity on behalf of the facility or to perform certain professional services for the facility, such as:
  - Billing
  - Legal
  - Quality Assurance
  - Claims Processing

Contracts

- Must be identified for all departments
- An OUM HITECH-compliant Business Associate Agreement (BAA) must be executed if PHI will be created, received, maintained, or transmitted
- Facility must maintain a listing of BAAs

Notice of Privacy Practices (NOPP)

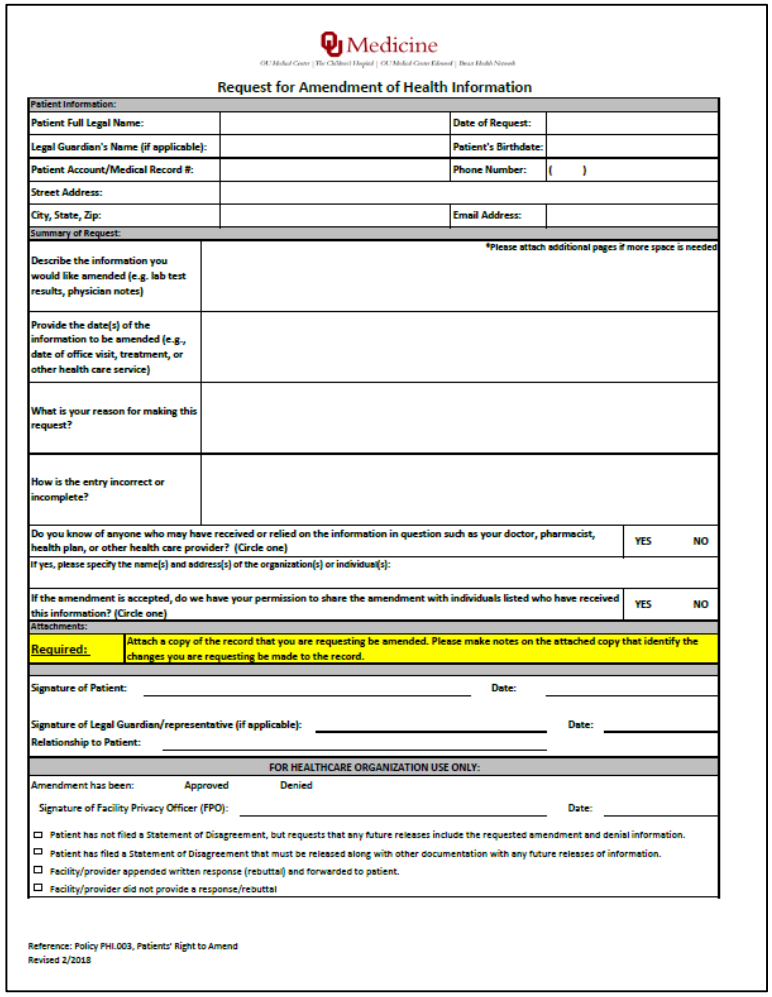
- Must be given to each patient that has a face-to-face contact with hospital staff
- Patient must acknowledge receipt of the NOPP
- Must be posted on the website and in each of the registration areas of the facility
- Patient privacy rights are outlined in the NOPP:
  - Right to Access (Inspect and Copy)
  - Right to Amend
  - An Accounting of Disclosures
  - Right to Request Restrictions
  - Right to Request Confidential Communications

Patient's Right to Access

- Patients have a right to inspect or obtain copies of their medical and billing records
- Facility will provide a readable hard copy of portions of the record requested
- Must provide access within 30 days (or an additional 30 days if stored offsite)

For More Information Review: PHI.032 Patient's Right to Access

Patient's Right to Amend



Medicine

OU Medical Center | The Children's Hospital | OU Medical Center Edmond | Breast Health Network

Request for Amendment of Health Information

Patient Information:			
Patient Full Legal Name:		Date of Request:	
Legal Guardian's Name (if applicable):		Patient's Birthdate:	
Patient Account/Medical Record #:		Phone Number:	( )
Street Address:			
City, State, Zip:		Email Address:	

Summary of Request:	*Please attach additional pages if more space is needed
Describe the information you would like amended (e.g. lab test results, physician notes)	
Provide the date(s) of the information to be amended (e.g., date of office visit, treatment, or other health care service)	
What is your reason for making this request?	
How is the entry incorrect or incomplete?	

Do you know of anyone who may have received or relied on the information in question such as your doctor, pharmacist, health plan, or other health care provider? (Circle one)	YES	NO
If yes, please specify the name(s) and address(s) of the organization(s) or individual(s):		
If the amendment is accepted, do we have your permission to share the amendment with individuals listed who have received this information? (Circle one)	YES	NO

Attachments:	
Required:	Attach a copy of the record that you are requesting be amended. Please make notes on the attached copy that identify the changes you are requesting be made to the record.

Signature of Patient: _____ Date: _____

Signature of Legal Guardian/representative (if applicable): _____ Date: _____

Relationship to Patient: _____

FOR HEALTHCARE ORGANIZATION USE ONLY:

Amendment has been: Approved Denied

Signature of Facility Privacy Officer (FPO): _____ Date: _____

- ☐ Patient has not filed a Statement of Disagreement, but requests that any future releases include the requested amendment and denial information.
- ☐ Patient has filed a Statement of Disagreement that must be released along with other documentation with any future releases of information.
- ☐ Facility/provider appended written response (rebuttal) and forwarded to patient.
- ☐ Facility/provider did not provide a response/rebuttal

Reference: Policy PHI.003, Patients' Right to Amend
Revised 2/2018

- Right to request an amendment of information within the DRS
- Request must be in writing
- Facility may deny the requested amendment
- Patient will be notified via letter from the FPO

Accounting of Disclosure (AOD)

Includes all releases of the DRS except those:

- Authorized by the patient
- Used for treatment, payment or health care operations
- Released to individuals themselves
- Used for national security or intelligence purposes
- Used for law enforcement agencies that have custody of an inmate
- Disclosed as part if a limited data set
- Releases that occurred before April 14, 2003

Additional requirements forthcoming as a result of HITECH regulations

Right to Privacy Restrictions

- Requests for such restrictions must be made in writing to the FPO

- No other facility employee may process such a request unless specifically authorized by the FPO.

For example: “I don’t want my information shared with anyone outside the hospital.” - This would not be appropriate because information is required for state reporting and also for accreditation purposes (e.g. TJC).

Confidential Communications

- Patients can request the use of an alternate address or phone number
- If there is a failure to respond by the patient, then the facility may revert to permanent address or phone number to collect payment
- Request must be communicated with facility FPO to work with the SSC FPO

Patient Privacy Complaints

- Route all patient privacy complaints to the FPO
- A complaint log must be maintained in accordance with the Privacy Complaint Process PHI.022
- Complaints must be investigated and documented with corrective action, if applicable
- There may be no retaliation due to a complaint being made
- Disposition of complaint must be consistent with PHI.023 Sanctions for Privacy and Security Violations policy
- The RL Solutions is the module used for complaint tracking

Safeguarding PHI

- Log off terminals when not in use and NEVER share your password
- Computers should have screen savers whenever possible
- Computer screens should be positioned so PHI is not readable by the public or other unauthorized viewers
- Printers should be positioned in protected locations so that printed information is not accessible or viewable by an unauthorized person
- PHI must be securely disposed of (e.g., shred bins)
- Double-check fax numbers prior to hitting " Send"

Impacts on Patient Care Areas/Ancillaries

- Passcode for family members and friends
- Patient rights may be requested at any time during hospitalization
- Verification of Requestors
- Required accounting of disclosures
- Photography policy

Examples of Privacy/Security Issues

- Lack of knowledge regarding permitted uses of PHI
- Discussions of patient information in public places such as elevators, hallways and cafeterias
- Printed or electronic information left in public view (e.g., charts left on counters)
- PHI in trashcan
- Not using appropriate safeguards when emailing or faxing
- Records that are accessed without need to know in order to perform job duties

Examples of Privacy/Security Issues Cont.

- Inappropriate control or use of documents containing PHI – paper or electronic
- Sharing PHI without an authorization when one is required
- Sharing passwords
- Failure to act proactively to prevent, detect, or correct privacy or security breaches
- Discussing patient information on social networking sites (e.g., Facebook, Twitter)

Sanctions

- There is a sanctions policy to address privacy and information security violations
- Types of violations can include:
  - Negligent (accidental or inadvertent)
  - Intentional (purposeful)

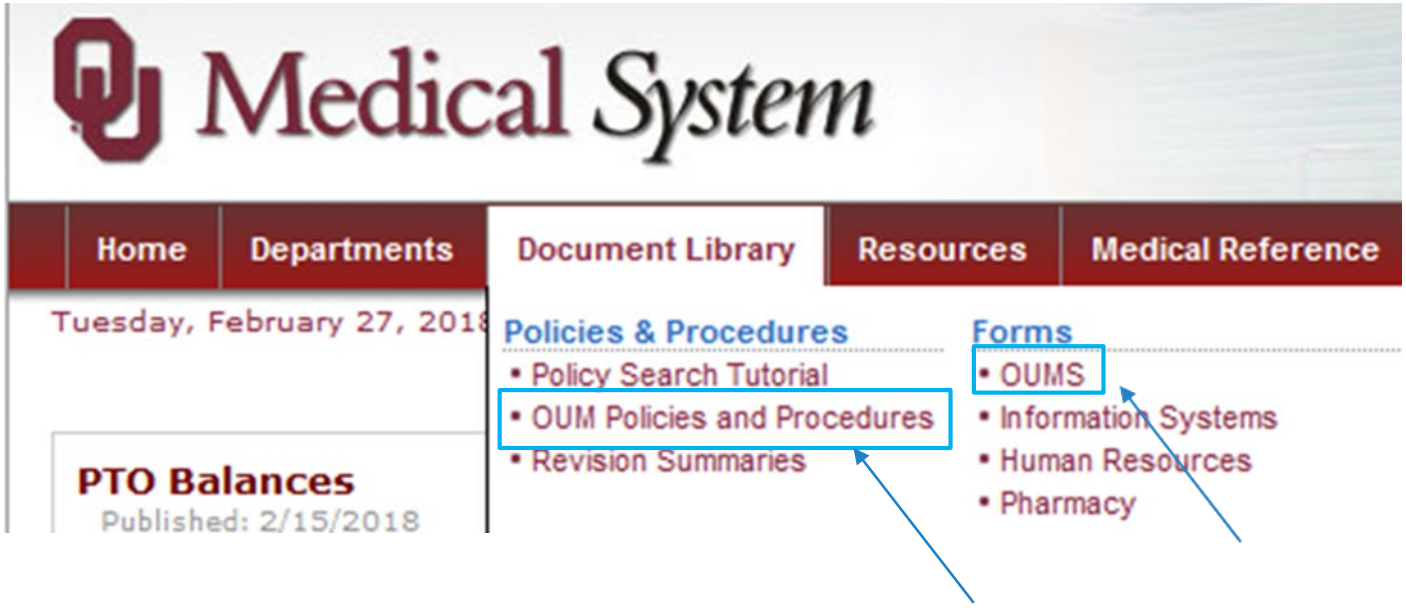
- For specific information on sanctions policy contact FPO and/or review the facility's policy

For More Information Review: PHI.023 Sanctions for Privacy & Information Security Violations

Test Your Knowledge

- Do you know who your FPO is?
- What kinds of privacy rights does the patient have?
- Can a patient amend their record?
- Do you know who to refer patient privacy questions or complaints to?
- What is an Accounting of Disclosures?
- When can you access, use or disclose the patient's PHI?
- Where do you dispose of patient information?

Patient Privacy Policies and Forms on the Intranet



OUM Privacy Policies

- PHI.001 - Mitigating Inappropriate or Unauthorized Access, Use and/or Disclosure of Protected Health Information
- PHI.002 - Protecting and Mitigating Inappropriate or Unauthorized Access, Use and/or Disclosure of Personally-Identifiable Information
- PHI.003 - Patients' Right to Amend
- PHI.004 - Patients' Right to Request Privacy Restrictions
- PHI.005 - Accounting of Disclosures
- PHI.006 - Protected Health Information Breach Risk Assessment and Notification
- PHI.007 - Notice of Privacy Practices
- PHI.008 - Safeguarding Protected Health Information
- PHI.009 - Minimum Necessary
- PHI.010 - Patients' Right to Request Confidential Communications
- PHI.011 - Patient Privacy Program Requirements

OUM Privacy Policies Cont.

- PHI.012 - Privacy Official
- PHI.013 - Fundraising Under the HIPAA Privacy Standards/HITECH
- PHI.014 - Community Clergy Access to Patient Listings under the HIPAA Privacy Standards
- PHI.015 - Designated Record Set
- PHI.016 - Determination of Uses & Disclosures of De-Identified Info
- PHI.017 - Authorization for Uses & Disclosures of PHI
- PHI.018 - Hybrid Entity
- PHI.019 - Limited Data Set & Data Use Agreement
- PHI.020 - Marketing Under the HIPAA Privacy Standards
- PHI.021 - Patient's Right to Opt Out of Being Listed in Facility Directory
- PHI.022 - Privacy Complaint Process

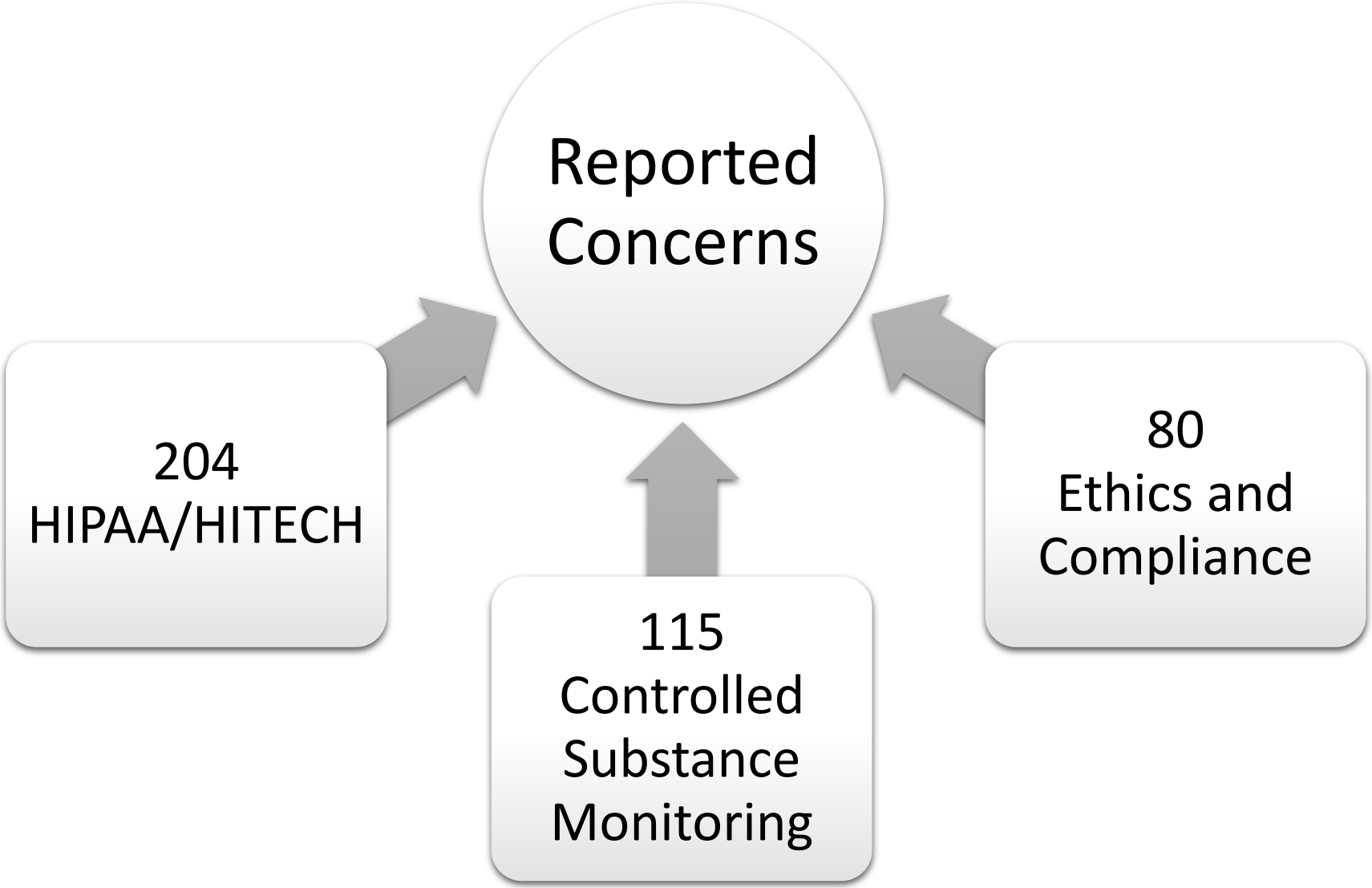
OUM Privacy Policies Cont.

- PHI.023 - Sanctions for Privacy & Info Security Violations
- PHI.024 - Uses & Disclosures for which an Authorization or Opportunity to Agree or Object is not Required
- PHI.025 - Uses & Disclosures of Protected Health Info to Other Covered Entities & Health Care Providers Under the HIPAA Privacy Standards
- PHI.026 - Uses & Disclosures of PHI for Involvement in Patient's Care & Notification Purposes
- PHI.027 - Uses and Disclosures Required by Law
- PHI.028 - Uses Verification of External Requestors
- PHI.029 - Electronic Incident Response
- PHI.030 - Confidential Patient Status
- PHI.031 - Photographing, Video Monitoring,/Recording, Audio Monitoring/Recording, and/or Other Imaging Policy
- PHI.032- Patents' Right to Access


Thank you for your attention and for protecting our patient's PHI.
Every patient, every time!
Medicine

2020 Code of Conduct Refresher Training

2019 Reported Cases



Ethics and Compliance

Harassment and Bullying

All OUM employees have the right to work in an environment free of harassment and bullying.

An environment free of harassment is one where all individuals are accepted and treated fairly regardless of any diverse characteristics or cultural backgrounds. All OU Medicine colleagues can expect to work in an environment free of harassing conduct to include sexual harassment of any kind.

OU Medicine

Harassment and Bullying

Other examples of workplace harassment and bullying include:

- Changing of schedules out of turn
- Unwanted nicknames or labels
- Gossiping or spreading rumors about colleagues (including physicians)
- Pinning staff against one another
- Purposeful exclusion from conversations or withholding of information

Conflict of Interest & Solicitation

A conflict of interest may occur if an OUM colleague's outside activities, personal financial interests, or other private interests interfere or appear to interfere with his/her ability to make objective decisions in the course of the colleague's responsibilities as an OUM employee.

OUM colleagues are obligated to remain free of conflicts of interest in performance of their responsibilities at OU Medicine.

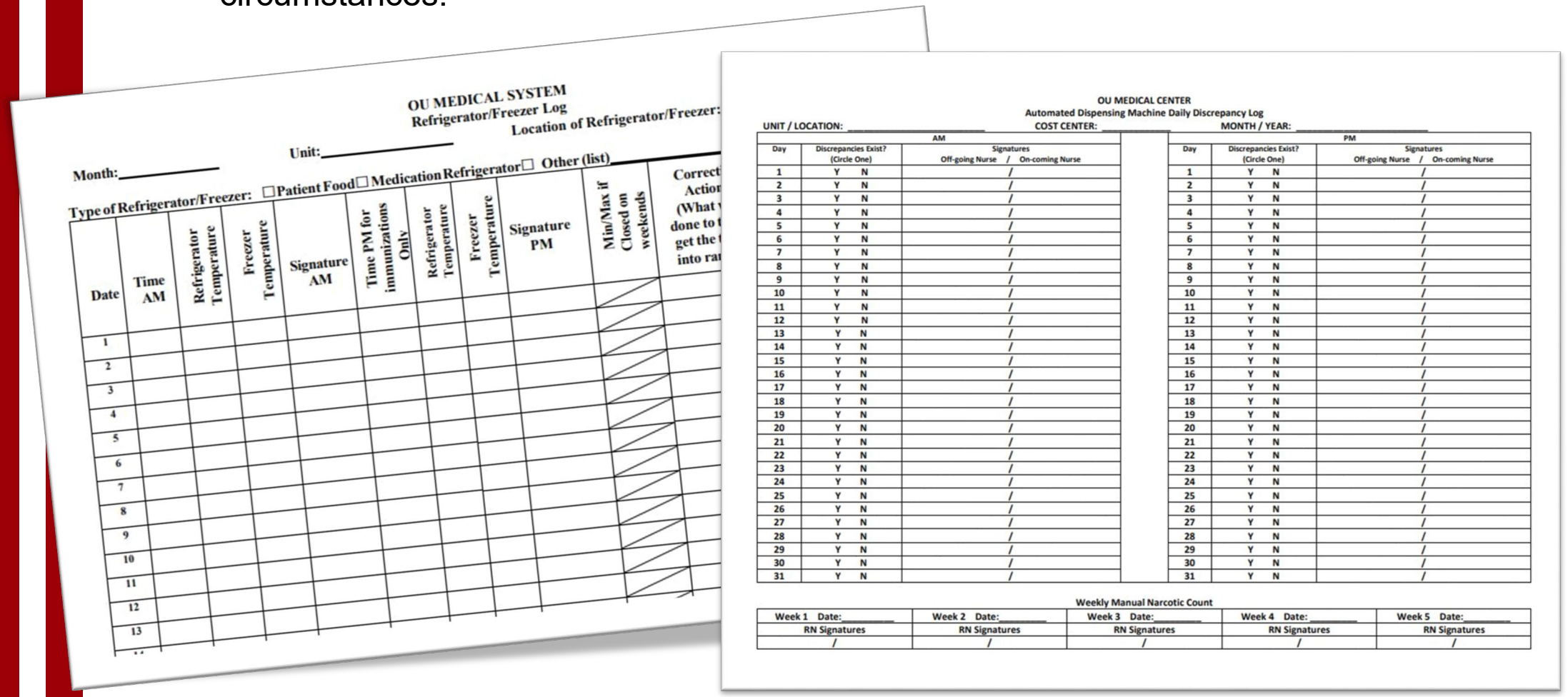
If a conflict of interest should present itself, the OUM colleague must disclose all pertinent information to their leader.

OUM Leaders, Directors and above, are required to complete a Conflict of Interest form annually in compliance with EC.005.

Additionally, OUM colleagues must not solicit referrals or resources to any company with which they have a vested interest. This includes the donation of supplies, monetary contributions or advertisement.

Falsification of Documents

No OU Medicine colleague should alter or falsify information under any circumstances.



OU MEDICAL SYSTEM
Refrigerator/Freezer Log

Month:_____ Unit:_____ Location of Refrigerator/Freezer:_____

Type of Refrigerator/Freezer: ☐Patient Food ☐Medication Refrigerator ☐ Other (list)_____

Date	Time AM	Refrigerator Temperature	Freezer Temperature	Signature AM	Time PM for immunizations Only	Refrigerator Temperature	Freezer Temperature	Signature PM	Min/Max if Closed on weekends	Correct Action (What done to get the into ra
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										

OU MEDICAL CENTER
Automated Dispensing Machine Daily Discrepancy Log

UNIT / LOCATION: _____ COST CENTER: _____ MONTH / YEAR: _____

AM			PM		
Day	Discrepancies Exist? (Circle One)	Signatures Off-going Nurse / On-coming Nurse	Day	Discrepancies Exist? (Circle One)	Signatures Off-going Nurse / On-coming Nurse
1	Y N	/	1	Y N	/
2	Y N	/	2	Y N	/
3	Y N	/	3	Y N	/
4	Y N	/	4	Y N	/
5	Y N	/	5	Y N	/
6	Y N	/	6	Y N	/
7	Y N	/	7	Y N	/
8	Y N	/	8	Y N	/
9	Y N	/	9	Y N	/
10	Y N	/	10	Y N	/
11	Y N	/	11	Y N	/
12	Y N	/	12	Y N	/
13	Y N	/	13	Y N	/
14	Y N	/	14	Y N	/
15	Y N	/	15	Y N	/
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25	Y N	/	25	Y N	/
26	Y N	/	26	Y N	/
27	Y N	/	27	Y N	/
28	Y N	/	28	Y N	/
29	Y N	/	29	Y N	/
30	Y N	/	30	Y N	/
31	Y N	/	31	Y N	/

Weekly Manual Narcotic Count

Week 1 Date:_____	Week 2 Date:_____	Week 3 Date:_____	Week 4 Date:_____	Week 5 Date:_____
RN Signatures	RN Signatures	RN Signatures	RN Signatures	RN Signatures
/	/	/	/	/

Duty to Report and Cooperate

Each individual has a responsibility to report any activity that appears to violate applicable laws, rules, regulations, accreditation standards, standards of medical practice, federal health care conditions of participation, or the OUM Code of Conduct.

You should first raise concerns with your direct supervisor, manager or director. If this is uncomfortable or inappropriate, you may discuss the situation with the Human Resources Business Partner, the ECO or the Ethics and Compliance Department.

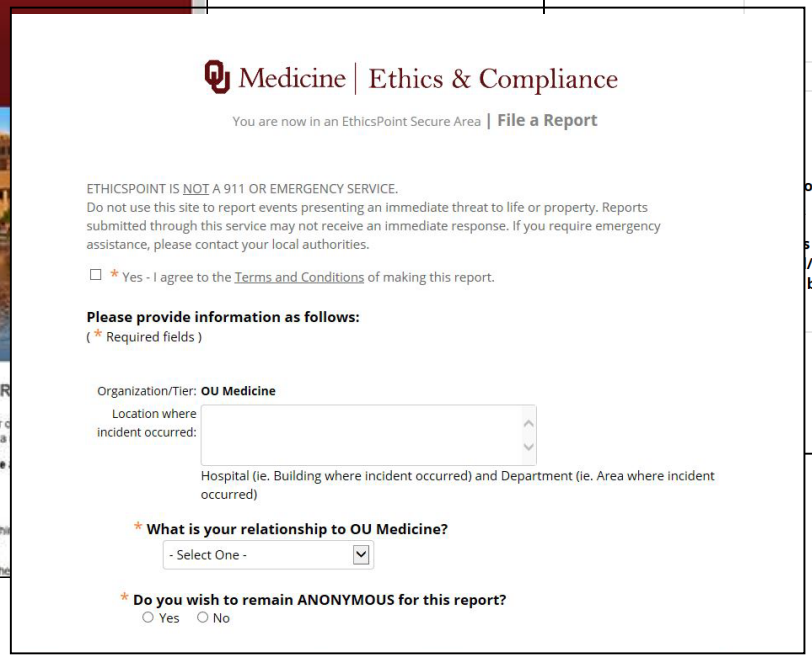
There can be no retaliation for reporting in good faith.

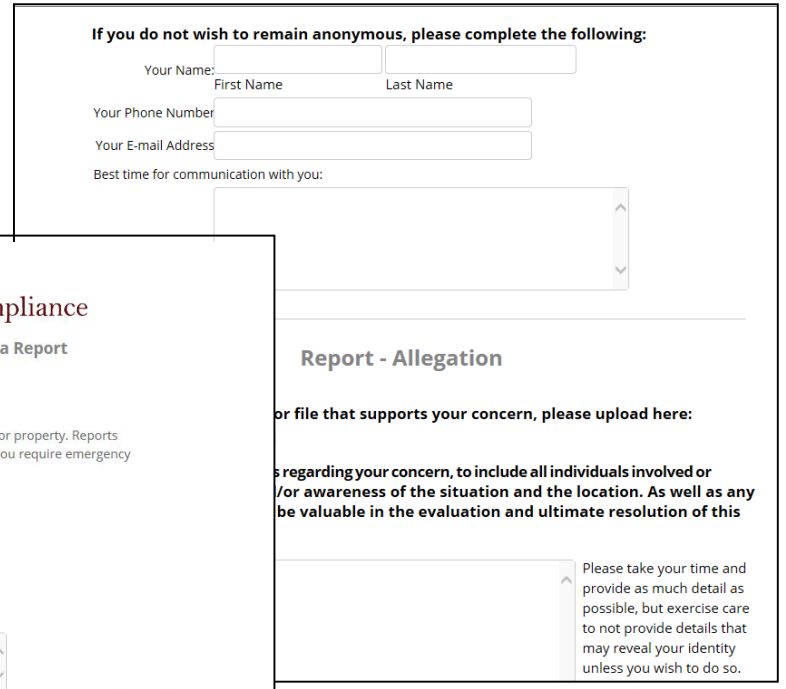
It is required that all OUM colleagues cooperate and participate in any ethics investigation that may take place.

EthicsPoint

You can contact the Ethics Hotline, EthicsPoint, at any time to make a report by calling 1-833-875-7677 or by going to www.oumedicine.ethicspoint.com.

EthicsPoint allows for anonymous reporting by all OU Medicine colleagues.





Patient Privacy

Consent

Release of Verbal PHI

- Before discussing PHI in front of family members, visitors or staff, you must obtain consent from the patient to do so.

- When providing new or sensitive information, obtain consent from the patient even if the patient has already consented for PHI to be discussed in front of that individual.

- You must obtain the patient passcode from an individual before releasing patient information if the patient is unable to give consent.

Photo/Video Consent

- Prior to taking photographs or videos of patients or within the hospital, an e-demand photo consent form must be completed.

- Only OUM devices may be used for photography/video purposes.

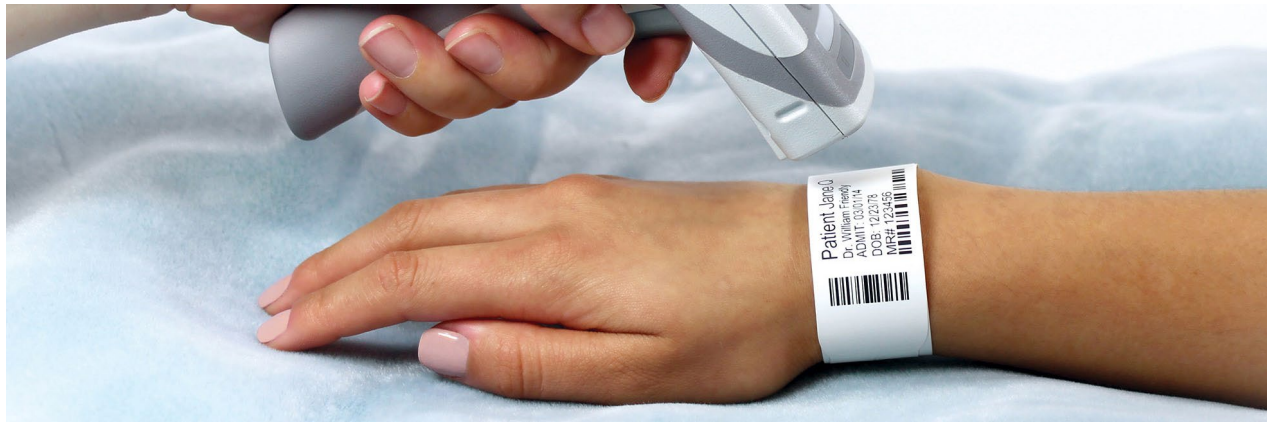
Patient Verification

Correct Documents-Correct Patient

- Before applying ID bands and/or patient stickers, use two patient identifiers to ensure that the correct identification is being applied to the correct patient and patient chart.

Patient Paperwork

- Prior to discussing and ultimately handing over discharge paperwork to a patient, verify that every page, including prescriptions are meant for the patient at hand.



Safeguarding PHI

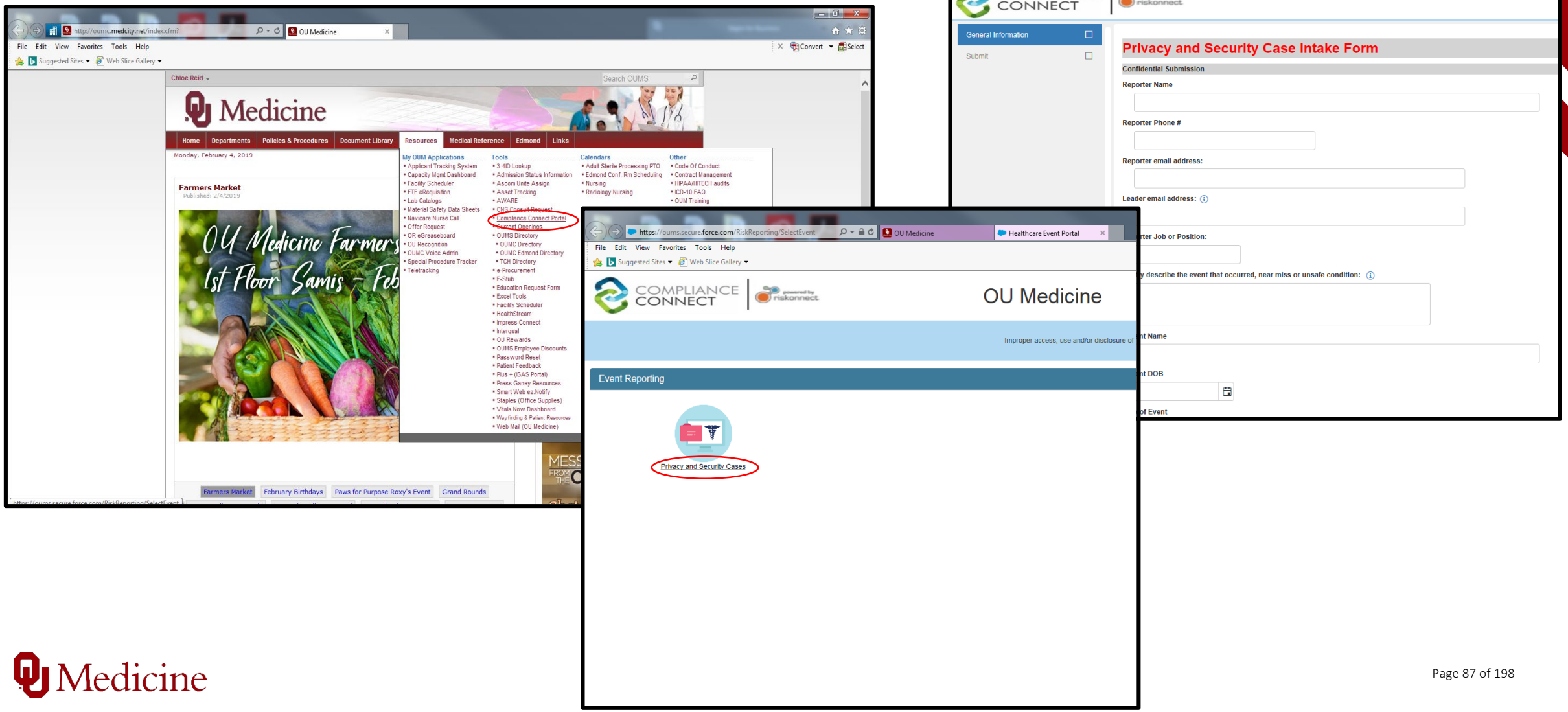
Avoid these common exposures:

- Discussions of patient information in public places
- Printed or electronic information left in public view
- Radiology films in public areas
- Discussing patient information on social networking sites
- PHI in regular trash or sharps bins
- White boards or monitors with full patient name

OU Medicine

Compliance Connect

Reporting HIPAA/HITECH Breaches



Information Security

Information Security

Email Communication

- Prior to sending any sensitive information,
  - Verify that the email recipients are correct
  - Use encryption in the subject line of email if necessary and never place sensitive information in the subject line
  - Do not send sensitive information to an individual's personal email account
- This ensures that you are communicating to the correct individual on a secure network.

User Behavior

- Only access records when necessary for your job
- Never look at the records of your family members, friends, neighbors, etc.

Information Security

Mobile Devices

- Devices must be encrypted
- PHI should never be sent to mobile devices – including pagers and text messages
- Enable passcode protection
- Do not connect devices to unsecured Wi-Fi
- Use discretion when downloading applications
- Avoid storing sensitive information on mobile devices
- Be cautious about internet usage
- Text message/Voicemail phishing

OU Medicine

Phishing Scams

What to look for:

- Some of these emails contain characteristics such as:
  - Subject line containing: “Scan Data”, “Scanned Document”, “Your booking #####”, “Documents”
- Abnormal senders
  - info@somecompany.com, Jean-123@somecompany.com, no-reply@mycompany.com

What to do at work:

- Refrain from checking non-OUM email
- Take extra precaution with EXTERNAL emails
- Click the *Report Phishing* button immediately if you have received one of these emails

Controlled Substance Monitoring

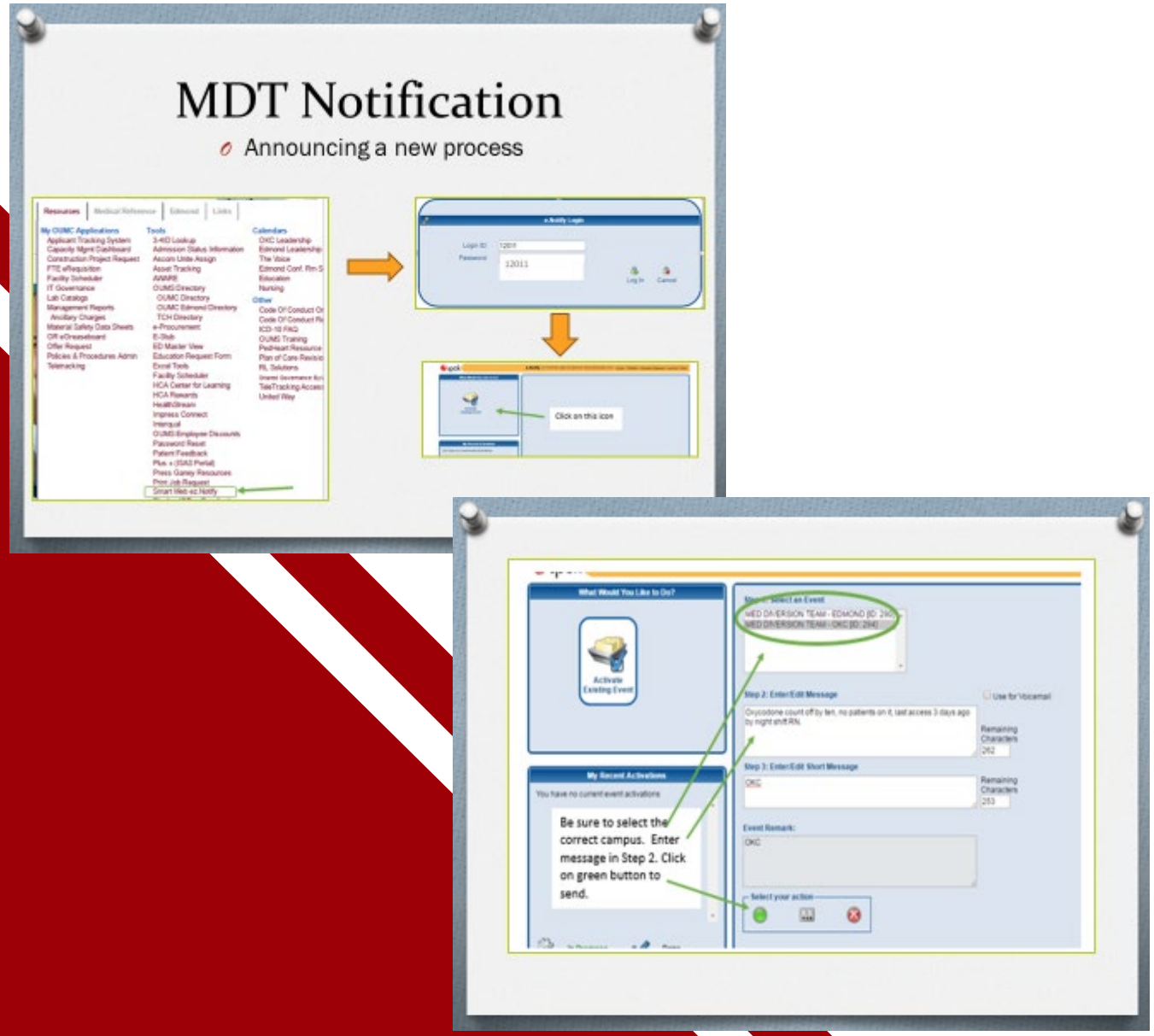
Controlled Substances

Prescription and controlled medications and supplies must be handled properly and only by authorized individuals to minimize risks to us and to patients. If one becomes aware of inadequate security of drugs or controlled substances or the diversion/theft of drugs from the organization, the incident must be reported to the supervisor, manager, or director immediately.

Controlled Substances and Medication Diversion Team

OU Medicine employs a robust diversion prevention and surveillance program that is overseen by the Medication Diversion Team. The necessity of diversion prevention processes is mandated by the Oklahoma Board of Pharmacy Law Title 535: 15-3-2.
OU Medicine facilities strictly enforce reporting of any violations of diverting medications by facility staff or privileged practitioners in accordance with OUM Policy PHARM.017: DEA and State Controlled Substance Diversion and Loss Reporting.

When and How to Notify the Med Diversion Team (MDT):
The team must be notified immediately of a suspected diversion or diversion currently taking place; if there is suspicious behavior; if the suspect is potentially under the influence of substances that could impair their performance or judgment; and for unaccounted for controlled substances. The MDT must confer and determine appropriate action within 24 hours.



Notifying MDT

Notification of the MDT will be available to all staff on the Intranet via Tools > Smart Web ezNotify > login ID 12011 (password 12011). One would choose to Activate an Existing Event and then choose whether to notify the Edmond Team or the OKC Team.

Examples of information to include in the message:
Possible diversion – TCH PICU – contact is Charge nurse Nancy @ 271-2222
Suspicious behavior – OUMC ER – contact is Supervisor Charlie @ 271-7777 – CC notified and UDS in process
Suspect possibly under the influence – Edmond ALC – contact is night coordinator at 359-9999 – UDS in process
PCA discrepancy in the TICU – approximately 20 ml unaccounted for – contact is Charge RN Grace @ 271-1111

Diversion Opportunities

Wasting Controlled Substances

Unused portions of controlled substances, including used fentanyl patches, must be placed in a CsRX Container to ensure the medication is not retrievable. Wastes of controlled substances may not be placed in sharps containers, other buckets/bins or trash cans.

Perforated Medication Packs

Medication packs that are packaged by OU Medicine should be divided at the perforation line with scissors to prevent accidental tearing of the pack at the seal. Accidental tearing could result in loss of the controlled substance or an opportunistic moment for someone diverting.

OU Medicine

Diversion Opportunities

Physical Items That Are Considered Controlled Substances

Physical items granting access to controlled substances including: keys, prescription pads, prescription paper, printers used for electronically printing prescriptions, etc. are to be treated with the same security and handling measures as controlled substance medications. Theft or loss of any of these items should be reported immediately to your Manager, Director and Med Diversion Team.

OU Medicine

Early Signs of Diversion

- Frequent disappearances, in the bathroom or dirty utility room for prolonged periods
- Volunteer for overtime, come to work when not scheduled or often starting a shift early or staying after shift
- Recurrent removal of controlled medications near or at the end of shift or at the end of a stretch of shifts
- Help colleagues medicate their patients and review medication orders of patient they are not caring for
- Heavy or no wasting of drugs
- Picking the same people to waste with
- Pattern of holding waste until oncoming shift

OU Medicine

Later Signs of Diversion

- Unpredictable work performance, recurrent mistakes, poor judgement and bad decisions
- Interpersonal relations suffer, become volatile, isolated, sullen
- Blames environment and others for errors
- Tardiness, unscheduled absences, excessive number of sick days used
- Frequent personal crises

OU Medicine

Patient Safety

Communication

- Open lines of communication
- Closed-Loop communication
- Questions to reflect on:
  - Do you participate in open communication?
  - Do you promote an environment of understanding where staff and peers are free to ask questions and understand the reasoning behind why certain decisions are made?
  - Are you respectful and receptive of information shared by others and their opinions?
  - Are you intentional when listening to others?

OU Medicine

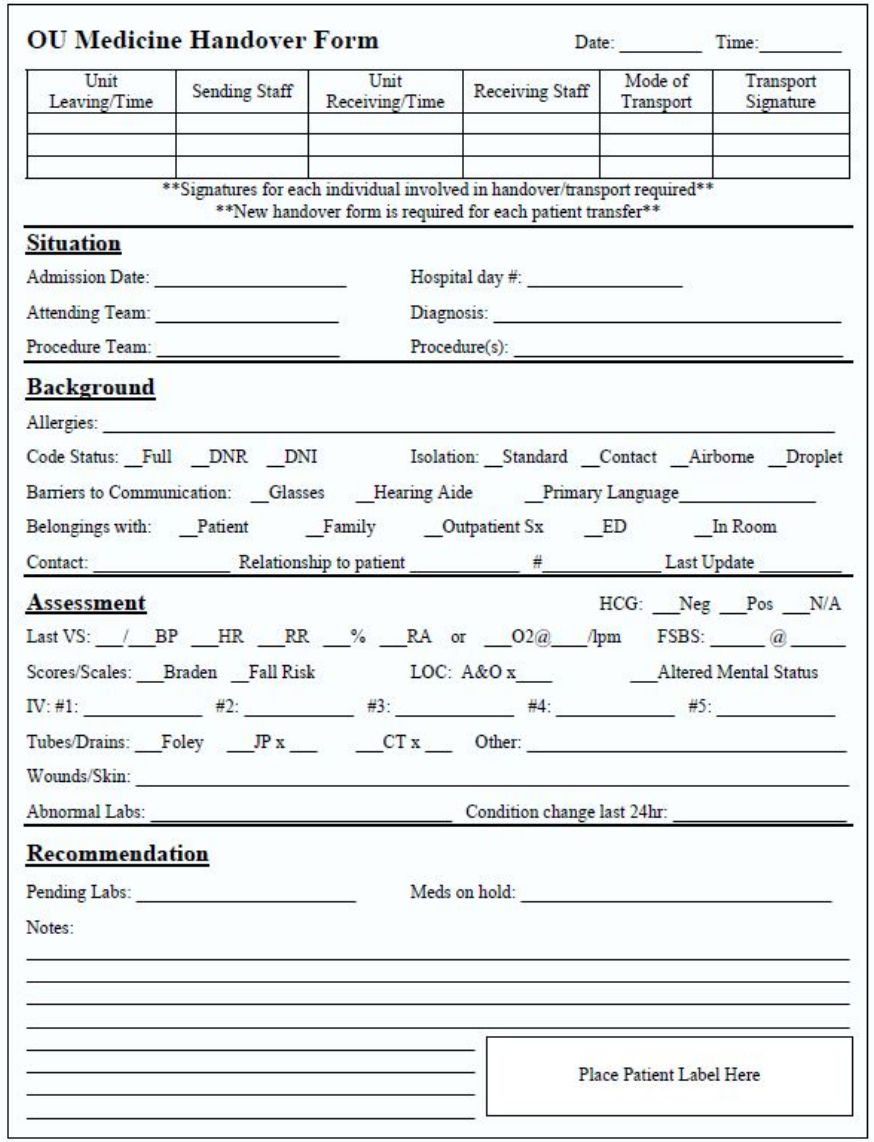
Handover Communication

Situation
- Introduction of the patient
- Patient situation or what is going on with them currently

Background
- Isolation
- Fall Risk
- Allergies
- Barriers

Assessment
- Current vital signs
- Any change in condition

Recommendation
- Any pending results
- Family availability or contact information
- Special needs during transport



OU Medicine Handover Form Date: _____ Time: _____

Unit Leaving/Time	Sending Staff	Unit Receiving/Time	Receiving Staff	Mode of Transport	Transport Signature

Signatures for each individual involved in handover/transport required
New handover form is required for each patient transfer

Situation

Admission Date: _____ Hospital day #: _____

Attending Team: _____ Diagnosis: _____

Procedure Team: _____ Procedure(s): _____

Background

Allergies: _____

Code Status: __Full __DNR __DNI Isolation: __Standard __Contact __Airborne __Droplet

Barriers to Communication: __Glasses __Hearing Aide __Primary Language_____

Belongings with: __Patient __Family __Outpatient Sx __ED __In Room

Contact: _____ Relationship to patient _____ #_____ Last Update _____

Assessment HCG: ___Neg ___Pos ___N/A

Last VS: ___/___BP ___HR ___RR ___% ___RA or ___O2@___/lpm FSBS: _____ @ _____

Scores/Scales: ___Braden __Fall Risk LOC: A&O x___ ___Altered Mental Status

IV: #1: _____ #2: _____ #3: _____ #4: _____ #5: _____

Tubes/Drains: ___Foley ___JP x ___ ___CT x ___ Other: _____

Wounds/Skin: _____

Abnormal Labs: _____ Condition change last 24hr: _____

Recommendation

Pending Labs: _____ Meds on hold: _____

Notes:

Place Patient Label Here

OU Medicine

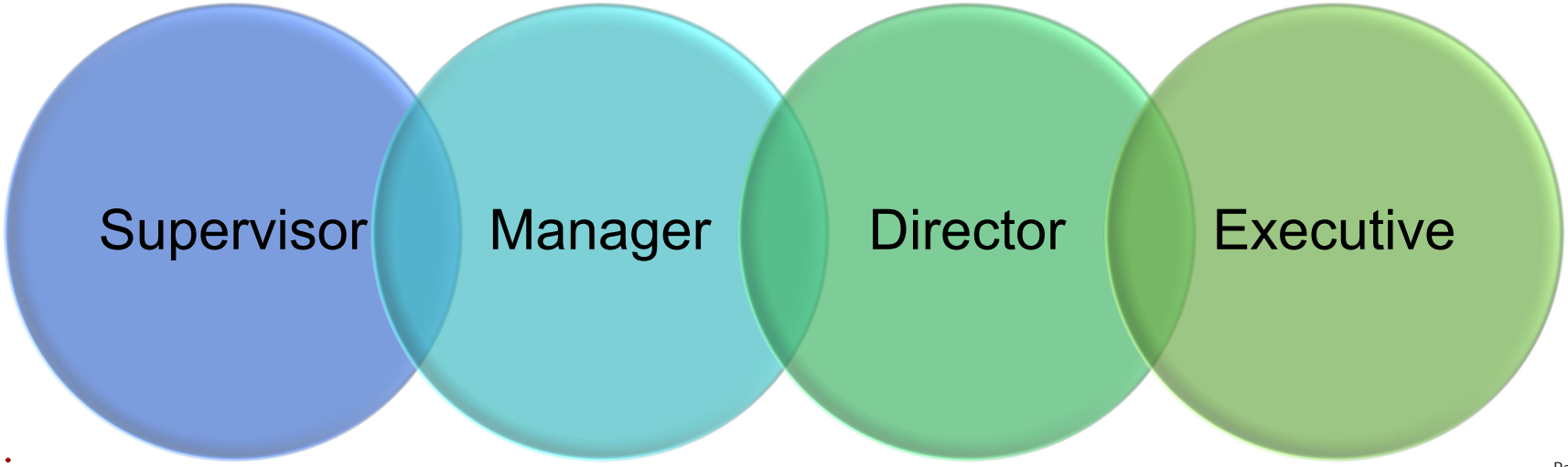
Utilizing Chain of Command

The chain of command includes all levels of leadership.

It is paramount that all OU Medicine colleagues who are confronted with information that they are unfamiliar with or that could potentially put the organization at risk escalate that information through their chain of command rather than attempting to handle it alone.

Additional resources outside your direct chain of command include:

- Clinical Coordinators
- Administrator On-Call



OU Medicine

Accountability

It is the responsibility of **all** OU Medicine employees to seek out the necessary information in order to perform their jobs safely and correctly.

After attesting to system policies, departmental processes or other organizational requirements, all colleagues will be held accountable for their ability to speak to and abide by the information.

Examples of information to aid in staying informed include:

- Updated Policy Changes
- Changes to Departmental Processes
- Regulatory Requirements

Thank you for completing the

2020 Code of Conduct Refresher Training

CONTENTS

This guidebook has been prepared to provide easy access to key information, policies and procedures at OU Medicine (OUM) as well as important regulatory standards from The Joint Commission.

Please take the time to familiarize yourself with the important information in this guide and to complete the departmental/area-specific information in the back of the book.

You may want to carry this guidebook in your pocket and reference it anytime you have questions or are asked a question for which you do not readily know the answer.

This book highlights OUM Policies and Procedures. Please access policies on OUM Intranet for further information.

Mission

Leading health care – In patient care, education, and research. Through our combined efforts we strive to improve the lives of all people.

Vision

To be the premier health system for advancing medical care, education, and research in the state and to be among the leaders nationally.

Values

- **People** – With a focus on teamwork and inclusion, instill and reinforce standards of behavior that will attract, develop and retain outstanding and diverse staff, physicians, faculty, and learners.
- **Quality and Safety** – Achieve the highest standards of patient care and innovation by implementing and continually enhancing a robust self-evaluation system; provide the highest quality education programs for all levels of learners.
- **Service** – Provide compassionate and seamless care; exceed our patient's expectations; ensure an organizational culture of respect and communication.
- **Growth** – Grow the enterprise to better serve patients and the community, ensure continued support and focus on the fundamental missions of teaching and research.
- **Stewardship** – By responsible management and accountability of what has been entrusted to us – commit to fiscal responsibility, collaborative planning, and adaptability to change.

Survey Readiness

A surveyor should always have a hospital employee accompany them to any hospital location or department. If you ever meet a surveyor that is alone, please contact the Regulatory Affairs team via SmartWeb and page the Administrator on-call. Remain with the surveyor until someone arrives that can accompany the surveyor and respond to their needs.

Survey Etiquette

- Ensure employee issued badge is placed at eye level
- Be readily available to greet surveyors and answer questions
- Listen carefully to what's ASKED
- Only answer the questions being asked and seek clarification if needed
- Answer questions confidently – "Process is" instead of "usually, sometimes or I think"
- Use your Resources
- Never give documents to a surveyor unless Regulatory Team deems appropriate
- Breathe and SMILE
- Be confident in your skills and be able to discuss how they apply to patient safety. You do this every day!
- Be positive – do not argue or act annoyed
- Do not scatter or run away – this gives the impression that you are not prepared
- Do not embellish or volunteer unnecessary information
- Do not make excuses or present false information
- Be able to give examples of what you do to ensure patient safety

It is important to **ALWAYS** be prepared, professional, and polite during a hospital survey and your normal workday!

Survey Resources

- Regulatory Guidebooks
- Badge Buddies
- Hot Topics
- Regulatory Newsletter
- Regulatory Intranet Department Page

Continuous Readiness Activities

- Make sure you know and understand the information in this guide
- Be familiar with The Joint Commission's National Patient Safety Goals
- Know how to locate and access policies and procedures on the intranet
- Ensure your nametag is visible at all times
- Look around! Make sure your unit is clean and organized at all times
- Never discuss patients in public or leave patient information in public view
- Be familiar with your role in fire safety and disaster preparedness
- Document timely, accurately, and completely
- Use good hand hygiene and hold patients, visitors, and staff accountable for washing hands

About The Joint Commission (TJC)

The Joint Commission accredits and certifies more than 22,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. *(Source:www.jointcommission.org/AboutUs)*

Chain of Command and Escalation of Issues

The chain of command should be used to address issues, concerns, and questions about patient care, the working environment and to report violations of policy or procedure.

Chain of Command may include:

- ✓ Charge Nurse (in nursing units)
- ✓ Supervisor
- ✓ Manager
- ✓ Director
- ✓ Administrative Officer for your area or the Administrator on Call, who may be reached through the page operator at any time
- ✓ Risk Services
- ✓ Regulatory Affairs Office
- ✓ Ethics and Compliance Office

Employees also have the right to contact other appropriate regulatory bodies to report concerns such as the Oklahoma Board of Nursing, Oklahoma State Department of Health, and the Department of Human Services

Employees have the right to report concerns regarding patient safety directly to The Joint Commission (TJC).
Phone: 1-630-792-5800
Email: patientsafetyreport@jointcommission.org

Risk Services
Cover risk management, patient safety and professional liability. All OU Medicine employees have a primary duty to report adverse occurrences through the confidential RL Solutions module.

For assistance: 405-271-1800

Regulatory Affairs
Provide resources, information and support about topics regarding continuous readiness, regulatory visits, and changes in regulations.

For assistance: OUMRegulatory@oumedicine.com and/or 405-271-8052

Ethics & Compliance
We support OU Medicine with any and all ethics and compliance issues, but not limited to: ethical concerns, policies and procedures, compliance alerts and training, and program leadership.

Ethics Line: www.oumedicine.ethicspoint.com and/or calling 1-833-875-7677

For assistance: 405-271-6847

Policy:
OUM Policy EC.030: Code of Professional Conduct

NATIONAL PATIENT SAFETY GOALS (NPSG)

Goal #1: Improve the Accuracy of Patient Identification

ALWAYS use 2 patient identifiers

- ✓ Name, Birth Date, and/or Medical Record Number (Name and Photo for Behavioral Health patients at Edmond)
- ✓ Ask the patient to verbally state their name and birth date when possible
- ✓ Identify the patient when doing the following:
  - Administering medications or blood products
  - Collecting blood samples or specimens for testing
  - Providing care, treatment, or services
- ✓ The patient's room number or physical location is **NOT** to be used as an identifier.
- ✓ Use two identifiers as part of the "TIME OUT" process
- ✓ Be able to talk about using two patient identifiers as part of medication administration process
- ✓ Label containers used for blood and other specimens in the presence of the patient.

Help eliminate blood transfusion errors

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

Policy:

OUM Policy PC.012: Patient Identification and Armbands
OUM Policy PC.041: Blood Component Administration
OUM Policy: PC.040: Identification and Labeling of Specimens

Goal #2: Improve Effectiveness of Communication Among Caregivers

Quickly report critical tests and critical results to the right person on a timely basis

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

Policy:

OUM Policy PC.028: Critical Results/Values

Goal #3: Improve the Safety of Using Medications

Label ALL medications

- ✓ Including syringes, cups, and basins
- ✓ This applies to ALL areas that complete procedures
- ✓ Label whenever a medication/solution is transferred from the original container to another container
- ✓ Applies even if only one medication is being used
- ✓ Labels should include name, strength, amount, diluents and volume (if not apparent from the container), expiration date (if not used within 24 hrs) and expiration time (if expiration occurs < 24 hrs)
- ✓ Verify verbally and visually by 2 qualified individuals when the person preparing the medication is not the person administering the medication
- ✓ One medication or solution is labeled at a time
- ✓ Unlabeled medications are discarded immediately
- ✓ Medications, solutions and their labels are reviewed at shift change or break relief
- ✓ At the conclusion of the procedure remove all labeled containers and discard their contents, except multiuse vials.
- ✓ Original containers remain available until the conclusion of the procedure

Reduce harm for patients taking anticoagulants

- ✓ Use caution caring for patient on blood thinners
- ✓ Assess patient's baseline prior to beginning therapy
- ✓ Only use approved protocols for anticoagulant therapy
- ✓ Use only oral unit-dose products, or premixed infusion bags for administering therapy
- ✓ Manage food and drug interactions for patients receiving anticoagulant therapy
- ✓ Provide education to regarding therapy to patients and families, including the importance of follow-up monitoring, compliance, and potential food and drug interactions
- ✓ Program the IV pump to provide accurate dosing

Maintain and communicate accurate patient medication information

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

Policy:
OUM Policy PHARM.004: Medication Management
OUM Policy PHARM.013: Food: Drug Interactions
OUM Policy PHARM.002: Medication Reconciliation

Goal #6: Reduce the harm associated with clinical alarm systems

- ✓ Identify the most important alarms based off the risk to the patient's condition
- ✓ Remember you are responsible for proper operation of the equipment that have alarms

Policy: OUM Policy REG.004: Clinical Alarms

Goal #7: Reduce the Risk of Healthcare-Associated Infections (HAI)

ALWAYS use appropriate hand hygiene and contact precautions

- ✓ Perform hand hygiene before AND after patient contact
- ✓ Hand washing with soap and water must be performed when hands are visibly soiled, after exposure to blood, secretions, excretions, or non-intact skin, before and after eating and after using the restroom
- ✓ Hospital-approved hand sanitizer can be used when hands are not visibly soiled, before and after contact with a patient's intact skin and after removing gloves
- ✓ No artificial nails or nail tips >¼ inch are allowed
- ✓ Follow strict PPE as determined by the type of precautions the patient is on

Prevent multi-drug resistant organism (MDRO) infections

- ✓ Use **ABCD**: **A**ctive surveillance, **B**arrier precautions, **C**ompulsive hand hygiene, **D**isinfect environment
- ✓ **Catheter-associated urinary tract infection** (CAUTI) prevention – monitor daily list of patients with Foleys

Prevent central-line bloodstream infections **(CLABSI)** and surgical site infections

- ✓ Care bundle:
  - Hand hygiene and skin asepsis
  - Maximum barrier precautions
  - Site selection – avoid femoral lines
  - Daily assessment of line necessity, and prompt removal of unnecessary lines

Policy:

OUM Policy TJC.011: Infection Control Plan
OR Policy 03-OR.301: Aseptic Technique for the Operating Room
OUM Policy IPIC.023: Isolation Precautions

Goal #15: The hospital identifies safety risks inherent in its patient population.

Identify patients at risk for suicide

- ✓ Initiate referral for patients who are a risk to self
- ✓ Screen for suicide risk factors
- ✓ Ensure the patient's immediate safety
- ✓ Evaluate environment and personal belongings
- ✓ Provide follow-up crisis information

Policy:

OUM Policy BH.002: Suicide Precautions: Patient Management

Universal Protocol: Prevent Wrong Site, Wrong Procedure, Wrong Person Surgery

Conduct a pre-procedure verification process, involving the patient wherever possible

- ✓ At the time the surgery/procedure is scheduled
- ✓ At the time of preadmission testing and assessment
- ✓ At the time of admission or entry into the facility
- ✓ Before the patient leaves the preoperative area or enters the procedure/surgical room
- ✓ Missing information or discrepancies are addressed before starting the procedure

Licensed Independent Practitioner marks procedural site

- ✓ Applies to bedside procedures except when the LIP is in continuous attendance with the patient

ALWAYS perform a **time-out** before the procedure

- ✓ Correct patient identity, side, site, and position
- ✓ Agreement on the procedure to be done
- ✓ Use standardized tool to verify items required for procedure area available

Policy:

OUM Policy SURG.007: Safe Procedural & Surgical Verification

HOSPITAL-ACQUIRED CONDITIONS

Keeping our patients safe and free of complications or untoward events that may occur during hospitalization has always been a top priority. Being treated in a manner that is evidence-based, supported by research, safely and effectively is how each of us would want to be treated, and is the type of care our patients deserve. It's simply the right thing to do.

The government has put incentives in place to ensure all healthcare facilities receiving payments through Medicare use evidence-based practice to protect patients, and to do all possible to ensure positive outcomes of care.

Specifically, the Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payment for certain hospital-acquired conditions. CMS has titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC & POA).

The categories of HACs include:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
- Manifestations of Poor Glycemic Control
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity

- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
- Iatrogenic Pneumothorax with Venous Catheterization

OU Medicine, Inc. has put in place several action plans designed to keep our patients safe and free from acquiring a problem during hospitalization. These actions include:

✓ Revised policies and procedures
✓ Additional staff training and competency validations
✓ Improved documentation systems
✓ Focused monitoring and follow-up
✓ Support /oversight by an administrative team

Monitoring and follow-up are in progress on each of the conditions. You can do your part by participating in the training provided, always practicing in a competent manner, identifying opportunities for improvement, and seeking clarification when questions arise.

ENVIRONMENT OF CARE (EC) and LIFE SAFETY (LS)

Safety

According to the Mutual Aid Memorandum of Understanding for Healthcare Facilities adopted by Homeland Security Regions 6 and 8, which includes OU Medicine, the following universal emergency code system shall be used:

- **CODE RED: Fire**
- **CODE PINK: Missing Infant or Child**
- **CODE BLUE: Medical Emergency/Cardiac/Respiratory Arrest**
- **CODE BLACK: Severe Weather**
- **CODE YELLOW: External/Mass Casualty Disaster**
- **CODE ORANGE: Hazardous Exposure Requiring Decontamination**

In addition, OU Medicine also uses:

- **CODE GRAY: Stroke Alert**
- **CODE PURPLE: Disruptive/Combative Person**
- **CODE SILVER: Hostage Situation/Active Shooter**

To report a code of ANY type, call 1-1911 (Downtown) or 444 (Edmond)

To report a Code Blue or Person Down in Medical Office Buildings, Pathways, Transplant Center, or other area outside the main hospital facilities, call 9-911. At the Edmond facilities outside the main building, dial 911.

Security

Security services are provided for staff, patients, and visitors by the OU Health Sciences Center Police and Edmond Security Services. Services include security, assistance with flat tires, and escorting to parking areas.

- ***Downtown campus: 271-4911***
- ***Edmond campus: 444***

Infant Security

All OUM employees have a responsibility in providing a secure environment. Multiple measures are employed to protect our infant population in perinatal and neonatal units.

Identification:

- Perinatal and NICU staff have pink identification badges
- Physicians and APN's have unique ID badges
- Unique scrubs for Perinatal and NICU staff
- Mom-Dad-Baby receive ID bands in delivery room with matching numbers
- All hospital employees, students and contractors entering the area MUST be wearing appropriate hospital identification to enter secured areas

Policy:

OUM SS.002: Infant Security

Tobacco Products

The use of any tobacco product is prohibited in facilities or on properties of OU Medicine. This applies to all OU Medicine employees, medical staff, patients, visitors, students, volunteers, vendors and contractors.

Policy:

OUM Policy SS.029: Tobacco and Smoke Free Workplace

Hazardous Materials and Waste

Hazards Communication

All OU Medicine employees will be informed of hazards from chemicals in their workplaces and measures they should take to protect themselves from potential hazards.

Every employee has the responsibility to:

- Learn, know and practice job tasks safely
- Use personal protective equipment as required
- Be aware of the precautionary information indicated on the manufacturer's label and/or the SDS for the chemicals being utilized in their work areas

Notify their supervisor of:

- Symptoms of potential hazardous chemical over-exposure
- Apparent exposures or potential accident-causing situations
- Missing labels on containers
- Malfunctioning safety equipment
- Any damaged containers or spills

Safety Data Sheets (SDS)

SDS can be found on the OUM intranet under **Document *Library > General > Safety Data Sheets***

In an emergency, SDS sheets can be obtained 24 hours a day/7days a week by calling: 1-800-451-8346.

Labeling

Per Federal Regulation, labeling must be done on all hazardous chemicals that are shipped and used in the workplace.

- Labels must not be removed or defaced
- Chemicals not in original containers must be labeled with information from original containers
- Unlabeled chemical containers are not permitted

Waste Types and Disposal

- **Non Hazardous Pharmaceutical Waste**: White with blue top containers
- **Potentially Hazardous Medical:** Black containers
- **Biohazardous Waste:** Red or orange tags or biohazard label
- **Chemotherapeutic/Antineoplastic/Cytotoxic Waste (Chemo Waste): Yellow** containers with white lids
- **Radioactive Waste:** Handled by the OUHSC Radiation Safety Office

Radiation Safety

- All employees whose work involves potential exposure to ionizing radiation must receive radiation safety training
- Designated workers are required to wear radiation dosimeters during procedures involving ionizing radiation
- All radioactive materials must be secured against unauthorized access. These areas may include the blood bank, gamma knife, and nuclear medicine

Chemical Hygiene Procedures

When handling chemicals, general precautions should be utilized to minimize exposure. However, review the chemical SDS for specific instructions.

Accidents and spills:

- **Eye contact:** promptly flush eyes with water for fifteen minutes and seek medical attention
- **Ingestion:** drink large amounts of water
- **Skin contact:** promptly flush affected area with water and remove any contaminated clothing. If symptoms persist, seek medical attention
- **Clean up**

To help remember what to do in case of a hazardous materials spill, use the acronym **CLEAN**.

C = Contain the spill

L = Leave area unless properly trained to clean the spill

E = Emergency medical treatment, seek if needed

A = Access the Safety Data Sheet (SDS)

N = Notify the Operator of a "**Code Orange**" at **1-1911** on the Downtown Campus and 444 on the Edmond Campus

Follow-up: medical consultations and examinations are available in Employee Health.

Policy:

OUM Policy SS.037: Hazards Communication (SDS) Program

***Fire Safety* (CODE RED)**

EMPLOYEE RESPONSIBILITIES IN THE PRIMARY FIRE AREA (RACE):

R Rescue anyone in immediate danger (if safe to do so)

A Activate the fire alarm (pull manual alarm pull box and call facility emergency #)

C Contain the fire (close all doors and windows)

E Extinguish the fire (if safe to do so), or Evacuate

TO EXTINGUISH THE FIRE WITH A PORTABLE FIRE EXTINGUISHER (PASS):

P Pull the pin

A Aim the nozzle at base of fire

S Squeeze the handle

S Sweep nozzle from side to side

EMPLOYEE RESPONSIBILITIES IN A SECONDARY FIRE AREA (CALM):

C Close all doors and windows

A Assure patients/visitors that situation is controlled

L Leave someone by the telephone

M Maintain normal operations

DO

- Stay between the fire and a path of safety
- Follow the RACE, CALM, and PASS procedures
- Ensure exit doors & stairwells are unobstructed
- Remove materials or equipment that may become corridor obstructions
- Prepare for possible patient evacuation orders if you are within the building of the fire alarm
- Notify the person in charge of the unit or Respiratory Care Supervisor (access through operator) immediately if oxygen shut off to the affected area is required

DO NOT

- **DO NOT** activate the fire alarm unless you actually see smoke or fire. If you smell smoke but do not see fire, call Facilities and Maintenance
- **DO NOT** call the emergency operator after the initial call, unless another fire has been discovered
- **DO NOT** unnecessarily alarm patients and visitors by shouting "Fire"
- **DO NOT** use elevators in the building with the fire
- **DO NOT** turn out corridor or room lights, as responding personnel will require lighting to find the fire site
- **DO NOT** disable fuses or circuit breakers
- **DO NOT** use the telephone unless it is imperative
- **DO NOT** allow re-entry to an area in which evacuation has been completed

Policy:

OUM Policy TJC.006: Fire Safety Management Plan
OUM Policy SS.036 Fire Prevention and Response

Medical Equipment
Any equipment on the premises of OU Medicine or any of its affiliated facilities shall be maintained in a safe and ready-to-use condition. Medical equipment used for diagnosis, treatment, and monitoring of patient care needs has a sticker with a Biomed inspection date. If inspection date is *past due,* contact Biomedical Engineering.

Lockout Tag-out
When any equipment or system is inoperable or taken out-of-service and whenever the unexpected start-up of this equipment could be harmful to personnel, the equipment, or the building; the equipment or system in question shall be tagged, DO NOT OPERATE, notifying personnel of this condition and locked closed if possible. The tag should also describe the nature of the problem requiring removal from service.

Policy:
OUM Policy TJC.007: Medical Equipment Management Plan
OUM Policy SS.028: Lockout/Tag-out

Oxygen Shutoff
The Respiratory Care Supervisor (access through operator) will determine the necessity to shut-off the oxygen flow to specific patient rooms/areas in the event of a fire and/or disaster.

The responsible staff include Facilities and Maintenance, Respiratory Care, and the areas affected by the shut-off. If the individual in charge is unable to perform the shut-off, he/she may direct another trained individual to do so.

Time permitting, patients requiring oxygen will receive an alternate supply of oxygen prior to the shut-off.

Policy: OUM Policy PLO.004: Oxygen Shutoff

Utility Systems

Failure of Electrical Service

The emergency generators should come on within 10 seconds. If this does not happen, contact the Facilities and Maintenance Dispatch at 1-4190 (Downtown) or 359-5554 (Edmond) as soon as possible.

Failure of Steam/Chilled Water

The Administrator-on-call will make arrangements for necessary services at the Downtown campus. At the Edmond Campus notify Maintenance at 359-5554

Failure of Water Distribution System

In case of a main line break, reserve water supplies will be distributed from an outside vendor and water rationing will be in effect. In case of outside water supply contamination, the communication office will notify all staff not to drink the water or flush toilets.

Emergency Loss of Communication

The primary means of communication between departments will be the Meditech system. The black emergency phone system will also be initiated. At the Edmond campus, hospital issued and personal cell phones will be used for external communication and 2 way radios will be issued for internal communication between departments.

Policy:

OUM Policy SS.021: Emergency Response, Internal

EMERGENCY MANAGEMENT (EM)

Emergency Preparedness Response Plan

Policies in the Emergency Preparedness Plan are in place to address the means and methods by which we will train, organize and respond to the community during a catastrophe.

Each OU Medicine campus facility maintains an addendum specifying the logistical details (i.e., patient treatment areas, location of triage area, location of Command Center, phone numbers, etc.) to implement this policy within their facility. An annual Hazard Vulnerability Analysis is performed to identify potential mass casualty incidents.

What to do when notified of a disaster?
Disasters can happen anywhere and anytime. A coordinated response from all team members across the enterprise will help contribute to the safety and care of employees and the larger community in a time of need.

If you are at work:

1. Stay calm.
2. Ensure your safety first. Refer to your OUM Badge Buddy for immediate actions to take if required.
3. Report immediately to the supervisor on duty to check in for further instructions.

If you are not at work:

1. Stay calm.
2. Begin making plans and arrangements to report to work if/when requested.
3. Be prepared to report your availability when called.
4. *Do not self-deploy to work.*

OU Medicine maintains plans and policies for disaster preparedness. You can learn more by reviewing the Emergency Management Plan (TJC.003) and the Emergency Operations Plan (TJC.004).

Evacuation

Evacuation of patients and staff may result from any of the following:

- Severe weather which renders the hospital unsafe
- Extended disruption of water, electricity, gas or other basic utilities
- Widespread and catastrophic illness, such as an infectious disease
- Chemical pollution/hazardous chemical spill
- Structural damage which renders a critical system unreliable or unusable

Partial Evacuation – Relocating from a dangerous area to a safe area within the facility; typically by moving from one smoke compartment to another.

Total Evacuation – Relocating all persons within the building to a safe area outside the facility; authorized by the facility Chief Executive Officer, or Fire Department Officials. This is used as a last resort.

Horizontal Evacuation – Lateral movement on the same floor; authorized by the person in charge of the area.

Vertical Evacuation – Downward movement away from danger and toward ground-level of the building; directed by Administrative Team, House Supervisor, or Fire Department.

Policy:

OUM Policy SS.020: Evacuation

Active Shooter/Hostage Situations (Code Silver)

Active Shooter

An "active shooter" is an individual or persons actively engaged in killing or attempting to kill people in a confined and populated area, usually with firearms, and there is no pattern or method to their selection of victims.

In the event of an active shooter:

Evacuate if there is an accessible escape path

- Leave your belongings behind
- Help others escape
- Keep your hands visible
- Do not attempt to move wounded
- Call **911** at Edmond or **1-4911** at OUM and TCH when safe

Hide out, if evacuation is not possible

- Be out of shooter's view
- Try not to leave yourself trapped or restrict options for movement
- Lock and block the door
- Silence your cell phone, remain quiet
- Turn off sources of noise, like TV/radio
- Hide behind large items

If evacuation and hiding are not possible

- Remain calm
- Call 911/14911 and if you cannot speak, leave line open and allow dispatcher to listen

As a last resort, take action against the shooter

- Act only when your life is in imminent danger
- Act as aggressively as possible
- Throw items, improvise weapons, yell

In the event of a hostage situation

- Notify the operator of the hostage situation

- Share location of the incident, number of hostages, number and description of hostage takers, and nature of incident at the time
- Institute partial or lateral evacuation from “danger zone”
- DO NOT try to be a “hero” or “take out” the hostage taker
- DO NOT give any drugs to the hostage taker, if this becomes a demand, only the Administrator on Call may authorize
- Wear your nametag in a highly visible location so that outside law enforcement can recognize you as staff

Hostages should adhere to the following guidelines

- Stay calm and avoid displays of emotion
- Do not speak unless spoken to
- Cooperate, but do not be helpful
- Never argue or make suggestions
- You do not have authority to grant demands
- Remain facing your captor
- Be observant
- Expect noise and lights during rescue attempt
- When rescue occurs, fall to the floor immediately and stay there

The operator will announce overhead a “Code Silver”. If you are outside of the hostage area

- Do not enter, call codes to, or send staff to the area until cleared by law enforcement
- Remain in your area, secure the area, close curtains
- Calm patients, visitors
- Area leader will take count of staff, patients, others, and any wounded and be prepared to report information to Incident Command Center

Policy:

OUM Policy SS.024: Active Shooter/Hostage

Bomb Threat

A bomb threat consists of a discovery of a suspicious object, written note, or a telephone call that a bomb has been placed somewhere within or outside of an OU Medicine facility or facility housing OU Medicine employees. It should be assumed that the person is making a serious threat to the life and safety of the inhabitants of OU Medicine.

Discovery of a bomb or suspicious package:

- Notify the departmental supervisor, who will in turn notify OUHSC Police or Edmond Security Services
- OUHSC Police/ Edmond Security will notify proper facility contacts and the OKC/ Edmond Police Bomb Squad, and will coordinate a search of facility

If a bomb threat is received via telephone:

- Remain calm and courteous
- Obtain as much information as possible from the caller by prolonging the conversation
- Complete the telephone bomb checklist, located in *OUM Policy SS.007: Bomb Threat,* while the conversation is in progress, or immediately following, and notify the department director/supervisor, who will in turn notify the OUHSC Police Services/Edmond Security
- DO NOT alarm patients, visitors or staff members
- DO NOT discuss details of the conversation with anyone except personnel from the OUHSC Police or Edmond Security Services, Risk Management representative, or Administrator

If a bomb threat is received via a letter or note:

- Immediately notify your departmental supervisor, who will notify OUHSC Police or Edmond Security Services
- DO NOT handle the letter or note any more than is necessary so evidence is not destroyed
- Remain calm and do not alarm patients, visitors, or staff members

- DO NOT discuss details of the letter or note with anyone except personnel from OUHSC Police or Edmond Security Services, Risk Management representative, or Administrator

Discovery of a suspicious device or article:

- DO NOT touch or move the device or article
- Notify the departmental supervisor, who will in turn notify OUHSC Police or Edmond Security Services
- The highest-ranking OUHSC Police Supervisor / Edmond Security Officer, with assistance from appropriate personnel, will coordinate evacuation of all persons from the building upon instruction from the OKC / Edmond Police Bomb Squad
- Ensure that all windows and doors leading to the discovery area remain open at all time
- Staff personnel in charge of the discovery area will notify patients, staff and visitors that a suspicious object is being investigated and remain calm and reassuring

Policy: OUM Policy SS.007: Bomb Threat

Duress Alarms

Duress alarms are in place throughout OU Medicine to ensure timely reporting and prompt response in case of emergent safety and security incidents, including aggressive or suspicious behavior.

How do duress alarms work?

- Duress alarms quickly notify OUPD/Security that help is needed. Alarms are commonly located under the desk at nurses' stations. When the alarm is activated, it provides a specific location to the responder
- Duress alarms are tested by the units to ensure functionality and to help staff become familiar with the procedure and use of the alarms

Who can I contact with questions? Contact the Safety Hotline at 271-3731 (Downtown) or the Director of Facilities Management Operations at 359-5590 (Edmond).

Person Down

If a visitor or staff member requiring or requesting immediate medical attention due to sudden illness or injury, the following steps should be taken:

- If you discover a "Person Down", immediately call OUHSC Police at **1-1911** or Edmond campus operator at "**444**".
- If the person "down" is unresponsive, activate a Code Blue by calling **1-1911** Downtown or "**444**" at Edmond.
- Be ready to convey exact location, nature and apparent severity of injury/illness, if any, potentially hazardous situations, the individual's age and status.

Policy:

OUM Policy PC.038: Person Down

Infant or Child Abduction (CODE PINK)

If an infant or child is missing or abducted, notify the hospital operator immediately at 1-1911(Downtown campus) or 444 (Edmond campus). A "Code Pink" will be announced overhead.

Actions to be taken include:

- Immediately check all adjacent stairwells and exits when a "Code Pink" is announced
- Remain on your unit and assist with the search or go to your assigned monitoring station
- Question any person with a large bag, purse, coat, jacket, etc. using the following phrase: "We are involved in a Code Pink. May I see into your bag?"
- If the person declines the search or exhibits suspicious behavior, DO NOT DETAIN him/her. Call OUHSC Police Services (1-4911)/Edmond Security at 444. Be prepared to give a detailed description

Policy:

OUM Policy SS.006: Infant/Pediatric Abduction

Severe Weather (CODE BLACK)

What is it?
The National Weather Service has issued a **Tornado Warning** for our area. A Tornado Warning indicates a tornado is in close proximity to the facility.

What will be announced?
"A Code Black has been issued. Initiate severe weather preparations at this time."

How should I respond?
- Seek shelter inside corridor rooms, stairwells, or basement areas away from outside windows
- Ensure that all patients/families/visitor have shoes on or protective foot covering readily available
- Protect patients who cannot be moved away from outside windows with extra blankets and pillows, or other rational means
- Stay sheltered until "ALL CLEAR" is announced

Policy:
OUM Policy SS.022: Severe Weather

Cardiac/Respiratory Arrest (CODE BLUE)
- Upon discovery of an individual in cardiopulmonary arrest, staff will initiate CPR, initiate AED if that capability is available and activate "Code Blue"/Emergency Medical Services
- Emergency intervention will be initiated in the event of any life-threatening situation. Basic Cardiac Life Support/Advanced Cardiac Life Support / Pediatric Advanced Life Support guidelines will be used to meet the patient's needs

Policy:
OUM Policy PC.011: Emergency Response & Resuscitation

Hazardous Exposure Requiring Decontamination (CODE ORANGE)

What is a Code Orange?
A hazardous exposure to a person, object, or location, which requires decontamination.

What will be announced? "Code **Orange**:
All available personnel please report to their assigned areas"

How should I respond?
Report to your unit and stay on your unit until "ALL CLEAR" is announced unless otherwise directed. Contaminated victims **will not be allowed to** enter an OUM facility until decontamination has been accomplished.

Precautions to minimize exposure: Management of spills

- Always have a spill kit available. Your manager or director can order them
- If there is a body fluid spill, isolate it and prevent others from contacting it
- For spills larger than 5cc, you will need to use a spill kit and report to your supervisor immediately

What kind of PPE should I use for hazardous material?

- Gloves – powder free latex or nitrile gloves; double gloving recommended if does not interfere with technique
- Gowns – lint free, low permeability fabric with a solid front, long sleeves, and tight fitting elastic or knit cuffs
- Facemasks/shields/goggles – use what is standard issue for your unit
- Contaminated PPE should be disposed of in a YELLOW 'chemo' bucket, not the regular trash. The bucket must:
    - Be puncture proof
    - Have a lid that seals securely and remains closed
    - Be labeled with appropriate warning

- Linens exposed to hazardous drug or body fluids should go in YELLOW linen bag

External/Mass Casualty Disaster (CODE YELLOW)

What is it?
A mass casualty incident or any situation in which the number of casualties is greater than the Emergency Department can handle.

What will be announced?
"Code Yellow: All available personnel please report to their assigned areas"

How should I respond?
Report to your unit and stay on your unit until "ALL CLEAR" is announced unless otherwise directed.

If an event in the community has occurred with reasonable potential that an External Disaster may need to be declared, OU Medicine is placed on alert and HICS (Hospital Incident Command System) may be activated accordingly.

Hospital Administration will activate the HAZMAT team, Trauma Team, HICS, satellite command center, and any other additional resources needed.

The Downtown campus **Command Center** will be located in the OUMC Tower. The Edmond campus command center will be located in the Boardroom. Remaining towers will either have a command post or will serve as an alternate Command Center location. The command centers will control operations and distribution of resources for that facility.

If necessary, the **External Command Center** will be located in the OU Physicians Building.
Base stations for campus-wide radio communication will be set up in the Central Command Center, each Satellite Command Center, and each Emergency Department.

Preparation and Follow Up:
To help prepare for emergent situations, drills will be held two times per year and may be coordinated with scheduled citywide drills. The drills will be designed to test the entire OUM campus and its ability to mobilize resources and conduct an appropriate response.

Following the termination of each disaster or disaster drill, the Emergency Preparedness Sub-Committee will meet to evaluate each phase of the hospital response.

Patient and Employee Processes:
How will patients enter & flow through the facility?
Patients will be triaged from the Emergency Department according to severity of their injuries and treatment needed. If the disaster involves biological, chemical or nuclear decontamination, patients will be directed to the decontamination site.

Patients requiring decontamination WILL NOT be allowed to enter an OU Medicine facility until decontamination has been accomplished. Decedents will be decontaminated prior to being transported to a morgue.

An Administrator/designee will be assigned to each treatment area to facilitate communication, coordinate support, and relay requests/ information via radio from the area to the Command Center.

The Charge Nurse or physician will determine bed availability and determine patient priority list for discharge/transfer if needed. This will be communicated to the Command Center.
Admitting will issue patients a disaster number used to identify the patient throughout their stay. Information will be provided to the Command Center as to the whereabouts of a specific patient.

Each patient treatment area will maintain a record of patients in and out of that area, identifying patient tracking numbers and time of arrival/ departure.

Where will employees report during a disaster?
Most staff, including clinical staff, will stay on their unit or in their work area until requested by the Command Center to report to a different area.

Specific duties during the disaster will be divided among OUM personnel based on the HICS model.

Policy: OUM TJC.004: Emergency Operations Plan

Surge Capacity

In the event of a flu pandemic, large-scale disaster, or emergency, it may be necessary to adjust current standards of practice to ensure that the care provided results in as many lives being saved as possible.

Because the specifics of any given situation cannot be fully anticipated and the scope of unexpected events may vary widely, OUM will follow the established Emergency Preparedness Response Plan.

The goal of this plan is to ensure the allocation of scarce resources in a fair and clinically sound manner to save as many lives as possible. Standards of care traditionally dictate not only the care provided, but also who can provide care, to whom, when and where. Should events occur, that require a deviation from normal standards or providers of care, the *Education Department* will provide training as required.

Policy:
OUM Policy SS.023: Surge Capacity Plan

Disruptive Person (CODE PURPLE)

Patients:

If an agitated patient's acting out behavior becomes unmanageable by staff in a particular working area, assistance will be provided by support personnel to reduce any threat to personal safety of the patient or others.

- **OKC Campus: dial 1-1911 to notify OUHSC Police**
- **Edmond Campus: dial 444 for Security**
- Staff trained in Non-violent Crisis Intervention and security personnel should also respond

At the Edmond campus, the person calling the Code Purple will assume the role of code coordinator and assign roles/delegate as needed. At the OKC campus, OUHSC Police will assume this responsibility upon arrival.

Visitors:

Visitors displaying aggressive or threatening behavior will be given the opportunity to vent their concerns in a controlled manner. When the behaviors become uncontrolled, the visitor will be asked to leave the premises. If the visitor is unable to comply with the request, the OUHSC Police/Edmond Security will escort the visitor off the premises. Staff will not attempt to physically manage any visitor unless necessary for self-defense or protection of a defenseless patient.

Policy:

OUM Policy SS.011: Code Purple - Disruptive Person

HUMAN RESOURCES (HR)

One important role of the Human Resources Department is to ensure that we have an adequate number of competent staff available at all times. Through development of clear, accurate job descriptions, recruitment and hiring, credential reviews, employee health services, orientation and on-going training, and provision of resources, we work to support the goals of OUM and its employees.

Understand Roles and Scope of Practice

You should be familiar with your job description and review it with your supervisor or manager. Job descriptions help us understand the role and scope of practice for each employee. Understanding roles are important in determining safe delegation of duties.

Ensuring a Competent Workforce

On hiring – A review of the applicants experience, education, training and certifications are done to ensure the applicant meets requirements.

During orientation – Employees are provided with training and education as required for their position. Employees are provided general and departmental orientation specific to their job. This orientation includes OUM Policies and Procedures, Hospital Mission, Vision and Values, Ethics and Compliance, Infection Control, Patient Safety, and other important items.

Initial Competency Verification – Prior to functioning independently, new employees are monitored to verify they demonstrate job specific competencies required for their position. Job specific competencies include hand hygiene and environment of care. Clinical staff job specific competencies may include restraints, medication administration, and Waived testing.

On-going Competency Verification – To ensure that staff maintain their level of competency, on-going education is provided. A variety of formats are used for training, including live courses, poster presentations, computer learning modules, and in-services at staff meetings. Periodically staff are expected to demonstrate competencies for certain high-risk, low volume of problem prone tasks.

Promotions, Transfers, or Floating – Training is provided and competencies are assessed when staff members are promoted, transferred, float to another unit, or any time when job duties change.

Population-Specific Competencies - It is important that our patients and families receive care that is appropriate to their individual situations. We provide care that is population appropriate. Specific population may be determined based on age, ethnicity, religion, or disease process. When competencies are verified we assess to determine that care givers can adjust their care to meet the specific needs of the population they are serving.

Population Specific Resources:

- **Age** – Policies and Procedures, Standards of Care, and Practice Guidelines address age-specific considerations.
- **Culture, Religion, and Ethnicity** – A link to a resource is available on the intranet, under Medical Reference – Culturally Appropriate Care, that will assist in providing care specific to religious, ethnic or cultural considerations.

Staffing

Staffing plans are in place for every department. Leaders work to ensure the appropriate amount of staff with the proper training and credentials are available at all times. Staffing levels are reviewed for appropriateness on an on-going basis. This includes:

- Workload, or number of patients
- Complexity of the work, or acuity of patients
- Number of staff members present
- Licensure, certification, and competency of staff

Other Individuals in the Facility

At times, other individuals may provide services with OUM. For these individuals, a review of credentials, training, and competencies is completed.

- **Volunteers:** Coordinated through Volunteer Services
- **Contract Staff:** Coordinated through Human Resources
- **Health Care Industry Representatives (HCIRS)/Vendors** – Coordinated through Materials Management. The HCIR will wear a facility-issued, dated identification label during their visit to any area within the hospital, including but not limited to patient care areas. HCIRs must check in and out for EACH visit to the facility using the Kiosks which are open 24/7
- **Students** – Coordinated through Human Resources

ID Badges & Access Cards

All individuals providing service within OU Medicine are required to wear a photo ID, displayed above the waist, at all times when on OUM campus. Only hospital issued stickers or any other objects may be placed on the badge, lanyards or badge holders. Holes may not be placed in the badge. All staff and contract staff are responsible for ensuring other do not "draft" entrance into a secure area when opening doors with badge access.

To receive an access card or replace a lost or stolen card, contact Human Resources at hr@OUMedicine.com.
Physician ID badges are issued through the OU Health Sciences Center at the Downtown campus and the Human Resources Department on the Edmond campus.

For medical staff, access cards must be utilized on primary doors into the hospital between the hours of 9:00 pm and 6:00 am. Anyone utilizing an access card is required to carry a valid photo ID. The access cards are the property of OUM, are non-transferable and may not be shared with another person. Access cards are not an acceptable form of identification. To receive an

access card or replace a lost or stolen card, contact Medical Staff/Credentialing Services.
Policy: OUM Policy HR.013: Identification Name Badges

Controlled Substances in the Workplace

Controlled Substance: Any drug or chemical substance whose possession and use are regulated under the Controlled Substances Act.
Illegal Substance: Any drug the possession or sale of which violates federal law (in the U.S.) or the county, state or local law of the jurisdiction in which the facility is located.
Impairment: Practitioner impairment occurs when a substance-related disorder interferes with his or her ability to engage in professional activities competently and safely.

Employee Responsibilities

Employees have a duty to report to his/her supervisor:

- Your own use of prescription or over-the-counter medications that could impair your ability to perform your job
- Any reasonable suspicions of a coworker, contractor or student who may be in violation of the Substance in the Workplace policy
- Cooperate fully with investigations of violations
- Safeguard controlled substances from unauthorized access

Remember:

- Reasonable suspicion of impairment regarding an employee, contractors or student can result in a for-cause drug screen
- Searches may be conducted as part of the investigation process

The Employee Assistance Program (EAP)
is available to all employees
1-800-327-1393

Policy:
OUM Policy HR.069: Controlled Substances in the Workplace

INFECTION CONTROL AND PREVENTION (IC)

Hand Hygiene and Splash Protection

- Hand Hygiene is the single most important procedure to prevent the spread of infections
- In accordance with recommendations from the Centers for Disease Control, OUM advocates the use of alcohol-based hand sanitizer for routine cleaning of hands when not visibly soiled
- Hand washing with soap and water is recommended when hands are visibly soiled, dirty or contaminated, when caring for patients with C. difficile, before eating and after using the restroom. Effective hand washing involves washing with soap and water for **at least 15 seconds**. The friction from rubbing the hands together is a critical component of effective hand washing. Perform the Seven Steps: Palms, Figures laced, Figures stacked, fingers linked, Thumbs, Tips, Wrists.
- Wearing gloves is not a substitute for hand washing
- Gloves should be changed between patients and changed frequently while caring for patients
- When there is a potential for eye, nose, or mouth contamination (such as when inserting, removing, emptying or otherwise manipulating any type of invasive tube such as IV, endotracheal tubes, nasogastric tubes, feeding tubes, catheters and drains) wear the appropriate PPE, including splash protection
- Appropriate isolation measures should be taken for all patients with infectious conditions
- Artificial nails are not to be worn by direct care providers. Artificial is defined as anything other than plain nail polish. Nails are to be kept no longer than 1/4 inch in length from end of finger to tip of nail. Nail polish should be in good condition, not chipped or peeling

Standard Precautions

To be used in ALL patient care

- Wear gloves when likely to touch body fluids or mucous membranes
- Wear gown when clothing is likely to be soiled
- Wear mask/eye protection when starting, discontinuing, or manipulating invasive devices such as IV catheters, NG tubes, Foley catheters, drains, etc.
- Place soiled linen in plastic laundry bag
- Dispose of needles, syringes, and sharps in appropriate containers. **DO NOT RECAP NEEDLES**
- Safety products, when available, must be utilized

Isolation Precautions

In addition to Standard Precautions, the following Transmission-Based Precautions are utilized:

Airborne-- known or suspected infection with microorganisms transmitted by airborne droplet nuclei; requires private room, negative airflow, and respiratory protection (N-95).

Droplet-- known or suspected infection with microorganisms transmitted by droplets during coughing, sneezing or during certain procedures.

Contact-- known or suspected infection or colonization with epidemiologically important microorganisms (i.e., MRSA/VRE/*C. difficile*/other MDRO's) transmitted by direct or indirect contact with patient, environmental surfaces or patient care items.

Protective-- for immunocompromised patients at increased risk for bacterial, fungal, parasitic and viral infections from endogenous and exogenous sources. These patients require private rooms and positive airflow.

Policy:

OUM Policy IPIC.023: Isolation Precautions
OUM Policy TJC.011: Infection Control Plan

Blood-Borne Pathogens

Blood-borne pathogens are organisms that can be passed from person to person in body fluids and tissues. Blood, body fluids containing visible blood, vaginal secretions, semen, and open wound drainage are potential sources.

- Examples include HIV and Hepatitis B and C
- Personal protective equipment, such as gowns, gloves, masks and eye protection are provided. It is the responsibility of the health care provider to utilize this equipment
- Dispose of infectious waste in appropriate infectious waste container (small red bag, sharps container or large biohazard container)
- Use available sharps safety devices and needleless systems to minimize exposure

Policy:

OUM Policy IPIC.026: Mngt of Exposure to Blood and Body Fluids
OUM Employees Print/Complete "Exposure Management of OUM Employees form from Intranet".

Tuberculosis (TB)

Those interacting with known or suspected TB patients must wear appropriate protective devices.

OUM employees are tested annually for latent TB infections by a Mantoux tb skin test. Health care providers identified to be at risk for exposure complete mandatory fit testing of approved respiratory devices for prevention of exposure to tuberculosis. A patient who has AFB sputum smears ordered will be placed in airborne infection isolation precautions until three smears are obtained and reported as negative. Pediatric patients may have 3 AFB gastric aspirates ordered in place of sputum, and would also require airborne infection isolation.

Policy:

OUM Policy IPIC.021: Tuberculosis (TB) Control Program
OUM Policy IPIC.022: Respiratory Protection For Tuberculosis (Fit Testing)

MRSA

MRSA impacts costs by prolonging hospital and critical care stays with complications. Eliminating MRSA transmission is as simple as **ABCD:**

***A**ctive Surveillance Cultures:*

Obtained on targeted high-risk patient groups, patients admitted/transferred from any outside healthcare facility or nursing home, all out-born neonates, or transfers to the NICU previous positive history (>6 months), pre-op CABG, valve, or any open heart procedure, total knee/hip, spinal surgery, hemodialysis/peritoneal dialysis, bone marrow/stem cell transplant patient admitted to the transplant unit. Adult ICUs follow the Universal Decolonization Protocol.

***B**arrier Precautions*

Patients with MRSA are placed on Contact Precautions.
In addition to standard precautions:

- Wear clean non sterile gloves and gown when entering the room to avoid contamination by contact with the patient or room surfaces.
- Limit movement and transport of the patient from the room to essential purposes only.
- Use dedicated patient-care equipment.
- Ask visitors to wear a gown when entering the room and remove before leaving.

***C**ompulsive Hand Hygiene*

- Perform hand hygiene before and after contact with the patient and the environment.
- Wear gloves for all contact with blood, body fluids and moist body surfaces. Change gloves when moving from dirty to clean site on the same patient.

- Ask visitors to wash or use an alcohol-based hand rub on entering and exiting the room.

D*econtamination of Environment and Equipment*

- MRSA can survive on surfaces (plastic chart, laminated tabletop, cloth curtain, etc.) for 9-11 days.
- Patients on Contact Precautions should have equipment solely for them and decontaminated before leaving the room at discharge.
- Daily cleaning of patient rooms by environmental services staff is essential.

Needle Sticks

- 16% occurred because patient moved.
- 70% occurred after use and before disposal-while activating Safety Device, or did not activate Safety Device, cleaning up after procedure, recapping, or not paying attention.

Actions to reduce exposures

- Reviewing monthly exposure information to include DOH – elevate training during New Employee Orientation.
- Reinforce activating safety device in vein, or as soon as SQ injection needle removed from patient.
- Reinforce emptying sharps containers when ¾ full.
- Reinforce NOT recapping needles, or if no other option, use one handed "scoop" method.

AIM for ZERO

The Aim for Zero program assists in meeting our goals for reducing or eliminating HAI's. Part of this program is the use of **bundles of evidenced–based prevention measures utilized on all patients at risk for HAIs.**

The CDC estimates ***30,100 Central line-associated bloodstream infections (CLABSI's)*** will occur in U.S. hospitals annually.

Evidence-based practices that are a part of the bundle for reducing CLABSI's are:

- Performing proper hand-hygiene
- Draping the patient using aseptic technique with full body drape
- Using 2% CHG plus alcohol for skin antisepsis
- Wearing maximum barriers during the insertion, to include sterile gloves, impervious gown, cap, and a mask with eye protection
- Using sterile technique when applying a CHG antimicrobial patch or dressing to the insertion site post-procedure
- Verifying that all team members participating in the catheter insertion procedure follow aseptic technique and evidence-based safety precautions

Cather-Associated Urinary Tract Infections (CAUTIs) are the second most common type of healthcare-associated infection in the U.S., accounting for more ***than 15% of all infections*** reported by acute care hospitals and, each year, more than ***13,000 deaths*** are associated with UTIs.

Evidence-based practices that are part of the bundle for reducing CAUTIs are:

- Perform proper hand hygiene
- Use urinary catheters only when necessary. Consider other methods of urinary drainage (e.g. condom catheters, intermittent catheterization, and use of bladder scanners)
- Aseptic insertion of a closed unobstructed drainage system kept below the level of the bladder at all times; secure catheter to prevent movement and urethral traction
- Discuss number of catheter days during handover as a reminder to reduce duration

INFORMATION MANAGEMENT (IM)

Information Security

- Treat all information as if it were your own
- Access only systems you are authorized to access
- Access only information you need to do your job
- Only share sensitive and confidential information with those who also have a "need to know", and follow OU Medicine policies for how to handle and send sensitive information
- Report all incidents to your Director, the Facility Information Security Officer, or the Facility Privacy Officer
- Use strong passwords and never share your password with anyone
- Log off or lock workstations when you leave them unattended
- Become familiar with the OUM Information Security polices located on the Intranet

Meditech is our Electronic Medical Record System. It allows us to see and document patient charts.

- You are allowed to use only your own ID and password. It is against policy to share your password
- Your access to Meditech is based on your "need to know" and required functions specific to your job
- You may have access to some systems your co-workers do not. DO NOT share your password or allow them to view your screens
- Meditech contains confidential information. You are ONLY allowed to share this information with others who have a "need to know" for their job
- ***It is against hospital policy to access your own Medical Record in Meditech.*** The proper method for obtaining it is to fill out a "Release of Information" form in the Medical Records Department.

Help Desk, 271-8660; Hours: 24/7

After Hours – IT personnel on-call for on-site emergent support

HIPAA: Health Insurance Portability and Accountability Act

OU Medicine is required by federal law to maintain the privacy of our patient's health information and to provide patients with a description of our privacy practices.

HIPAA is designed to control access to and disclosure of **Protected Health Information (PHI).** Health information that can identify or be linked to an individual is PHI. Identifiable information may contain, but is not limited to:

- Name
- Address including street, city, county, zip code
- Names of relatives and/or employers
- Birth date
- Telephone and/or fax numbers
- Electronic e-mail addresses
- Social Security Number
- Medical record or health plan beneficiary number
- Account number or certificate/license number
- Any vehicle or other device serial number
- Web Universal Resource Locator (URL)
- Internet Protocol (IP) address number
- Finger or voiceprints
- Photographic images
- Any other unique number, characteristic, or code

Notice of Privacy Practices brochures will be given to patients at each visit. Patients sign a form confirming receipt of the notice.

Treatment, Payment and Health Care Operations - OU Medicine may use medical information to provide treatment or services and may disclose information to doctors, nurses, technicians, medical students, or other practice personnel involved in the patient's care and have a "need to know" to perform their job. OU Medicine may also provide a partner physician a copy of various reports for the purpose of peer review, plan of treatment

consultation, and/or to substitute care in the physician's absence. Members of the medical staff and/or quality improvement team may use information in a patient's health record to assess the care and outcomes of the case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. Wherever possible, identifying information will be removed to protect patient privacy.

Need to Know - Any member of the workforce with a legitimate need to know to perform their job responsibilities may access a patient's health information. However, the amount of information accessed should be limited to the minimum amount necessary to perform their job responsibilities.

Telephone Inquiries - Patient information can be released in two ways. If the caller has a patient's full name (first and last), and the patient is not confidential, the hospital can provide the location of the patient and one word description of the patient's condition; "good", "fair", "serious" or "critical".
If a patient is designated as confidential, the patient and the fact of his/her admission shall be treated as confidential information and will not be confirmed or denied. Personnel may state "I am sorry; we do not have any information on an individual under that name". All flowers, gifts, and mail shall be rejected.

Electronic Communication of PHI

- When faxing - use pre-programmed numbers if possible, verify the identity of the fax recipient and the fax number, and always use a cover sheet
- When emailing PHI or confidential information – use encryption. Internal OU Medicine email is automatically encrypted, for email addressed outside OU Medicine place [encrypt] in the subject line, verify the identity and email address of recipient. Never use PHI in the subject line of an email

Physical Workspace & Information Security

- Computer screens should be positioned so PHI is not readable by the public or other unauthorized viewers
- Printers should be positioned in protected locations so that printed information is not accessible or viewable by an unauthorized person
- Patient information **should not** be communicated via cell phone, email, or by texting unless the information is encrypted
- Text messages sent to pagers from any internet-based system (such as Metro-Call or Smart Web) are not secure. PHI should not be texted to pagers or through secure texting.
- Report any suspected violations to your Director, Facility Information Security Officer, or Facility Privacy Official
- Never download and install unauthorized software onto hospital computers
- Never open emails or attachments to emails from unreliable sources
- Be cognizant of email phishing attempts, never release personal information if requested by email, don't open emails from unreliable sources, and never click on embedded links in emails unless you know the source

Visitors to Patient Care Areas

Ensure that visitors, including vendors, suppliers, and our own friends and family, do not access areas where protected patient health information is visible or enter areas where patient information is displayed, such as work stations where computer screens are visible and meeting rooms where patient information is displayed.

Visitors in Patient Rooms

The assumption should not be made that the patient has agreed to have PHI shared in front of family or visitors, even if the patient did not ask them to leave the room. Family, friends, and visitors,

must have the patient's password to receive PHI relevant to their involvement in the patient's care.

Policies:

OUM Policy PHI.023: Pt. Privacy - Sanctions for Privacy & Info Security Violations

OUM Policy PHI.028: Pt. Privacy - Uses Verification of External Requestors

OUM Policy PHI.026: Pt. Privacy - Uses and Disclosures of PHI for Involvement in Patient's Care & Notification

Photographing/Videotaping

Photographing patients or patient test results with any device is prohibited and considered a violation of HIPAA. OUM asserts the following guidelines:

1. Photographs/videotapes may be taken for educational or informational purposes with the consent of the patient and/or visitor. Consent must be obtained even if the picture does not depict the face or other identifiable image.
2. These photographs/videotapes will not be duplicated or publicized without the appropriate consent from the patient/visitor.
3. If commercial use is intended, Marketing & Communications will obtain written consent from patient or physician.
4. Consent to photograph/videotape the patient must include a properly completed Authorization for Release of Protected Health Information form.
5. Patients/visitors have the right to request cessation of recording or filming.
6. Patients/visitors have the right to rescind consent before the recording or film is used.
7. Photographs taken for personal use or with personal devices are prohibited.
8. The use of "wearable" technology (GoPro, Google Glasses) is prohibited.

Please note: Displaying and/or distributing images of patients without approval is not permitted. This includes images taken by others and images on non-OUM computers. Demonstrating respect and confidentiality of all patient information and images is expected of all employees at all times.

Policy: OUM Policy PHI.031: Pt. Privacy - Photographing, Video Monitoring/Recording, Audio Monitoring/Recording, and/or Other Imaging Policy

Media Contact/Press Release

Only the Marketing & Communications Department or the Clinical Coordinators are authorized to respond to media inquiries.

All employees should direct questions from the media concerning any patient's condition to the on-call Marketing & Communications representative at 271-7900 for the Downtown campus and 359-5580 on the Edmond campus. After hours and holidays inquiries should be referred to the Clinical Coordinator via the Hospital Operator. Recognize the confidential nature of all matters pertaining to the condition or care of patients and discuss such matters only with authorized persons.

Inquiries regarding past or current employees should be referred to the Human Resource Department.

Policy:
OUM Policy MKTG.001: Media Contact/Press Release

Vendors (HCIRs)

- Vendors must check in and out for EACH visit
- Staff must verify the appropriate vendor badge is at least chest high **before** entering their hospital area
- Vendors who do not have the appropriate **dated** badge should be directed to the Materials Management Department to complete necessary paperwork for access.

Social Media Guidelines

General Provisions

Unless specifically authorized, employees are restricted from speaking on behalf of OUM. Employees may not publicly discuss patients, employees, or other stakeholders outside of Company-authorized communications. Employees are expected to protect the privacy of OU Medicine, its patients, employees and other stakeholders and are prohibited from disclosing patient information, personal employee and nonemployee information and any other proprietary or confidential information to which they have access.

Monitoring

Employees are reminded that they should have no expectation of privacy while posting information to social networking sites. Postings often can be reviewed by anyone. As described in Policy EC.026, OUM reserves the right to use content management tools to monitor comments or discussions about the Company, its employees, its patients and the industry posted on the Internet.

Reporting Violations

OUM strongly urges employees to report any violations or possible or perceived violations to supervisors, managers or the HR department, to the Facility Privacy Official (if patient information is involved) or to the Ethics Line (800-455-1996).

Consequences

OUM investigates and responds to reports of violations of EC.008 these Social Media Guidelines and other related policies. Violations may result in disciplinary action up to and including termination.

Personal Use of Social Media

OUM respects the right of employees to participate in blogs and use social networking sites during non-working hours and does not discourage self-publishing or self-expression. Employees are

expected to follow these guidelines and policies to provide a clear distinction between you as an individual and you as an employee.

- *Personal Responsibility*. You are personally responsible for your commentary on social media. You can be held personally liable for commentary that is considered defamatory, obscene, proprietary or libelous by any offended party.
- *Non-threatening*. Employees should not use blogs or social networking sites to harass, threaten, discriminate or disparage employees or anyone associated with or doing business with OUM.
- *Disclaimer*. When you identify yourself as an employee of OUM or an affiliate, some readers may view you as a spokesperson for OUM and/or that affiliate. Because of this possibility, you must state that the views expressed by you through social media are your own and not those of the Company, nor of any person or organization affiliated or doing business with OUM and/or an affiliate.
- *Privileged or Confidential Information*. Employees cannot post on personal blogs or other sites the name, trademark or logo of OUM its affiliates, or any business with a connection to OUM or its affiliates. Employees cannot post Company-privileged or confidential information, including copyrighted information, Company-issued documents, or patient protected health information.
- *Workplace Images*. Employees must follow OUM Policy PHI.031: Pt. Privacy - Photographing, Video Monitoring/Recording, Audio Monitoring/Recording, and/or Other Imaging Policy.
- *Advertising*. Except as authorized or requested by OUM or an affiliate, employees may not post on personal blogs and social networking sites any advertisements or photographs of Company products, nor sell Company products and services.
- *Patient Information*. Do not use your personal social media account to discuss or communicate patient information with

one of your patients, even if the patient initiated the contact or communication. Always use Company-approved communication methods when communicating with patients about their health or treatment.

- If you have any questions relating to these guidelines, a personal blog or social networking, ask your supervisor, another member of management, Human Resources, Marketing Director, Ethics and Compliance Officer, Facility Privacy Office or Facility Information Security Officer.

MEDICATION MANAGEMENT (MM)

Do Not Use Abbreviations

- Be familiar with the list of prohibited abbreviations and how to access it for review.
- Use only approved abbreviations.
- Stedman's Abbreviation Books are available for reference.
- If an unapproved abbreviation is used in an order, contact the physician for clarification.
- Ensure preprinted orders use proper abbreviations.

⇒ **Never use** "u" or "U" for "units"-May look like "0", "4", or "cc"

⇒ **Never use** "IU" for "International Unit"-May look like "IV" or "10"

⇒ **Never** abbreviate drug names

⇒ **Never use** "MS", MSO4" or "MgSO4"-Spell out "morphine sulfate" or "magnesium sulfate"- Abbreviations may be confused

⇒ **Never use** "QD"/"qd" for daily or "QOD"/"qod" for every other day

⇒ **Never use** a trailing zero (X.0 mg) or leave off a leading zero (.X mg) - The decimal point is often missed

Policy: OUM Policy HIM.001: Approved and Prohibited Abbreviations

Medication Administration

1. Call and question orders that are not readable
2. Use proper hand hygiene
3. Use two patient identifiers (name, birth date, or med. record number) prior to giving medication
4. Prior to administration, scan the patient's armband and medication
5. Educate the patient about the medication

Adverse Drug Reactions (ADR)

- Call the pharmacy or **ADR Hotline – 1-8186 (Downtown) or 6308 (Edmond)**
- Provide patient's name, medical record number, suspected drugs, description of reaction, treatment
- File an event in RL Solutions and update patient's profile

Medication Security

Medications should be stored behind a locked door or in an area where unauthorized individuals do not have access. Access to these areas is restricted to ONLY those employees who need to access them in order to perform their routine job duties.

When job duties require that you access these areas, it is important that you ensure the security of medications by:

- **NEVER** leave area unlocked if unattended
- **NEVER** share the door combination to medications rooms with other staff
- **NEVER** allow individuals to access these areas unless they are authorized to be there

Medication Storage

- Mark multi-dose vials with new expiration date once opened and discard within appropriate timeframe
- Document Pyxis discrepancies
- Assure med refrigerator daily temperature log is complete with actions noted
- No expired meds
- No food, specimens, or supplies stored with meds

Look Alike / Sound Alike Medications

- Know which meds are easily confused with each other and should be stored away from one another
- "Look-Alike/Sound-Alike" posters are placed in medication rooms for quick review
- Contact Pharmacy for questions about med orders

High Alert Medications

High-alert medications are defined medications which are involved in a **high percentage of errors and/or sentinel events,** as well as medications that carry a **higher risk for abuse** or other adverse outcomes.

Processes ensuring the **safe** selection/procurement, storage, ordering/transcribing, preparation/dispensing, administering and/or monitoring of high-alert medications within OUM are in place at all times.

Crash Carts

- Lock is in place and the lock number is accurately recorded on the log
- Daily log is complete and accurate
- Oxygen equipment is available
- Defibrillator is plugged in & checked appropriately
- Emergency meds are secured in crash cart or "emergency med" tackle box with break-away lock

Definition of a Medication

- Traditional prescription/over the counter medications
- IV solutions
- Oral and IV Contrast Media
- Medical kits containing medication components
- Vaccines, Herbal Remedies, Vitamins
- Any product designated by the FDA as a drug

MEDICAL STAFF (MS)

Medical Staff/Credentialing

The Executive Chief of Staff and the Medical Staff Services/ Credentialing Department establish a master file of practitioners and their privileges.

Practitioner privileges can be accessed by the nursing staff in the I-Priv Systems.

If you have questions regarding a practitioner's medical staff membership and privileges, contact Medical Staff/Credentialing Services at 271-3741.

Impaired and/or Disruptive Practitioner

OU Medicine will provide assistance to practitioners seeking self-referral, identify impaired practitioners, investigate reports of suspected impairment, refer practitioners for diagnosis, treatment and rehabilitation when warranted, investigate reports of uncooperative and disruptive behavior, track and monitor disruptive incidents, and educate practitioners on the prevention of impairment and disruptive behavior.

Impairment includes any physical, psychiatric, emotional or behavioral disorder that interferes with the practitioner's ability to engage safely in professional activities.

Disruptive Behavior interferes with the regular operations of the hospital. It may consist of one incident, a series of incidents or a pattern of behavior.

Examples include, but are not limited to:

- Physical attacks on patients, visitors, employees or other practitioners
- Inappropriate physical contact which is threatening, intimidating or unwanted
- Verbal attacks on patients, visitors, employees or other practitioners, including non-constructive criticism which intimidates, demeans, undermines confidence or belittles
- Use of profanity, gestures, or language with inappropriate overtones
- Refusal to provide care to certain patients or to accept assignments or responsibilities when under an obligation to do so
- Impertinent or inappropriate entries in the medical record that may impugn quality of care or attacking particular practitioners, nurses, or hospital policies

Reporting*:* Provider Actively Providing Patient Care – In instances when any employee, practitioner or Human Resources Department (HRD)personnel suspects that a practitioner may be impaired while actively providing patient care, that employee, practitioner or HRD person should contact the Departmental Director, Medical Director or Chief Medical Officer immediately and should provide a verbal report as to the nature of the concern.

Policy:
OUM Policy MSS.010: Impaired Practitioner
OUM Policy MSS.007: Disruptive Practitioner

PROVISION OF CARE, TREATMENT, AND SERVICES (PC)

Excel Standards

Specific goals have been developed to assist us in achieving our goals of making OU Medicine a great place for employees to work, physicians to practice medicine and patients to receive care. Excel Initiatives assist us in achieving these goals.

AIDET

Five Fundamentals of Consistent Communication

A Acknowledge
I Introduce
D Duration
E Explanation
T Thank You

These are five behaviors to use in **every patient/staff interaction** to anticipate, meet, and exceed expectations of patients, family members, co-workers and reduce anxiety of patients/families.

The goal of communicating this manner is to increase compliance by decreasing anxiety. This help to ensure patient safety and quality of care.

Patient and Family-centered Care:

- People are treated with dignity and respect.
- Health care providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful.
- Patients/family members build on strengths through experiences that enhance control and independence.

- Collaboration among patients, family members, and providers occurs in policy and program development, professional education, and in the delivery of care.

Care Planning

The interdisciplinary plan of care will be reviewed daily and revised as necessary. After collaboration with other team members, Nursing will prioritize and document care needs. Interdisciplinary communication regarding patient/family needs and assessment is ongoing and occurs through both formal and informal methods. Methods may include:

- Documentation in patient medical record
- Interdisciplinary team meeting
- Phone consultations/referrals
- Rounds

Patient Education

All patient education should be documented which may include:

- Discharge planning instructions and follow up care, and community resources
- Patient's response and understanding
- Potential food and drug interactions
- Use of medications and medical equipment
- Pain Management Techniques
- Condition-specific information
- Rehabilitation Techniques
- Fall Precautions

School-age patients will be assessed for their academic needs. Social services will work to assist families in meeting needs.

Policy:

OUM Policy PC.006: Patient and Family Education

Pain Management

- ***Adult patients*: Numeric Pain Distress Scale**. A 0 – 10 scale where 0=no pain and 10= worst possible pain (Mild, Moderate and Severe).
- ***Non-verbal Critical Care:* CPOT 0 – 8 Scale**
- ***Children and cognitively impaired adults*: Wong Baker FACES Scale**. This is also a 0 – 10 scale with 0 being no pain and 10 the worst pain imaginable.
- ***Pediatric and non-verbal patients*: FLACC Scale.**
- ***Patients 24-60 week's gestational age*: EDIN Scale.**
- Please assist in making your patients comfortable by using appropriate scales to document your patient's pain goals, scores and the effectiveness of pain management interventions (re-assessments) in the electronic medical record.
- Contact the Pain Management Nurse for pain management issues, questions or educational needs
- Contact the Pain Management Service for a formal pain management consult with an order from the primary team at **523-0385,** 24 hours a day, 7 days a week.

Policy: OUM Policy PC.013: Pain Management and Opioid Naivety Guidelines

Response to changes in a patient's condition

Rapid Response/ Condition Help (Code H)

The purpose of the Rapid Response Team (RRT) is to assess and assist with the non- Intensive Care, Labor and Delivery, or Emergency Department patients experiencing acute respiratory, cardiovascular, or neurological changes or any other changes causing concern to the patient, staff or families.

To active the Rapid Response Team, call:

- **11911 (Downtown) or 444 (Edmond)**

Policy: OUM Policy PC.011: Emergency Response & Resuscitation

Abuse and Neglect

Every hospital staff member is responsible for reporting signs of abuse, neglect, or maltreatment through their chain of command.

Assessing for Signs of Abuse and Neglect

Look for injuries that are: inconsistent with the story given, in various stages of healing, or are part of a pattern.

Child Abuse or Neglect

- Physical evidence of abuse such as welts, human bite marks, burns, bruises on the face, ears, back, buttocks, genital area, thighs, and back of legs.
- Injury may indicate type of abuse, for example, spiral fracture from twisting, whiplash from shaking.
- Conflicting stories as to how injury happened.
- Injury inconsistent with the history; such as bruises on face, back and chest from falling off a bed or fracture from falling off a couch.
- History of injury is inconsistent with the developmental level of child.
- A complaint other than the one associated with the abuse, "He has diarrhea" and there is evidence of a black eye and a broken arm.
- Repeated visits to different emergency facilities.
- Neglect evidenced by loss of weight, a failure to gain weight, or unkempt appearance.

Elder Abuse or Neglect

- A caretaker’s refusal to allow visitors to see elder alone.
- Elder's report of being abused or change in behavior.
- Physical abuse including bruises, black eyes, lacerations, rope marks, welts; bone fracture; broken eyeglasses or frames; open wounds, cuts, punctures, untreated injuries/bleeding.
- Sexual abuse; bruises around the breasts or genital areas; unexplained venereal disease or genital infections; vaginal or anal bleeding; torn or bloody underclothing.

- Emotional abuse; patient is emotionally upset or agitated; extremely withdrawn and non-communicative; or shows unusual behavior such as sucking, biting, rocking
- Neglect; torn clothes, unkempt appearance, loss of weight.
- Financial exploitation, unexplained insufficient funds.

Domestic Abuse

- Physical evidence including bruises, black eyes, lacerations, welts, rope marks, bone fractures, open wounds, cuts, punctures, untreated injuries, sprains, dislocations, and internal injuries/bleeding.
- The spouse's/partner's refusal to allow patient to be alone with medical staff.
- Reluctance to seek medical attention for injuries.
- Reluctance to discuss injuries in front of other family members.
- Spouse/partner speaking for the suspected victim.
- Conflicting or inconsistent stories about the injury.
- Complaint other than abuse.

Assault

- A person's report of being assaulted.
- Physical evidence of assault, such as bruises, black eyes, rope marks, lacerations, fractures, open wounds, cuts, punctures, internal injuries/bleeding, gunshot wounds.

Rape and/or Sexual Molestation

- A person's report of being raped or molested.
- Bruises around the breasts or genital areas.
- Unexplained vaginal or anal bleeding.
- Torn or bloody underclothes.
- An injury inconsistent with the history.
- Reluctance to seek medical attention or talk about the incident
- A complaint other than the one associated with abuse.
- Repeated visits to different emergency facilities.

Abuse/Neglect While Hospitalized

OUM has no tolerance for and prohibits all forms of abuse, neglect and harassment whether from staff, other patients or visitors. OUM ensures that patients are free from all forms of abuse, neglect, or harassment while within the facility. Any incidents of abuse, neglect or harassment are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State, or Federal law.

Every person in Oklahoma who has reason to believe that a child under 18 has been abused or neglected or is in danger of being abused or neglected is required to promptly make a report. If you suspect that a vulnerable adult is the victim of abuse, neglect or exploitation, please notify DHS via Hotline.

- Call the Department of Human Services directly at: 1-800-522-3511 (Child or Adult Abuse Hotline)
- Social Services may assist in assessment by phone at: 271-4518 (TCH), 271-4610 (OUMC/POB). At the Edmond campus, call the operator by dialing "0" and they will notify the on-call person
- Abuse or injuries that are the result of criminal conduct, (gunshot wounds, sexual abuse, or suspicious injuries) should also be reported to the OUHSC Police Department at 1-4911 or on the Edmond campus at 359-5470 or 200-3551. On evenings, nights or weekends – call the clinical coordinator and/or administrator on call.
- On evenings, nights or weekends – call the clinical coordinator and/or administrator on call once report has been made or with any questions/concerns
- All allegations of abuse or neglect that occurred during hospitalization or OP visit must be reported as a grievance through RL Solutions.

The confidentiality of the patient is protected at all times.

Policy: OUM Policy SS.050: Protecting Patients from Abuse, Neglect, and Harassment

End of Life Care

OU Medicine provides care that optimizes the dying patient's comfort and dignity and addresses the patient's and his/her family's psychosocial and spiritual needs, recognizing that the patient has the right to physical and psychological comfort. Goals (key desires) of patients and families at the end of life may include the following:

- Pain and symptom management – patients want assurance that physical discomfort will be relieved.
- Family involvement – most patients want their families involved in decision-making. Family may mean different things to different individuals. The patient's view of "family" should be respected.
- Care at home – when asked, most patients express a desire to receive their end of life care at home or in a home-like environment.
- Completion – patients want the opportunity to say good-bye and leave some kind of legacy.
- Affirmation of the whole person – patients want to be recognized as still having something to contribute.

Palliative Care Team, Social Services, Chaplains and Child Life Specialists are available to assist with end of life issues.

Operative or High-Risk Procedures Time-Out

A time-out **MUST** be conducted prior to procedures including:

- Lumbar Puncture
- Endoscopy and Bronchoscopy procedures
- Central Line, PICC line, or chest tube insertions
- Bone Marrow procedures
- Biopsy
- Cardiac Catheterization
- Medical device implantation
- Fracture reduction

Immediately prior to the start of any invasive procedure, a final verification process, where members of the surgical/procedural team verbally confirm the correct patient, procedure and site will be conducted.
The surgical/procedural site will be marked to verify the correct patient, correct procedure, and correct site. If possible, the patient should be involved.

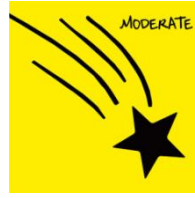
Time-out documentation includes:

- The participants in the "time out" process
- The oral confirmation of:
- ⇒ Correct patient,
- ⇒ Correct surgical/ procedural side/site,
- ⇒ Correct procedure,
- The time of "time-out" and time procedure began
- Any discrepancies and actions taken

Policy:

OUM Policy SURG.007: Safe Procedural & Surgical Verification

Fall Prevention



All patients receive comprehensive screening for fall risk.

Patients determined to be at risk for falls:

- ✓ Receive a yellow armband
- ✓ Have a "falling star" sign placed on their door and in front of their chart if they are adult
- ✓ Have a "Humpty Dumpty" sign placed on their door if they are pediatric

These patients are automatically considered high risk for falls and will not have a sign placed:

- ✓ Autumn Life
- ✓ Outpatients
- ✓ Pediatric patients under age 3

Policy

OUM Policy PC.022: Fall Risk Assessment and Prevention

Restraints and Seclusion

OUM is dedicated to fostering a culture that supports a patient's right to be free from restraint or seclusions. Restraint, (chemical or physical) will be limited to clinically justifiable situations, and the least restrictive restraint will be used with the goal of reducing, and ultimately eliminating, the use of restraints or seclusion.

If restraints are used, they will always be used in a manner that respects the patient's privacy, dignity and well-being to the extent possible.

There are situation-specific differences between restraints used in the provision of acute medical and surgical care and those used to manage behavioral symptoms.

Restraints may <u>never</u> be written as PRN or standing orders.
A patient must be continually monitored, assessed and reevaluated with a goal of release from the restraint or seclusion at the earliest possible time.

<u>Please review OUM Policy PC.023 for detailed requirements related to restraints/seclusion for violent or self-destructive behavior and restraints for non-violent, non-self-destructive behavior</u>

Death Reporting Requirements:
The following information must be reported to the Center of Medicare and Medicaid (CMS) for all deaths associated with the use of seclusion or restraint, except for soft wrist restraints:

- Each death that occurs while a patient is in restraint or seclusion.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- Each death known to the facility that occurs within 7 days after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.

Each death must be reported by Regulatory Affairs to the CMS regional office by telephone no later than the close of business the next business day following knowledge of the patient's death.

When no seclusion has been used and when the only restraints used are soft wrist restraints, the following information must be documented on the "death with restraint" log in Compliance Connect within 7 days of the date of death:

- Any death that occurs while a patient is in restraint.
- Any death that occurs within 24 hours after the patient has been removed from restraint.
- The patient's name, date of birth, date of death, attending physician, medical record number, and primary diagnoses must be documented on the log.

Staff must document in the patient's medical record the date and time the death was reported to CMS or the date and time the death was reported on the log.

At the time of discovery of the patient's death, staff are also to complete a patient notification in RL Solutions.

Policy: OUM Policy PC.023: Restraints and Seclusion

Blood Administration

It is the policy of OU Medicine that a signed consent form shall be obtained from all patients before blood and/or blood component transfusions.

The attending physician/physician designee of the service that is ordering the transfusion shall be responsible for obtaining the appropriate completion of the consent.

Policy:

OUM Policy PC.041: Blood/ Blood Component Administration

Stroke Awareness: (Code GRAY)

What is the definition of a Code Gray?

Code Gray = Stroke Alert = emergency response to a patient with possible onset of stroke symptoms within 7 hours even if symptoms have resolved

Who can activate a Code Gray?

Any physician, nursing staff, or support staff recognizing a patient with signs or symptoms of stroke can page a "Code Gray."

How is Code Gray activated in hospitalized patients?

For hospitalized patients with stroke symptoms and possible onset within7 hours

Any nurse, physician, or advanced practice provider should dial **1-1911** for "**Code GRAY**". Know patient's room number and last time seen normal

Signs and Symptoms of Stroke

- Numbness and /or weakness in face or extremities
    - One side of the body may be affected
    - Facial droop may be minor or whole side of face
- Confusion
- Difficulty seeing, speaking, and/or walking;
- Lack of coordination
- Severe headache, with no cause

Risk Factors for Stroke

- Advancing age and/or family history of stroke
- Diabetes, hypertension, and/or high cholesterol
- Obesity and/or Inactivity
- Smoking
- Coronary Artery Disease (CAD)

Types of Stroke

- Hemorrhagic: Rupture of blood vessels in the brain
- Ischemic (most common): Blocked blood vessels in brain

What can you do?

- Watch for changes in your patients
- Educate patients/families to recognize signs of stroke
- Chart all education including patient/family response
- Chart all observations, interventions, and results
- Call a **Code Gray** by calling "**1-1911"** at the Adult Tower, Rapid Response "1-4911" at Children's and "**444"** at Edmond campus
- Call Rapid Response if you need help maintaining ABC's
- Contact the OUM Stroke Coordinator with questions via smartweb On call> group name: Stroke> Stroke bed coordinator.

Note: Patients must receive written instructions on all stroke medications on discharge.

Where can I find the clinical practice guidelines (CPGs) that form the basis of the OUMC stroke orders and processes?

OUM Intranet > Medical Reference > AHA/ASA Stroke Guidelines

Where is the location of the OUMC stroke orders and policies?

- Electronic versions of all stroke orders and policies are available in PolicyTech and/or eDemand

PERFORMANCE IMPROVEMENT (PI)

OU Medicine uses the Lean Six Sigma **methodology** for performance improvement. To determine the priorities of the project to study, we gather and analyze data (historical, variance, patient complaint/satisfaction survey, or issues/ areas of High Volume, High Risk, or Problem-Prone) and examine our patient populations and top DRGs. The Six Sigma structured approach is **DMAIC.**

D– Define
M– Measure
A– Analyze
I– Improve
C– Control

OUM PI projects include, but are not limited to:

- Decrease Risk Adjusted Mortality Index (RAMI)
- Eliminate Hospital Acquired Conditions (HAC)
- Decrease Readmissions
- Core Measure Performance

Be sure to add your department's PI projects to the back page.

Core Measures

Core Measures are performance based quality measures that are mandated by both the Center for Medicare and Medicaid Service (CMS) and the Joint Commission. OUM's results are publicly reported on the internet at: www.hospitalcompare.gov

OU Medicine's Core Measures include:

- ✓ Stroke
- ✓ Sepsis
- ✓ Venous Thromboembolism
- ✓ Inpatient ED Throughput
- ✓ Perinatal Care
- ✓ HBIPS – Hospital-Based Inpatient Psychiatric Services (Edmond)
- ✓ Immunizations
- ✓ Outpatient AMI and Chest Pain
- ✓ Outpatient Stroke
- ✓ Outpatient Colonoscopy
- ✓ Outpatient ED Throughput
- ✓ Outpatient Externa Beam Radiotherapy

Results for each of the Core Measures can be found on the OUM intranet.

RECORD OF CARE, TREATMENT, AND SERVICES (RC)

Medical record complete and timely

The medical record is vital for accurately documenting the patient's course of treatment at OU Medicine.

Make sure you *completely and accurately* document patient care information including patient education and interdisciplinary care.

Verbal orders

Verbal orders are only taken in emergency situations. When verbal orders are given, the receiver will legibly write down the complete order and read it back to the dictating physician for confirmation.

Policy: OUM Policy PC.026: Verbal/Telephone Orders

Accommodations for Limited English Proficiency (LEP), Deaf and Hard of Hearing and Blind or have Low Vision

OUM will provide qualified interpreters and other auxiliary aids to persons who are LEP, deaf or hard of hearing, blind or have low vision, when necessary to afford such persons an equal opportunity to access and/or benefit from services provided.

OUM employee will inform patients or Companions involved in care decisions, which have needs, of the availability, at no cost to them, of interpreters, telecommunication devices, and/or other aids. These aids will be provided promptly upon request. This notification will be provided in writing
Interpretation services are made available to OUM inpatients, outpatients and those receiving ancillary services. Spanish language assistants are available to patients upon request and as determined to be necessary by hospital personnel. Sign language interpreters are available for those patients who are deaf or hard of hearing.

Additional languages are addressed on an as needed basis and are coordinated via MARTTI video, an audio interpretation system with the service support of Language Access Network.

Patients Companions who decline use of service will sign a **Waiver of Services**, which will be placed in the patient's medical record.

When should interpreters/translated materials be used?
OUM may exercise discretion as to when an interpreter is necessary since routine care may not require extensive communication.

Selected vital documents will be provided to OUM patients/ Companions in translated formats as available.

Situations in which an interpreter should be used include, but are not limited to, the following:

- Determining a patient's history or description of ailment or injury;
- Obtaining informed consent or permission for treatment;
- Provision of patient's rights;
- Explanation of living wills or powers of attorney (or their availability);
- Diagnosis or prognosis of ailments or injuries;
- Explanation of procedures, test, treatment, treatment options or surgery;
- Explaining administration and side effects of medications, including food or drug interactions;
- Discharge instructions or planning;
- Explaining and discussing advance directives;
- Explaining blood donations or apheresis;
- Explaining follow-up treatment, test results, or recovery;
- Discussing billing and insurance issues; and
- During educational presentations (i.e., classes about birth, nutrition, CPR, smoking cessation, etc.).

EVERY time an interpreter is used for conveying important information to the patient, documentation should be placed in the patient's chart. Additionally, any and all inquiries about the use of interpreters must be document in medical record

Who can interpret?

- Only qualified competent interpreters/translators, who have passed a written and verbal competency assessment will be utilized to provide interpretation or translation services. No one under 16 years of age is permitted to formally interpret at OUM.
- Family members, friends, advocates, case managers, physicians and other people who are at the hospital to support the patient may assist with **basic communication,** but for situations listed as requiring an interpreter they **are not appropriate** or qualified interpreters, regardless of their language abilities.
- Asking such persons to interpret may represent a HIPAA violation, denies the patient the support they need, and compromises the accuracy and effectiveness of OUM staff communications with the patient.
- In case of emergencies, or while awaiting the arrival of an interpreter, other auxiliary aids may be used. These aids may assist in communication but are not a replacement for interpreters.

These aids may include:

- Flashcards/Communication boards
- Telephone amplifiers
- Telecommunication devices/Braille
- Taped materials/Large print materials
- Reading aloud to patient
- Lip reading/Note writing/Use of gestures

How do I get the auxiliary devices and aids for patients with needs?
Contact the Clinical Coordinator to obtain auxiliary devices and aids, or for assistance in setting up devices.

Policies:
OUM Policy ADA.003: Accommodating Persons with Limited English Proficiency (LEP) (Interpreters & Translation)
OUM Policy ADA.004: Accommodating Persons Who are Deaf or Hard of Hearing (Interpreters & Translators)
OUM Policy ADA.002: Accommodating Blind Persons or Persons Having Low Vision

Informed Consent

The explanations of the procedure to the patient, in addition to the signature on the form, are both components of the informed consent process.

This explanation should include:
- Potential benefits and risks
- Potential problems related to the recuperation
- The likelihood of success
- The possible results of non-treatment
- Significant alternatives

The patient will be informed of:
- The name of the physician primarily responsible for the patient's care
- The identity and professional status of individuals responsible for performing the procedure
- Any relationship to another healthcare provider or institution that might suggest a conflict of interest

The patient and witness must **sign, date, and time** the informed consent document.

It is the responsibility of the practitioner performing the procedure (attending physician/operating physician/nurse performing the procedure, and/or the anesthesiologist) to obtain informed consent.

Policy:
OUM Policy RISK.004: Informed Consent

Do Not Resuscitate (DNR)

It is the policy of OU Medicine to comply with valid DNR requests made by patients or their representatives.

All DNR orders will be appropriately recorded in the patient's medical record and shall be signed by the patient's attending physician. At any time, a patient, parent or guardian of a minor child, a mature minor or a representative of an incapacitated person may revoke a DNR order or DNR Consent Form.

The physician will conduct and document an ongoing assessment of the patient's condition in the progress note section and shall review a DNR Order at a minimum of every seven days on general medical/surgical units and every 48 hours for pediatric patients. The physician shall modify or discontinue a DNR Order as appropriate.

Patients will be identified by means of a purple armband (or blue highlighted arm band for small infants) as to their DNR status. Without the order or DNR armband, full resuscitative measures will be carried out.

Policy:
OUM Policy EC.021: DNR
OUM Policy EC.022: Life Sustaining Treatment, Withholding, or Withdrawal

Advanced Directives

Upon admission to the OU Medicine every patient age 18 years or older, or emancipated minor, will be asked if they have a completed Advance Directive. If they do not, they will be asked if they would like additional information regarding advance directives and/or assistance with executing an advance directive. If so, they will be directed to the Chaplains/Pastoral Care Services.

Advance Directives are honored on all patients with a properly executed advance directive once the patient's attending physician and a second physician determines that the patient is no longer able to make decisions concerning their own medical treatment.

The lack of an advance directive will not hamper access to care. Advance Directives are not honored if the form is incomplete. Advanced Directives will not be honored if the patient is pregnant and has not delivered or is under the effects of anesthetic agents, unless the patient has specifically addressed these conditions in the advanced directive.

Policy:
OUM Policy EC.024: Advanced Directives

RIGHTS AND RESPONSIBILITIES OF THE INDIVIDUAL (RI)

Patient Rights and Responsibility

We ensure that patient rights are respected by using open communication with patients and families and making them active participants in their care.

Some of the patient rights include:

- The right to impartial access to treatment
- The right to considerate, respectful care
- The right to reasonable safety and security insofar as hospital practices and environment are concerned
- The right to pain assessment and management
- The right to be free from all abuse or neglect

Some of the patient responsibilities include:

- The responsibility to provide accurate and complete information
- The responsibility to report unexpected changes in his/her condition
- The responsibility to follow hospital rules and regulations
- The responsibility to be considerate of others

Patients are given a copy of the Patient's Bill of Rights upon admission. This information is also posted in several locations throughout the hospital.

Policy:

OUM Policy EC.031: Rights & Responsibilities of the Patient

Risk Management

Notification reports (occurrences) are used to identify opportunities to improve patient care, to minimize risk exposure, and to enhance safety for the patient, medical staff, house staff, visitors, or volunteers of the facility. These reports are not intended to be used in a punitive manner.

Notification reports should be completed in RL Solutions. The utmost care should be given to protecting the confidentiality of these reports. Reports should **NOT** be referenced or permanently placed in the medical record or photocopied and given to anyone.

General types of events that should be reported include, but are not limited to:

- Unforeseen changes arising out of the health care management of the patient
- Variance from established policies and procedures that involve patient care. Examples include medication errors, treatment delays, and IV-related complications
- An accident with or without personal injury
- Falls
- Mishaps due to possible faulty/defective equipment or environmental equipment
- Unexpected adverse results of professional care and treatment that necessitate additional hospitalization or a significant change in patient treatment regimens
- Damage or loss to hospital property or equipment

Specific examples of events to be reported include:

- Invasive diagnostic or surgical procedure performed on wrong patient or wrong body part.
- Absent or improper evidence of informed consent.

- Injury due to documented improper technique, personnel error, equipment failures, instrument breakage/malfunction, or unexplained cause.
- Chemical/electrical burns due to treatment.
- Leaving against medical advice.
- Surgery for removal of a foreign object left in operative site unintentionally; sponge, needle, foreign object or other material left in operative site unintentionally or because of impossible retrieval; incorrect sponge/needle count.
- Delay in responding to an emergency situation.

Policy:
OUM Policy RISK.010: Occurrence Reporting

Sentinel Events

A sentinel event is an unexpected event involving death or serious physical or psychological injury, or the risk thereof.

"Sentinel Events" signals the need for immediate investigation. Report the issue through your chain of command.

Examples (not an inclusive list)

- Events that result in an unanticipated death or major permanent loss of function that are not related to the natural course of the patient's illness or underlying condition
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Surgery on the wrong patient or wrong body part
- Unintended retention of a foreign object in a patient after surgery or other procedure

Policy:
OUM Policy RISK.006: Sentinel Events

Near Miss Reporting

An undesired event or finding that, under slightly different circumstances, could have resulted in or caused harm to people or damage to property, materials or the environment.

Report the event in RL Solutions or to the Supervisor. If you are unsure if the event should be reported, they may contact the Department of Risk Services (271-1800) for assistance.

Examples of near miss events that should be reported:

- Threat of physical violence or damage to property
- Weapons found on a person (knives with blades over 4", guns, etc.)
- Verbal or physical violence or related act
- Intentional destruction of property
- Any issues that require police intervention

Ethical Issues of Care

The Medical Ethics Committee, comprised of a multidisciplinary team representative of each facility at OU Medicine, is available to address ethical issues concerning the care of our patients. Staff, patients, visitors, physicians or family members can request review from the Medical Ethics Committee by contacting the on-call member through the communications operator.

Policy:
OUM Policy EC.023: Ethical Issues of Care

Patient Complaints and Grievances

Patients/families are informed of the right to voice complaints without fear of retribution, to have complaints investigated and resolved promptly.

Patients/families may contact **ANY** OUM employee to express a complaint. Each employee is expected to resolve a complaint immediately as appropriate to his/her scope of service. If beyond their scope of service, they should follow their chain of command.

If a substantive complaint is not properly resolved to the satisfaction of the patient and/or family and the complainant wishes to proceed, the complaint will formally become a grievance. The grievance will be documented in writing by the complainant, reviewed by the responsible leader and a written response given within 7 days.

Examples may relate to any of the CMS Conditions of Participation:

- Quality of care concerns
- Premature discharge
- Patient rights or privacy violations

Patients/families have the right to contact the Oklahoma State Department of Health, The Department of Human Services Ombudsman Program, the U.S. Department of Health and Human Services Office for Civil Rights or The Joint Commission directly if they are not satisfied with the response they receive.

Policy:

OUM Policy RISK.003: Patient Complaint and/or Grievance Resolution

TRANSPLANT SAFETY (TS)

Organ, Body and Tissue Donation

It is the policy of OUM that every hospital death will be recognized as a potential organ/tissue donor. It is the responsibility of the hospital to call in to our Organ Procurement Organization (LifeShare) at every death and potential deaths. LifeShare will than evaluate and the option to donate organs or tissues will be done by LifeShare to officially request.

OUM involves the patient and/or family about end of life decisions. OUM honors 1st person consent. If the decedent is a candidate for organ/tissue donation, and family agrees, a witnessed consent for organ/tissue donation must be completed for each organ and/or tissue to be donated. Consent may be made before or after the official pronouncement death.

Policy:

OUM Policy EC.025: Organ, Body, and Tissue Donation

EMTALA (Emergency Medical Treatment and Active Labor Act)

Screenings, Duty to Accept, and Transfers

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), all patients who present to the ED must be provided an emergency medical screening exam and necessary stabilization and treatment or appropriate transfer; regardless of the patents ability to pay.

If you work in the Emergency Department, Labor and Delivery, or otherwise might provide emergency care, please be familiar with and follow our facility-specific policies.

Policy:
OUM Policy EMS.001: EMTALA Signage
OUM Policy EMS.002: EMTALA Provision of On-Call Coverage
OUM Policy EMS.003: EMTALA Provision of Central Log
OUM Policy EMS.004: EMTALA Medical Screening Examination and Stabilization Policy
OUM Policy EMS.005: EMTALA Transfer Policy

Oklahoma False Claims Act

One of the primary purposes of false claims laws is to combat fraud and abuse in government health care programs. False claims laws do this by making it possible for the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims.

Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds is liable for significant penalties and fines. The False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid. It also allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government. The purpose of bringing the suit is to recover the funds paid by the Government as a result of the false claims.

The federal False Claims Act also contains a provision that protects an employee from retaliation by his employer. This applies to any employee who may have been discharged, demoted, suspended, threatened, harassed, or discriminated against in his/her employment as a result of the employee's lawful acts in a false claims action.

The State of Oklahoma has adopted a generally applicable Medicaid anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the Oklahoma Medicaid program. Violations of the statute are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties.

OU Medicine takes issues regarding false claims and fraud and abuse seriously. All employees, managers, and contractors are encouraged to report concerns to their immediate supervisor when appropriate.

Employees may also report concerns to Human Resources, the Ethics and Compliance Officer, or the Ethics Hotline if necessary.

Ethics and Compliance at 271-6847
Ethics Hotline at 1-833-875-7677

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Access full policies and procedures on OUM Intranet, Policies & Procedures, POLICYTECH

My Emergency Response and PI Page:

- **The fire extinguisher in my work area is located: _____**
- **The fire alarm in my work area is located: _____**
- **The oxygen shutoff in my work area is located:_____**
- **The nearest Crash Cart is located:_____ _____**
- **The evacuation route in my work area is: _____ _____**
- **My Department Employee Safety Officer (DESO) is _____**
- **Performance Improvement (PI) activities in which myself or my unit are participating: _____ _____**

EMERGENCY TELEPHONE NUMBERS

- **Code Red/Code/Code Pink/Medical Emergency/Code Blue/Code Gray/RRT**
  - **Children's** **1-1911**
  - **OUM** **1-1911**
  - **POB** **9-911**
  - **Edmond** **444**
- **Person Down**
  - **Children's** **1-1911**
  - **OUM** **1-1911**
  - **POB** **9-911**
  - **Edmond** **444**
- **Page Operators**
  - **Children's** **1-3636**
  - **OUM** **1-5656**
  - **Edmond** **0**
- **Security/Police**
  - **Downtown** **1-4911**
  - **Edmond** **444**
- **Facilities & Maintenance**
  - **Downtown** **1-4190**
  - **Edmond** **5527/5554**
- **Facility Safety Officer**
  - **Downtown** **Safety Hotline 271-3731**
  - **Edmond** **359-5590**
- **Radiation Safety Officer** **271-6121**
- **IT Helpdesk** **271-8660**
- **Poison Control** **271-5454 or 800-222-1222**
- **Employee Assistance Program** **1-800-327-1393**

Ethics Line **1-833-875-7677**