




Student Packet

Version SP.02

Table of Contents:

1. HR.069 – Controlled Substances in the Workplace.....page 2
2. NUR.063 – Student Nurses.....page 8
3. Guidebook.....page 10

 <i>OU Medical Center The Children's Hospital OU Medical Center Edmond Breast Health Network</i>	POLICIES AND PROCEDURES PAGE 1 OF 6 POLICY #: HR.069
TITLE: CONTROLLED SUBSTANCES IN THE WORKPLACE	
REPLACES: 14-35	EFFECTIVE DATE: 4/1/07, 11/1/08, 2/1/11, 4/1/11, 5/1/11, 9/1/13, 11/1/2016, 02/2018, 01/2021

- I. PURPOSE:** To prohibit inappropriate drug or alcohol use by our employees, contingent workers, and students in the workplace in order to prevent a threat to the quality of care we provide to patients, the safety of our workplace and a healthy work experience.

To articulate our intent that all conduct be consistent with all relevant federal, state and local laws and regulations relating to drug or alcohol use by employees (this includes employees and Facilities outside the U.S. and the laws of the country where the Facility is located) and students. To the extent that this policy conflicts with such laws and regulations, such laws and regulations will govern.

SCOPE: All Company-affiliated facilities including, but not limited to, hospitals, ambulatory surgery centers, home health agencies, physician practices, service centers, outpatient imaging centers, and all System Departments, Groups, and Markets. This policy covers all employees and students as well as those applying for employee positions.

II. DEFINITIONS:

Controlled Substances: Any drug or chemical substance whose possession and use are regulated under the Controlled Substances Act.

Illegal Substances: Any drug possession or sale of which violates federal law (in the U.S.) or the country, 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.

Medical Review Officer (MRO): A licensed physician not employed by OU Medicine or an OU Medicine affiliate who oversees the medical aspects of this policy. The MRO can be recommended to the Facility by the contracted Reference Laboratory. The MRO should have appropriate medical training to interpret and evaluate an individual's positive test results, medical history and any other relevant medical information.

OU Medicine Affiliate: Any entity (partnership, corporation, joint venture, LLC, etc.) that OU Medicine ultimately owns or controls 50% or more of, including its 50% owned joint ventures.

Facility: A facility owned by an OU Medicine Affiliate, including, but not limited to, hospitals, ASCs, urgent care and imaging centers, billing offices, revenue service centers, and system, and market offices.

III. POLICY:

TITLE: CONTROLLED SUBSTANCES IN THE WORKPLACE

1. Assistance

- a. The Company recognizes that alcohol abuse, substance abuse, and addiction arise out of treatable illnesses. The Company also realizes that early intervention and support improve the success of rehabilitation. To support employees, the Company:
 - i. Encourages employees to seek help if they are concerned that they or their family members may have a drug and/or alcohol problem.
 - ii. Encourages employees to utilize the services of qualified professionals in the community to assess the seriousness of suspected drug or alcohol problems and identify appropriate sources of help.
 - iii. Offers all employees and their family assistance with drug or alcohol problems through the Employee Assistance Program (EAP).
 - iv. Allows staff the ability to request leave, in accordance with applicable leave of absence policies, while seeking treatment for drug or alcohol problems.
- b. Treatment for alcoholism and/or drug use disorders may be covered by a personal benefit plan. However, the ultimate financial responsibility for treatment belongs to the individual.

2. Shared Responsibility

- a. A safe and productive workplace free of inappropriate alcohol or drug use is achieved through cooperation and shared responsibility.
- b. It is the responsibility of each employee and student to:
 - i. Adhere to this policy.
 - ii. Notify his or her supervisor at the Facility of any arrest or conviction involving drugs or alcohol prior to his or her next scheduled shift or clinical duty.
 - iii. Cooperate fully with any investigation related to alleged violations of this policy.
 - iv. Report and/or intervene in the event of reasonable suspicion of violations of this policy.
 - v. Safeguard Controlled Substances from unauthorized access.
- c. It is the responsibility of each Facility's management to:
 - i. Inform employees and students of this policy.
 - ii. Make the policy easily accessible to employees and students.
 - iii. Contract with an accredited reference lab for drug testing, transmit to the lab a copy of this policy, and ensure that there is a non-employed physician who will serve as a Medical Review Officer (MRO) for testing and interpretation.
 - iv. Periodically conduct substance abuse training for supervisors.
 - v. Promote employee awareness of the Company's assistance programs, including the Employee Assistance and Rehabilitation Assistance Programs.
 - vi. Investigate reports of reasonable suspicion of violations of this policy.
 - vii. Take action with respect to violations of this policy. Such action could include counseling with respect to professional help, referral to the Employee Assistance Program, disciplinary action, or termination.
 - viii. If required by accreditation, certification, licensure, or legal requirements, or if management of the Facility believes it to be appropriate, timely notify the appropriate authorities of any such action.
 - ix. Maintain all documents pertaining to reports and investigations pursuant to the Records Management Policy, ADMIN.009.

TITLE: CONTROLLED SUBSTANCES IN THE WORKPLACE
3. Prohibited Behavior

- a. The following activities are strictly prohibited and will be subject to discipline, including possible termination of employment:
 - i. The sale, manufacture, distribution, purchase, use, or possession of alcohol, alcoholic beverages, marijuana (including medicinal marijuana), illegal substances, non-prescribed controlled substances, or drug paraphernalia by an employee or student on Facility premises or during his or her working hours.
 - ii. Reporting to work, or being at work, while under the influence of or while impaired by alcohol, alcoholic beverages, marijuana (including medicinal marijuana), illegal substances, prescribed or non-prescribed controlled substances. For the purpose of the Policy, an employee or student is presumed to be under the influence of alcohol if a blood test or other scientifically acceptable testing procedure shows a blood alcohol level of .04 or more.
 - iii. Reporting to work, or being at work, with the smell of alcohol on one's breath or person, a measurable quantity of marijuana, or a measurable quantity of non-prescribed Controlled Substances in one's blood or urine.
 - iv. A conviction for sale or possession with intent to distribute any drugs, including prescription drugs.
 - v. Theft or diversion of facility and/or patient medications.
 - vi. Refusal for any reason to submit or consent to a drug/alcohol screen requested by any management personnel at the Facility.
 - vii. Participation in any act that would create or allow false documentation of security and/or safety practices.
 - viii. Tampering with or otherwise altering drug testing samples or security equipment or systems.
- b. Notwithstanding the foregoing, during facility-sponsored activities, the facility CEO, Administrator, Practice Manager or individual with senior level responsibility for the facility, at his/her discretion, may approve the responsible and limited serving of alcoholic beverages.
- c. Prescription medications are not prohibited under this policy when taken as prescribed under the direction and monitoring of a physician.

4. Duty to Report, Detection and Reasonable Suspicion

- a. An employee or student must notify his or her supervisor whenever he or she is taking a prescribed or over-the-counter drug that the employee or student has been advised will, or based upon the drug profile is likely to, impair job performance (e.g., drowsiness or diminished ability to focus).
- b. An employee or student must notify his or her supervisor if the employee or student has reasonable concerns that another employee or student has violated this policy.

5. Searches

If a supervisor has a reasonable suspicion that an employee or student has violated this policy, the supervisor may require the employee or student to submit to a search or inspection. By entering Facility property, each employee or student consents to such searches. Searches can be conducted of pockets, clothing, lockers, wallets, purses, briefcases, lunchboxes, backpacks, duffel bags, desks, work stations, equipment, and other areas. See also the Company's general policy regarding searches in the Theft and Violence in the Workplace Policy, SS.001.

TITLE: CONTROLLED SUBSTANCES IN THE WORKPLACE**6. Drug and Alcohol Testing**

- a. To ensure the accuracy and fairness of our testing program, all collection and testing will be conducted pursuant to guidelines established by the Medical Review Officers and, if applicable, in accordance with Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines; a confirmatory test; the opportunity for a split sample; review by an MRO, including the opportunity for employees or students who test positive to provide a legitimate medical explanation, such as a physician's prescription, for the positive result; and a documented chain of custody, with the exception of medicinal marijuana.
- b. All drug-testing information will be maintained in separate confidential records.
- c. Employees and students will be required to participate, at a minimum, in testing as follows:
 - i. Post offer, pre-employment;
 - ii. Prior to an acquisition which includes the employment of the seller's employees, Human Resources will compare the seller's drug testing policy to this policy in the required due diligence process and will make a recommendation to the OUM Chief Human Resources Officer and the Chief Executive Officer expected to operate the newly acquired business based on that comparison;
 - iii. Upon reasonable suspicion;
 - iv. When it is reasonably possible that drug and/or alcohol use by an employee contributed to or caused an illness or injury to the employee or to any person (e.g., employee, student, patient).

An event that will not trigger testing is an accounting change initiated by an Affiliated Employer.

- d. Substances tested for at hire must at a minimum include amphetamines, barbiturates, benzodiazepines, opiates, marijuana, methadone, and cocaine. Reasonable suspicion and reportable accident testing should include amphetamines, barbiturates, benzodiazepines, carisoprodol, opiates, fentanyl analogues, methadone, meperidine, marijuana, and cocaine.
- e. Testing for the presence of alcohol will be conducted by analysis of breath, saliva, blood or other accepted testing methodology.
- f. Testing for the presence of the metabolites of drugs will be conducted by the analysis of urine, blood, saliva, or other accepted testing methodology.
- g. The MRO will review all non-negative reports. Any non-negative drug test result due to a physician-approved medication will be reported as a negative result. If it appears that the person tested is impaired by the use of medications for which the employee or student has a valid prescription, the report should note that fact. Medications that could affect an applicant's ability to perform his or her job may result in restrictions or recommendation for accommodation with respect to those tasks.

7. Violations of Policy

Employees and students will be subject to discipline, including possible termination, if they violate this policy in any way.

TITLE: CONTROLLED SUBSTANCES IN THE WORKPLACE

8. Pre-Employment Tests

With respect to a person who has been offered employment, if the person refuses to take the pre-employment drug tests described above, or tests positive for any non-prescribed Controlled Substances or Illegal Substances, the offer of employment will be withdrawn.

Current employees who accept employment with another affiliated employer are required to participate in Pre-Employment Testing. If test results are positive for any non-prescribed Controlled Substances or Illegal Substances, the offer of employment will be withdrawn. Additionally, the positive test results will be communicated to the current affiliated employer; the current affiliated employer will conduct its own investigation, the results of which will be subject to discipline, including possible termination of employment.

IV. PROCEDURE:**1. General**

- a. Upon notification that any person has a reasonable suspicion that an employee or student of a Facility is violating, or has violated, this policy, the leadership of the Facility shall conduct an investigation. If, after an initial investigation, there appears to be some credibility to the suspicion, the Facility shall take whatever action necessary to protect patients, students, and employees, including, if the circumstances indicate that it is appropriate, the action may include immediately removing the employee or student from his or her work area and escorting him/her to a designated testing location, and conducting a search of the work area. The employee or student will be asked to sign a consent form prior to testing.
- b. Any employee or student who is tested based upon a reasonable suspicion of a violation of this policy shall be immediately suspended pending results.
- c. Any employee or student whose blood alcohol content exceeds the maximum set forth in this policy, or tests positive for non-prescribed Controlled Substances or illegal substances, will be immediately suspended. The Facility shall then seek legal review by the employment section of the Legal Department.
- d. During a suspension for violation of this policy, the employee or student shall not be allowed access to the Facility with the exception for medical treatment.
- e. The Facility may provide employees and students who test positive with contact information for substance abuse resources.

2. Voluntary Self-Reporting

An employee or student who voluntarily self-reports substance abuse maybe offered an opportunity to participate in a rehabilitation program. In such cases, the Facility may require, as a condition of continued employment, that the employee or student abide by the terms set forth by the Facility. Circumstances related to substance abuse will be taken into consideration on a case-by-case basis.

3. Organizational Reporting

TITLE: CONTROLLED SUBSTANCES IN THE WORKPLACE

In the event of a violation of this policy, the Facility will, if required by law, or if not required then if the Facility deems it appropriate, notify: (a) governmental agencies with jurisdiction over drug and alcohol issues (e.g., police, FDA, DEA); (b) if applicable, any professional licensing boards; and (c) appropriate Company executives (e.g., HR, Legal, PR, Risk Management, HCI).

4. Confidentiality

All information received by the Facility through compliance with this policy is confidential. Access to this information is limited to those who have a legitimate need to know within the Company or those outside the Company in law enforcement.

5. Communication and Training

Communicating this policy is critical to the Company's success. To ensure all employees or students are aware of their role in supporting this policy, each Facility shall prepare a plan for ensuring:

- a. The policy will be reviewed in orientation sessions for all employees and students.
- b. The policy will be reviewed annually by all employees and students.
- c. Leadership/designee will discuss the policy and organizational procedure during orientation of staff managers.

6. Financial Reporting

- a. Charges for employee drug screens, physician physicals, and fit for duty physicals are invoiced and a check request is submitted for payment.
- b. Charges for potential employee drug screens, physician physicals, and fit for duty physicals are invoiced and a check request is submitted for payment.

7. Policy Monitoring

Monitoring of policy compliance will occur through Compliance Process Reviews by the Ethics and Compliance Department and Quality Review System Surveys by the Clinical Services Group.


REFERENCES

1. Records Management, ADMIN.009
2. Theft and Violence in the Workplace, SS.001
3. Controlled Substances, PHARM.006
4. Medication Diversion Prevention, PHARM.015
5. Performance and Corrective Action, HR.023
6. Employment Separation, HR.002

APPROVED BY:

OUM Policy & Procedure Committee: 10/28/2016

OUM Board of Directors: 1/23/2018

 <small>OU Medical Center The Children's Hospital OU Medical Center Edmond Breast Health Network</small>	POLICIES AND PROCEDURES PAGE 1 OF 2 POLICY #: NUR.063
TITLE: STUDENT NURSES	
REPLACED: 5.2A/P	EFFECTIVE DATE: 11/1997, 7/2003, 11/2006, 4/2010, 8/2013, 1/2017, 10/2020

I. PURPOSE

To designate nursing activities, appropriate for nursing students in registered nurse/licensed practical nurse programs at OU Medicine.

II. POLICY STATEMENT

1. Nursing students will comply with all OU Medicine policies and procedures. Policy and Procedure resources will be made available to all students and faculty on the unit/clinic.
2. All patients with student assignments will have a registered nurse assigned to them who will maintain final responsibility for patient care.
3. Communication between the nursing student and staff nurse will include:
 - a) The student will receive a report on the assigned patient from the nurse who is assigned to care for the patient.
 - b) The student will report to the nurse any change in observation or patient condition and any time the student will be absent from the floor, i.e. breaks, lunch, etc.
 - c) The nurse should be present for all medication administration and procedures
 - d) The nurse and nursing instructor must oversee any student document of care activities
 - e) Prior to the students leaving the unit/clinic the student will report off to the staff nurse responsible for the care of the patient. This report will include:
 - (1) Nursing care completed by the student.
 - (2) Nursing care that needs to be completed.
 - (3) Intake and Output for shift.
 - (4) Vital Signs for the shift.
 - (5) Early Warning Scores for the shift if applicable.
 - (6) Medications administered and procedures completed and charted.
4. Nursing students will adhere to hospital policy regarding confidentiality, [Confidential Patient Status](#).
 - a) Only persons who are direct caregivers will have access to the medical record.
 - b) Discussions with the patient/family regarding prognosis, medical plan and future treatment will be conducted by the physician.
 - c) Discussion regarding patient information will be conducted in privacy and will not take place in public areas.
 - d) Any written information such as care plans or plan of care cards that are not part of the patient's medical record will not identify the patient by name or chart number.
 - e) Copying any part of a patient's medical record for data collection is not permitted.
5. Nursing students will administer all medications only under the direct supervision of their instructor/licensed nurse. IV medications may be given by students after obtaining approval of their instructor.

TITLE: STUDENT NURSES

6. Only OU Medicine licensed staff may access automated dispensing machines or carry controlled substance/patient-controlled analgesia (PCA) keys. Wastage of controlled substances by student must be documented by two licensed nurses.
7. Students may not administer by any route:
 - -Chemotherapeutic Agents
 - -Blood or blood products
 - -Emergency or life sustaining drugs
 - -Research drugs
8. Students may perform invasive procedures, i.e. IV insertion, foley placement, only under the direct supervision of faculty member or OU Medicine licensed nursing staff.
9. Students may not:
 - a) Perform arterial puncture
 - b) Defibrillate or cardiovert
10. Students will report variances according to the [Occurrence Reporting](#) policy, RISK.010. The student will immediately notify the instructor and the charge nurse when an occurrence happens.
11. Student blood and body fluid exposures caused by needle sticks, cuts, or splashes will notify the supervisor and refer to policy IPIC.026 [Management of Exposure to Blood and Body Fluids](#). The student will contact their instructor immediately and will follow their specific agency/school process for immediate and subsequent follow up and treatment. The school is responsible for subsequent follow-up and treatment.
12. The school assumes full responsibility for instruction, supervision and evaluation of students in the clinical area. Faculty is to be accessible to students while they are in the facility to deliver patient care. OU Medicine nursing staff who have signed official preceptorship agreements with schools may supervise leadership students on the school's behalf.
13. No part of the patient's medical record may be removed from the nursing unit/clinic.

III. RESOURCES

RELATED POLICIES AND SUPPORTING DOCUMENTSIPIC.026 [Management of Exposure to Blood and Body Fluids](#)PHI.030 [Confidential Patient Status](#)RISK.010 [Occurrence Reporting](#)**APPROVED BY:**

Nursing Policy & Procedure Committee:9/2/2020

HISTORY

Origination Date: 11/1997

CONTENTS

2	Introduction
3	Mission, Vision, Goals, & Values
4	Survey Readiness
5	The Joint Commission
6	Chain of Command and Escalation of Issues
8	National Patient Safety Goals
15	Environment of Care and Life Safety
23	Emergency Management
36	Human Resources
40	Infection Control and Prevention
46	Information Management
55	Medication Management
58	Medical Staff
60	Provision of Care, Treatment, & Services
72	Performance Improvement
74	Record of Care, Treatment, & Services
80	Rights & Responsibilities of the Individual
85	Transplant Safety
86	EMTALA
88	Index
92	My Emergency Response & PI Page
93	Emergency Telephone Numbers



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:

Active 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.

Barrier 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.

Compulsive 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.

Decontamination 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 $\frac{3}{4}$ 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 policies 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 (0X 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 never 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.

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

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 within 7 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 External 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:

OUN 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 then 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 patient's 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

INDEX

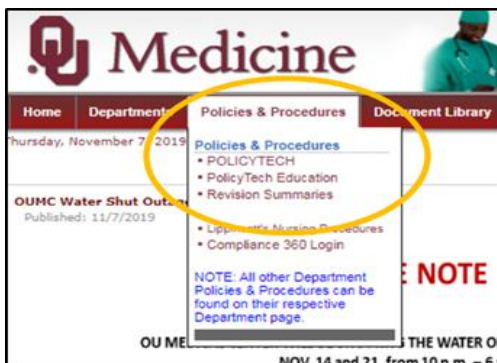
Abbreviations	56
Abuse and Neglect	64
Accommodations for Disabilities	75
Active Shooter	26
Advance Directives	80
Adverse Drug Reactions (ADR)	57
AIDET	61
Aim for Zero	45
Anticoagulants	11
Badges	39
Blood Administration	71
Blood Transfusion	9
Blood-borne Pathogens	43
Bomb Threat	28
CALM	20
Cardiac Arrest	31
Care Bundle	12
Care Plan	62
Catheter-associated Urinary Tract Infection (CAUTI)	46
Central line-associated bloodstream infection (CLABSI)	46
Chain of Command	7
CLEAN (Hazardous Spills)	20
Code Black	31
Code Blue	31
Code Gray	71
Code Orange	32
Code Pink	30
Code Purple	36
Code Red	20
Code Silver	26
Code Yellow	33
Command Center	33
Competencies	38
Complaints	85
Controlled Substances in the Workplace	40
Core Measures	74
Crash Carts	58
Credentialing	59
Critical Tests	10
Disaster	24,33

Disruptive Person	36
DMAIC	73
DNR	79
Duress Alarms	29
Emergency Preparedness Plan	24
Employee Assistance Program	40
EMTALA	87
End of Life Care	67
Ethical issues	84,88
Evacuation	25
Excel Standards	61
External Disaster	33
Falls	68
False Claims Act	87
Fire	22
Hand Hygiene	46
Hazardous Exposure	32
Hazardous Materials / Waste	19
Healthcare Industry Representatives (HCIR)	35
Healthcare-associated Infection (HAI)	12
High-alert Medications	58
HIPAA	51
Hospital Acquired Conditions (HAC)	14
Hospital Incident Command Structure (HICS)	33
Hostage Situation	26
ID Badges	39
Impaired Practitioner	59
Infant Security	30
Infant or Child Abduction	30
Information Security	47
Informed Consent	76
Interpreters	75
Isolation Precautions	42
Joint Commission, The	7
Labeling, Hazardous Materials	18
Labeling, Medication	18
Lock-out Tag-out	22
Look Alike, Sound Alike (LASA)	58
Media Contact	52
Medical Gases	22
Medical Record	47
Medication Administration	56

Medication Reconciliation	11
Medication Security / Storage	57
Mission , Vision, Values	4
MRSA.....	44
Multi-drug resistant organisms (MDRO)	12
National Patient Safety Goals (NPSG)	9
Organ donation	86
Oxygen shutoff.....	21
Pain	63
PASS.....	20
Patient and Family-centered Care.....	61
Patient Education.....	62
Patient Identifiers.....	9
Patient Rights	81
Performance Improvement (PI)	73
Person Down	30
Photographs.....	51
Policy and Procedure Access	92
Population Specific Care	38
Press Release	52
Protected Health Information (PHI)	48,51,54
RACE.....	20
Radiation	19
Rapid Response	63
Respiratory Arrest	31
Restraints and Seclusion	70
Risk Management.....	82
Safety Data Sheet (SDS)	18
Safety	16
Security	16
Sentinel Events	83
Smoking.....	17
Social Media.....	54
Spills.....	19,32
Staffing	38
Standard Precautions.....	42
Stroke.....	71
Suicide	12
Surge Capacity.....	35
Telephone Inquiries.....	49
Time-out.....	13
Tornado Warning.....	31

Translation.....	77
Transplants	86
Tuberculosis (TB)	43
Universal Protocol	13
Utility Failure	23
Vendors	53
Verbal Orders	75
Videotaping	51
Volunteers.....	39
Weather	31

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