Hutchinson Regional Medical Center

Key Safety Packet

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INTRODUCTION

WELCOME TO HUTCHINSON REGIONAL MEDICAL CENTER

We believe that every employee and provider help to make Hutchinson Regional Healthcare System (HRHS) successful. We hope that you will be proud to be a member of our team.

HRHS is comprised of four entities. Hutchinson Regional Medical Center (HRMC), Inc. is the parent organization. Aside from the hospital, there are three affiliates which provide healthcare services; Horizons Mental Health Center, Hospice and Home Care of Reno County and Health-E-Quip. HRHS employs approximately 1,400 people.

We wish you the best in your position and hope that your relationship with us will be beneficial to all.

USE OF THIS GUIDE

This guide has been developed to provide you with critical information on a variety of standards and requirements necessary for our organization to provide safe and quality care to our patients. You are encouraged to review the information contained in this guide – particularly those subjects that directly impact your job function.

While we have attempted to provide you with a wide variety of information, there may be other requirements, issues, or subject matter of importance that is not addressed in this guide. We encourage you to contact your supervisor if you have any questions or concerns.

OVERVIEW OF THE ACCREDITATION / CERTIFICATION SURVEY PROCESS

Federal law requires that any organization billing Medicare for services meet Conditions of Participation that govern quality patient care. On a triennial basis, the federal government (or an authorized entity of the federal government called a "deemed status agency" or "accrediting organization") performs a survey to assess our compliance with regulations. There are currently four deemed status agencies:

- CIHQ – The Center for Improvement in Healthcare Quality
- HFAP- Healthcare Facilities Accreditation Program
- TJC-The Joint Commission
- DNV Healthcare - NIAHO®

The deemed status agency that surveys HRMC, Hospice and Home Care, and Health E-quip is **The Joint Commission**

While survey activities vary depending on the size and complexity of the organization, most surveys consist of the following:

- Review of key policies and procedures and other documents
- Tour of patient care and support areas
- Review of medical records
- Interviewing of staff and physicians on different topics
- Interviewing of patients
- Review of staff personnel files
- Review of provider credential files

HOW TO INTERACT WITH SURVEYORS

The Surveyor's job is to determine if the organization is meeting standards and regulations. The survey is not designed to try and trick you or be hostile. In fact, don't hide from the surveyors, but welcome them and support each other in your interactions with them. The Surveyors simply want to know that you understand your job and its impact on patient care and service.

Be Honest

If you are unsure of the answer to a question, it's okay to say so. Don't make up an answer. Instead say something like: "I'm not certain of the answer to that question, but I know that I can go to the policy located in my department to find the

answer". It's important that you know the correct process, so know what resources you have available and know how to access them during a survey.

Know how to access policies and procedures and other important documents! Policies are located on the intranet at http://www.hhosp.com, and click on the appropriate entity under the PowerDMS icon.

NOTE: Many nursing procedures are found in Dynamic Health – also located on the intranet page under the DH icon:

Ask for Clarification

If you don't understand a question posed by a Surveyor, ask them to repeat or rephrase the question. Ask them to give you an example of what they are asking for.

Answer Questions Completely

It's important to answer a Surveyor's question(s) completely. However, do not provide any additional information or information that is not necessary to sufficiently answer the question(s).

Be Proud of the Good Work You Do

Speak with pride about the care and service you provide. It's okay – in fact it's great – to talk about how you made a positive difference in a patient's care experience. Talk about what your department or work area has done over the past year to improve care or increase patient safety.

Know Your Patients

If you provide patient care, it will be critically important that you are familiar with your patients. Surveyors may ask you about the following:

- Why is patient in the organization or seeking care?
- What are the patients' major health problems?
- What type of care is the patient receiving?
- What is your role in providing care to that patient?
- If other disciplines are involved in the patient's care, what care and services do they provide?
- How do you work together to assure that the patient's healthcare needs are met?
- Early on, how do you start to think and plan for a patient's discharge?

Prepare Your Work Area to Receive the Surveyors

Surveyors are likely to visit your department or work area. Making a "good first impression" will help surveyors understand your commitment to providing top quality care. You can help prepare your department or work area for a visit by doing the following:

- Keep your area clean and organized
- Smile and have your ID badge visible at all times
- Assure patient's privacy and rights by following HIPAA guidelines
    - Knock on doors
    - Use privacy curtains
    - Lock desktops and portable computers when not in use
    - Whiteboards – current information
    - Use two patient identifiers
- Assure that all quality control activities have been appropriately documented
    - Glucometer checks – controls and strips correctly labeled with expiration dates
    - Refrigerator checks – no expired items, temperature documented and fixed if out of range if applicable
    - Crash Cart
    - No expired supplies
- Follow good infection prevention and control practices
    - Hand Hygiene
    - Appropriate isolation precautions and signage
    - Linen carts need to be covered
    - No food or drinks in the patient care areas
- Keep medications secured
    - No expired medications

- Multi-dose vials (i.e.: insulin) are labeled with the expiration date

- Keep halls clear and maintain egress
- To stay prepared, it is a good idea to perform environmental rounds of your area/department on a routine basis. You don't want any surprises when your survey team arrives!

LEADERSHIP & PERFORMANCE IMPROVEMENT

MISSION, VISION, AND VALUES

Our Mission: Entrusted with people's lives, we make health and healing available to all.

Our Vision is to be the best health system in a thriving community.

Our Core Values We live these values daily, leading us on a path to Excellence!

- **Accountability** – We humbly take ownership of our actions and words, with commitment to exceptional quality, safety, and teamwork.
- **Respect** – We honor the dignity and worth of every human being.
- **Curiosity** – We explore, question, and learn without fear of failure or judgement.
- **Kindness** – We serve our community and each other with warmth, joy, compassion and empathy.

You must use these *Core Values* every day. If you do, it will help ensure that we operate legally and ethically. While you are acting for us, especially when dealing with those we serve, our decisions and behavior should ALWAYS reflect our *Core Values*.

HIGH RELIABILITY ORGANIZATION (HRO)

We work in a high-risk industry. Our Core Values require us to anticipate and detect potential harm and limit the effects of harm. To avoid tragic results, you must voice your concerns. You have the absolute right and obligation to stop errors/mistakes before they happen.
The five key characteristics of an HRO are:

1. *Preoccupation with failure* – everyone is aware of and thinking about the potential for failure
2. *Reluctance to simplify observations* – Look beyond surface explanations to find the events that cause errors. Reduce variations in your workflows
3. *Sensitivity to operations* (situational awareness)- You must find hidden threats and help resolve them. How does the current state create risk or threaten safety?
4. *Commitment to resilience* – Promote a team approach so that everyone looks to identify threats. By doing this, we can anticipate threats and respond to them before they cause harm.
5. *Deference to expertise* – Seek to understand hazards and risks and be open to learning about threats or concerns from the people closest to the work.

CONFLICT OF INTEREST

We require employees to act legally and ethically. You must avoid conflict(s) of interest while conducting our business. You may not conduct business for us if personal interests are in conflict, or reasonably appear to conflict, with our interests. In general, a conflict of interest may exist if you or a relative stand to gain personally from our transactions.

Conflict of interest is defined as a situation in which a person is in a position to derive personal benefit from actions or decisions made in the official capacity. Conflicts of interest can be actual or potential conflicts of interest. Organization policy requires any employee disclose a potential conflict of interest. If you have a potential conflict of interest, a Disclosure Form must be completed. (See policy *Conflicts of Interest – Employees SYS:CCE010*)

CORPORATE COMPLIANCE

The goal of HRHS is to have an effective compliance program. To be effective, our program must prevent, detect and resolve misconduct and illegal activities (including fraud, waste, and abuse).
To make sure our Compliance Program is effective, we will:

- Exercise due diligence to prevent, detect, and correct illegal or unethical conduct; and
- Promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

We are committed to creating a culture that encourages and allows you to seek help, voice concerns and report violations. We do not allow retaliation against anyone who, in good faith, raises concerns or makes a report.

You are a vital part of our Compliance Program. You need to be involved. In general, our Compliance Program seeks to:

- Promote honest and responsible conduct.
- Help us identify and correct unethical or unlawful conduct.
- Encourage everyone to report concerns so we can take appropriate action.
- Minimize financial loss to Federal Healthcare Programs by early detection of improper or illegal conduct.
- Address specific risk areas to help us minimize unethical or unlawful conduct.

You should consider compliance-related issues as a part of everything that you do.

If you have any questions, please contact the Corporate Compliance and Ethics (CCE) Department. The CCE Department is located on the first floor of our hospital, across from the Human Resources department. (See policy *Compliance Consults SYS:CCE002*)

To report a concern or a violation you may speak to your chain of supervision or the Corporate Compliance Officer (CCO), call the Compliance Hotline at 855-998-9907 (English) or 800-216-1288 (Spanish), or you may email our Hotline at reports@lighthouse-services.com. The Hotline is available 24 hours a day, seven days a week, and you are not required to give your name.

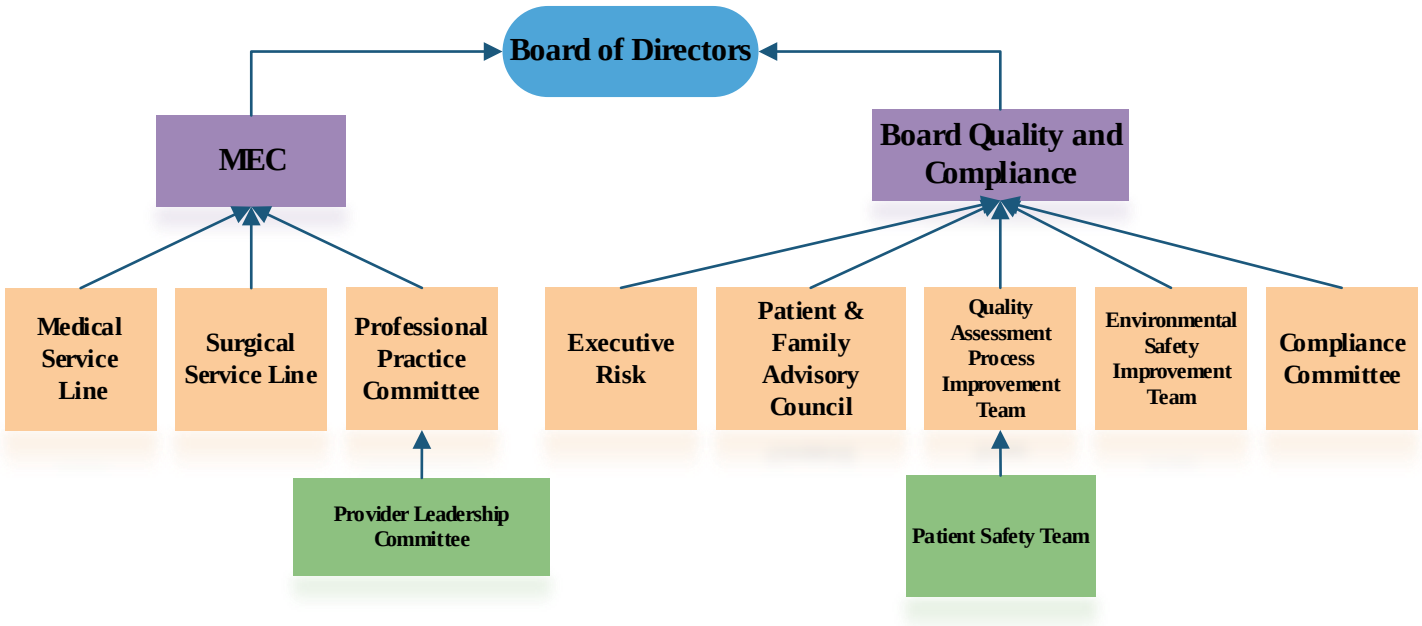
The Corporate Compliance Officer (CCO) can be contacted at 620-665-2203 or 620-665-2009; or, you can email the department at compliancereports@hutchregional.com.

CODE OF CONDUCT

All staff and physicians are expected to display professional and appropriate behaviors in their interactions with patients and each other. Our organization has a policy that outlines expected and unacceptable behaviors. Our Code of Conduct is located on the intranet under the "Corporate Compliance" tab.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT PROGRAM (QAPI)

Our organization has an **organization-wide** established program to assess the quality of care, treatment, and service we provide. We incorporate the fundamental principles of performance improvement: collecting data, analyzing data, and acting to improve and monitor performance into our program. The ultimate responsibility for the organizational performance improvement lies with the Leaders including the Board of Directors. Our plan focuses on performance and safety improvement of care provided to all patients throughout the HRHS. (See policy *Performance and Safety Improvement Plan RR100*).



Staff play an important role in performance improvement by:

- Bringing ideas or suggestions for improvement to the attention of leadership
- Implementing performance improvement action plans
- Being educated and familiar with performance improvement activities

<u>Performance Improvement Methodology</u>

- Performance Improvement Model
  The organization will undertake efforts to improve existing processes, patient safety efforts, and outcomes, as well as sustaining the improved performance. To accomplish this, the Board of Directors has adopted the following performance improvement model:
  - Plan-Do-Study-Act (PDSA) process as the organizations primary tool for performance improvement (PI) activities.
    - PDSA is a quality improvement method used to implement changes in medical practice patterns in areas where therapeutic advances occur at a rapid rate.
- The Board of Directors also recognizes that PDSA might not always be the best suited model for specific performance improvement activities, and as such has authorized the use of the following Robust Process Improvement (RPI) Models:
  - DMAIC – Define, Measure, Analyze, Improve, Control Process
  - Lean Management-
    - Lean management is a technique targeted at minimizing waste and maximizing the value of the product or service to the customer, without compromising quality.
  - Kaizen Improvement-
    - Kaizen is the practice of continual improvement
  - Six Sigma-
    - Six Sigma is a management technique based around reducing variance/error/defects
- These performance improvement models may be used formally or informally in improvement efforts throughout the organization.

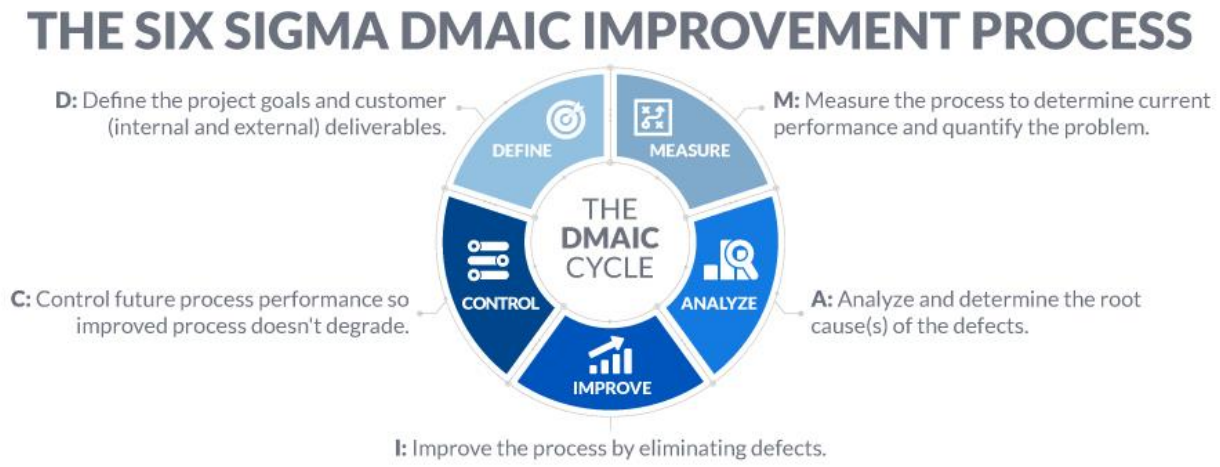
The PDSA Cycle may be repeated as often as necessary, as additional opportunities for improvement are identified.

These three questions are to be considered for each PI activity:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes will result in improvement?

Description of steps in the PDSA cycle:

PLAN an improvement / change	***DO***	***STUDY***	**ACT**
• Identify problem or opportunity for improvement • Study the process by collecting baseline data; evaluate initial results • Select the specific problem or opportunity for improvement • Formulate a plan for improvement; determine goal/establish a target; determine methods for reaching goal	• Make the change • Implement plan for improvement (small scale, trial basis, small area) • Document observations • Educate and train as necessary	• Observe and/or gather data to evaluate results of change • Analyze results and compare to the original goal • Evaluate the impact of the change • Determine if improvement has occurred • Determine if modifications are necessary	• Decide what changes can be implemented • Implement change permanently or on a larger scale • Develop a strategy for maintaining the improvement ***OR*** • Abandon the plan and rework the cycle • Return to the PLAN step



REPORTING QUALITY & SAFETY CONCERNS, INCIDENTS, & UNUSUAL OCCURRENCES

Staff members are the eyes and ears of our organization. Often, you are the first to become aware of something unusual or a potential safety or quality of care issue. It's important to report these issues or concerns in a timely manner so that corrective action can be taken. These events are incorporated in the organization-wide quality improvement programs to identify opportunities for improvement.

A safety culture operates effectively when the hospital fosters a cycle of trust, reporting, and improvement. In hospitals that have a strong safety culture, healthcare providers trust their coworkers and leaders to support them when they identify and report a patient safety event. When trust is established, staff are more likely to report patient safety events, and hospitals can use these reports to inform their improvement efforts. In the trust-report-improve cycle, leaders foster trust, which enables staff to report, which enables the hospital to improve. In turn, staff see that their reporting contributes to actual improvement, which bolsters their trust.

Promoting system improvements over individual punishment, a *Just Culture* in healthcare does much to improve patient safety, reduce errors, and give nurses and other healthcare workers a major stake in the improvement process. A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively. We use a proactive approach to identify potential failures in a process, the proactive risk assessment we use is called, Failure-Mode-Effects-Analysis (FMEA). In the event of a close call or actual occurrence, the comprehensive system analysis we use is Root Cause Analysis (RCA) on events to determine why the breakdowns or failures did occur.

Our goal is to create a culture of trust – improving error and good catch reporting. We look for ways to improve the process to help our staff not make errors. We hold each person accountable, regardless of "position" and accountability for the system as well as the person. (See Policy *Risk Management Plan KK116*)

The event reporting system used by HRMC is MIDAS, which can be found on the intranet page:

MIDAS
Event Reporting

Communication

- Handoff Communication – the transfer of essential information and the responsibility for care of the patient from one healthcare provider to another is an integral component in healthcare.
- Effective handoffs require an environment free of interruptions and distractions, allowing for the appropriate staff and or medical provider receiving the handoff to listen actively and engage in a discussion when necessary.

In speaking with our patients or clients remember to **AIDET**:

- **Acknowledge:** greet the patient and family, make eye contact and smile.
- **Introduce:** Introduce yourself, skill set, professional certification and experience.
- **Duration:** Give an accurate time expectation for test, physician, procedure, etc.
- **Explanation:** Explain step-by-step process and allow to ask questions.
- **Thank you:** Thank the patient/family for their time.

ENVIRONMENT OF CARE & EMERGENCY PREPAREDNESS

GENERAL SAFETY & SECURITY

Our organization maintains an active program to provide a safe and secure environment on a routine basis as well as during the activation of our emergency preparedness plan.

General Guidelines

- Do not bring purses or other valuables to work; secure storage space may not be available.
- Lock valuables and personal items in the trunk of your car prior to arriving at the clinical facility. This includes purses, CD's, cell phones etc. that might be visible in your vehicle.
- Only carry minimal cash on your person.
- Leave jewelry at home.
- Always wear proper identification (your name badge) while on affiliating agency property.
- Always be aware of your surroundings and alert for any suspicious activities or individuals.
- Security will provide a hospital ID badge to you.
    - The badge must be worn while working on hospital premises. The badge is to be displayed on the left-hand side, with picture and name facing out. It may be attached to a collar, and/or shirt or coat pocket, or other material in this general area. It is not appropriate to attach the badge to a sleeve, at the waist or any other area where it cannot be clearly seen.
    - Loss of a badge will result in a $10 replacement fee. Key replacement is $50

Parking Areas

- Park in your assigned parking area.
- Always be alert when walking through parking lots.
- Be alert for and report any suspicious individuals or activities.
- When entering or leaving the facility in the early morning or late evening when it is dark:
    - Park in well-lit areas.
    - Use a buddy system, so you are not walking in and out alone.
    - Have your keys ready to unlock your car.
- Student Parking:
    - Park in the lot south of the Chalmers Cancer Center. Enter through the main entrance.

Hospital Safety

- Report all accident/incidents to your unit management (or other faculty as appropriate)
- Know and comply with safety rules and use the safety equipment provided.
- Report all unsafe or hazardous conditions.
- Obey safety signs and notices.
- Know personal responsibilities in the event of a fire or other disaster.
- Keep personal work areas neat and clean.
- When in doubt, ask the person in charge.

Providing for a Secure Environment

- Actions every employee & provider can take to provide for a secure environment
    - Wear your identification badge at all times
    - Question the presence of individuals in your work area that are unfamiliar to you or lack proper identification
    - Report any suspicious individuals or activity to your immediate supervisor or to Security
    - Keep your personal articles and valuables secure. Do not bring personal items of value to work with you
    - Lock desks or doors to offices when not in use
    - Lock computers when not in use
    - Secure equipment in their appropriate area(s)
    - If you have any questions or concerns about security issues in your work area, contact your immediate supervisor for assistance

FIRE SAFETY

The Joint Commission requires that healthcare facilities manage fire safety risks. The Occupational Safety and Health Administration (OSHA) and other governmental groups also require regular fire drills and staff training. All employees have important roles in preventing fires and taking action if a fire occurs and patient evacuation is required.

Fire Response Procedure:

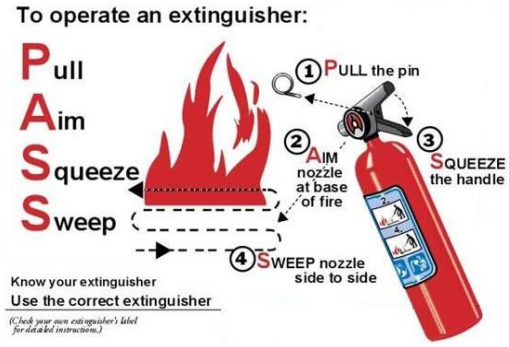
We have developed a formal procedure called "Code Red". If a fire occurs in your work area, you should do the following:

- **RESCUE** – Rescue people from the immediate area of the fire. You may need to evacuate your area either horizontally to the next smoke compartment, or vertically to a lower floor.
- **ALARM** – Pull the nearest fire alarm and dial the emergency number 777
- **CONTAIN** – Close doors to prevent the spread of smoke and fire
- **EXTINGUISH** – Put out the fire if you are able to do so.

Responding Away from the Origin of the Fire

Staff should take the following actions:

- Clear hallways of equipment
- Close doors to rooms
- Reassure patients
- Prepare for possible evacuation
- Continue normal care activities and await instruction



When a potential fire is identified, PBX will announce it on the overhead paging system by saying "Fire alarm reported at _____ (location)" , "Fire alarm reported at _____ (location)", "Fire alarm reported at _____ (location)"

PBX will update as the event dictates. An announcement of "All Clear" will be made over the overhead paging system.

Assuring a Fire Safe Work Area

- Staff can take the following actions:
- Know where the fire alarm pulls stations are located in your work area. In general, these are located near the exits and the elevators.
- Know where the exits are from your work area. There are two exits from each department. You should be familiar with both locations.
- Practice good general housekeeping.
- You should be prepared to act whenever you see a situation or practices that might cause a fire in your area or in another area of your facility. If you cannot correct the situation yourself, communicate immediately with someone who can rapidly correct the problem.
- Know the location of the fire extinguishers in your work area.
- Know where your smoke compartment starts and ends.
- You can help keep your work area fires safe by taking the following actions:
  - Do not store equipment or supplies in fire egress corridors unless for immediate use.
  - Do not store supplies within 18 inches of sprinkler heads or suspend anything from a sprinkler head.
  - Keep area around fire extinguishers and alarm pull stations clear.
  - Do not block fire or smoke doors. Do not disengage the self-closing mechanism.
  - Do not store items in electrical closets.
  - Remove and report any electrical item from service if there is a frayed or damaged cord.
    - Report medical equipment issues to Clinical Engineering.
    - Report computer related issues to Information Systems.
    - All others report to Plant Operations.
  - No appliance utilized in the cooking or reheating of food products will be left unattended while in use (i.e. microwave ovens, toasters, hot plates, stoves, open flames, crock pots, or any heat source). All appliances must have a valid UL rated tag and plugged into an outlet.
  - The use of unapproved power strips is prohibited. Approval of power strips is granted by Plant Operations
  - Use of extension cords is prohibited.

Fire Drills
- All staff are required to participate in fire drills.
- Fire drills will be conducted periodically to assure patient and employee safety.

Life Safety
Developed by the National Fire Protection Association (NFPA), the Life Safety Code is a set of rules that helps all types of businesses prevent the spread of fires. Federal, state, and local governments (and other groups) require that the Life Safety Code is followed for fire protection.

The code establishes special rules for healthcare facilities where patients stay overnight or may need special help to evacuate the facility quickly if there is a fire. The Life Safety Code covers:
- Building design
- Evacuation routes
- Best practices for employees who must protect patients and evacuate them if a fire occurs.

Evacuation Routes: Special evacuation routes are planned so patients can quickly be moved to safety. All facilities post evacuation routes in visible locations to allow employees, mobile patients, and visitors to evacuate. Each employee is responsible for knowing where to locate the evacuation maps.
- First evacuate horizontally from area, then vertically as directed.

Employee Practices:
Every employee has a role in preventing fires and helping to evacuate patients, visitors, and other employees if there is a fire. Some individual staff may have a special designated action they must carry out every day to prevent fires. Employee life safety practices include:
- Keeping fire doors closed so a fire can be contained
- Keeping door exits and hallways clear so patients can be safely evacuated if there is a fire
- Knowing the evacuation plan and where fire exits are located
- Remembering to look over evacuation routes posted in your work area as well as evacuation maps posted in other areas of your healthcare facility

What Are Interim Life Safety Measures?
Interim, or short-term life safety measures are used during construction or when a Life Safety Code deficiency is discovered that cannot be corrected immediately. When interim life safety measures are identified, they are put in place as extra safety measures until the physical environment once more meets the NFPA's Life Safety Code.

Why Are Interim Life Safety Measures Needed?
Interim life safety measures are needed any time the building does not meet the normal fire safety requirements due to construction or when a Life Safety Code deficiency is discovered that cannot be immediately corrected. An example of when an interim life safety measure is needed is when a fire door is not functioning properly for any of the preceding reasons. This may require new exits to be posted as well as new evacuation routes.

INFANT & CHILD ABDUCTION (CHILD ABDUCTION ALERT)
Keeping babies and children safe is very important to us. We have an infant and child abduction plan that is designed to promote awareness and prevent attempted abductions. This plan provides procedures to be implemented in the event that abduction is attempted or occurs. Everyone has a role in protecting infants and children. (See the Child Abduction Alert – Infant and *Child Abduction Policy AA111*) for the procedures specific to your area.
- Do not leave infants unattended.
- Educate parents on infant security.
- Question individuals who do not belong in the area.
- All staff including travelers must wear proper identification (ID) badge at all times. Badge must be visible at all times.
- Do not leave photo IDs where someone could get it to use in an infant abduction.
- Do not leave hospital attire such as scrubs, lab coats, and surgical gowns where unauthorized individuals could use them.

If you hear "Enact Infant or Child Abduction Alert" or "Code Pink" over the PA system:
- Go to the closet exit in the area you are in and watch for any individual with an infant or large package.
- Employees must continue to watch exits until released by Security. Stop any suspicious individuals or individual with an infant or large package and contact security.
- Explain to the individual that we have enacted an emergency response plan because of a possible infant abduction.
- Reassure patients, families or visitors as necessary.
- Do not discuss the situation with media persons or non-employees.

HRHS is a Smoke Free Campus – The policy is intended to protect HRHS employees and the public from exposure to environmental tobacco smoke and tobacco products. Electronic/vapor smoking apparatus commonly known as vapor cigarettes, electronic cigarettes, cigars, or pipes on the campus are also prohibited.

- There are no areas located on campus for smoking.
- Never ignore persons smoking in a smoke-free area; this activity could easily cause a fire or explosion.
- Staff locating visitors smoking will use the following script: "My name is _____ I'm with the _____department, you may not know, but Hutchinson Regional Medical Center is a no smoking environment. We ask that you please honor that and not smoke on the property."
- (See Policy: *Use of Tobacco Products/Electronic/Vapor Smoking Apparatus at Hutchinson Regional Medical Center DD111*)

VIOLENCE IN THE WORKPLACE (See policy *Workplace Violence SYS:SEC010*)

HRHS promotes a workplace free from harassment and intimidation. Harassment or intimidation in any form is prohibited. Any healthcare provider found to have engaged in such conduct will be subject to disciplinary action.

- Workplace violence is any physical assault, threatening behavior, or verbal abuse occurring in the work setting. Examples of workplace violence/harassment may include the following:
  - Verbal threats to inflict bodily harm, including vague or covert threats.
  - Attempting to cause physical harm, striking, pushing, and other aggressive physical acts against another person.
  - Verbal harassment, abusive or offensive language, gestures, or other discourteous conduct towards others.
  - Disorderly conduct, such as shouting, throwing or pushing objects, punching walls, and slamming doors.
  - Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of sexual nature constitutes sexual harassment when:
    - Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment
    - Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or
    - Such conduct has the purpose or effect of unreasonable interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.
  - If you witness or experience any form of harassment/violence, please report the incident to your director or faculty – if you are a student, management or Human Resources following hospital policy. See Employee Handbook.

MRI SAFETY:

The MRI system produces a very large magnetic field that will attract ferromagnetic objects. This attraction will draw objects towards the center of the magnet regardless of what is in the path of the object. Patients or other individuals in or near the magnet could be seriously or even fatally injured by the projectile.

The following MRI precautions should be followed when you are working near an MRI machine:

- Remember that the MRI magnet is always on, whether or not the equipment is in use.
- All staff, patients and material will be thoroughly screened for possible safety risks prior to entering the magnet room.
- All material and equipment will be tested for ferromagnetic properties with a hand-held magnet outside the fringe field before being brought within the magnetic field inside the scanner room.
- Always check with the MRI technologist before entering the room if there is a possibility that there is a metallic object in your body or attached to your body in a way that cannot be removed.
- For the protection of all employees, access to the MRI is restricted with a four-zone concept that provides for progressive restrictions:
  - Zone I: General Public
  - Zone II: Unscreened MRI patients
  - Zone III: Screened MRI patients and staff
  - Zone IV: Screened MRI patients under constant direct supervision of at least one level II trained MRI staff.

For reference: See policy: (*MRI Safety and General Requirements RAD112*)

MANAGEMENT OF HAZARDOUS MATERIALS AND WASTE

Community Right to Know Act

All employees and students shall comply with federal, state, local and institutional regulations and guidelines when working with chemicals that pose a hazard to the worker, other persons or the surrounding community. Each employee and student are responsible for their own personal safety and health; for the safety and health of others nearby and for the protection of the environment. The Right-to-Know Act was enacted to protect employees, and students by making available pertinent information about any chemicals with which they might be working.

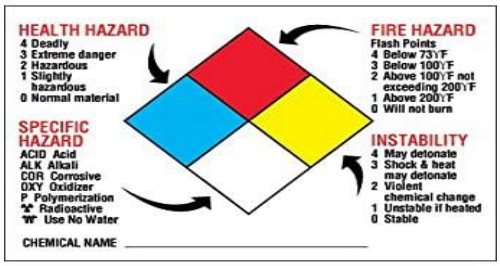
There are three components to a Hazardous Communication Program, Training, Labels, and Safety Data Sheets (SDS).

Regulations list many specific hazardous chemical wastes and define criteria for other categories. Generally, if a substance is **ignitable, corrosive, reactive, or toxic**, it is hazardous. All hazardous material must be labeled, and it must be handled, packaged, transported and disposed of according to directions.

Common substances that may be considered hazardous include bleach and other disinfecting solutions. For nursing and pharmacy, chemotherapeutic or antineoplastic agents are among the most hazardous substances. Special training is often required before a nurse may administer such medications.

Labels

- Each person is responsible for knowing about the chemicals used in the course of work in that setting.
- Each container must be labeled with the chemical name, and not merely its function.
- Always use containers in such a way that the labels will continue to be readable. If a label is missing or damaged, notify your supervisor.
- Labels must tell you what the chemical is, any danger or hazard that may exit with that chemical or ingredients and the name, address and telephone number of the manufacturer.
- Always read the label before you use the contents of a bottle, can or other container.
- The National Fire Protection Association (NFPA) has a four-part colored diamond warning label. There is numerical rate 0 (mild) to 4 (greatest) if there is a hazard of a particular category.



Safety Data Sheets

Safety Data Sheets (SDS) provide information on chemicals found in your work area. The SDS give basic information about the chemical and how to use it safely. Each areas SDS for all chemicals is located on the intranet. To access the SDS for hazardous chemical in your work area – click on the SDS tab on the top of the intranet home page [hard copies can be found in Environmental Services and Plant Operations].
The SDS includes the following information:

- The name of the substance, the manufacturer and the date the SDS was prepared.
- Other names the chemical(s) may be called or listed as including exposure limits.
- Physical characteristics: For example, how a chemical looks or smells, melting and boiling points, how easily it dissolves or if it does not, and whether it floats or sinks in water.
- Fire and explosion data tell you if a substance is flammable or combustible and the lowest temperature it could catch fire. It also tells you the safest way to put out a fire with this chemical.
- Reactivity tells you what happens when that chemical comes in contact with air, water, or other chemicals. This part tells you when it might burn, explode or release dangerous vapors.
- Health Hazards list how a chemical might enter your body. This might be inhalation, ingestion, absorption (through skin) or injection.
- Use, handling and storage describe how to clear up a spill or leak in addition to handling, storage and disposal of the chemical.
- Special protection and precautions explain any need for personal protection equipment (PPE) (such as goggles or a respirator) or signs or other equipment (such as ventilation hood over a lab or pharmacy area) when using the chemical.

Staff Rights and Responsibilities:

- Staff have the right to refer to the SDS.
- Remember that all healthcare staff members are responsible for familiarizing themselves with the hazardous chemicals used in their work areas and the proper protective measures that must be taken when those chemicals are being used.

Management of a Chemical Spill

We have established the following plan for managing a chemical spill: (See *the Hazardous Materials Management Plan SYS:SEC020*).

- By definitions – there are three categories of spills:
  - Minor – spills of less than 5ml and/or any spills that can be cleaned up by the people involved using the training and PPE they have at hand or immediately available. Minor spills include most spills and cleanup of a routine nature.
  - Special content spill – include mercury and hazardous medications such as chemotherapy for which staff are trained in cleanup procedures and have specific spill kits.
  - Major – Spills larger than 5ml and that are beyond the training and PPE available to staff. These spills may represent an immediate danger to personnel in the area because of physical and health effects.
- Contain the spill and evacuate the area if necessary
- Obtain a copy of the SDS on the chemical or material in question.
- Obtain the necessary clean up supplies and PPE.
- Clean the spill per instructions on the clean-up kit and/or SDS.
- If large spill, evacuate and notify your immediate Supervisor.

MEDICAL EQUIPMENT

Assuring that equipment used on patients is safe and properly maintained is critical to providing a safe environment of care. Electrical equipment failure is the second leading cause of fires in healthcare facilities. Because electrical equipment is used throughout patient and support areas of healthcare facilities, all employees should know how to use electrical equipment safety and the steps to take in case of an electrical hazard. Staff' plays an important role in safely managing medical equipment.

Some medical equipment provides the potential for electrical hazards.
Electrical hazards include:

- Electrical cords that are damaged or have broken insulation
- Electrical cords or connections that are in or near water or other liquids
- Electrical tools that spark, shock, or smoke as a result of damage or a defect
- Loose electrical connections
- Loss or lack of grounding

Using Electrical Equipment Safely

Whenever you use medical equipment, you should assure the following:

- Use equipment only for its intended purpose.
- Follow manufacturer instructions and/or our procedures when using equipment.
- Inspect the equipment prior to use. Look for obvious breakdown or disrepair such as frayed cables, broken dials, cracked housing, etc. If there is any question as to the safety of the equipment, do not use it. Pull it from service and notify Clinical Engineering.
- Check to see if the equipment has been electrically safety checked and maintained. Each piece of equipment has a sticker that tells you when it was checked / maintained. If you are unsure, contact Clinical Engineering before you use the equipment.
- Do not use equipment that you have not been trained to use or are not competent to use. See your supervisor if you require additional training.
- Do not use adapters that convert three prongs to two prongs in healthcare facilities.
- Do not attempt to fix outlet connections by bending prongs on the plug.
- Do not use extension cords.
- Use only approved Plant Ops provided power strips.

Report these problems as soon as you become aware of them to prevent any further danger. Also report for repair:

- Broken or cracked electrical outlets.
- Outlets that emit smoke or odor.

Do not use damaged outlets until they have been repaired or replaced by a trained electrical worker.

Use of Patient and Employee Supplied Electrical Equipment

(See policy *Managing Use of Patient and Employee Supplied Electrical Equipment QQ104*)

- This policy provides guidelines for electrical equipment that is allowed, restricted or prohibited in the facility. Every employee is responsible for following this policy.

Equipment Failures

- Know what actions to take before the equipment fails. Be familiar with failure response procedures.
- Make sure you have the standby supplies and equipment you need in case of failure.
- Support the patient and provide for immediate care needs.
- Pull the equipment, mark it as "out of service" and notify Clinical Engineering.

OSHA Lockout and Tagout Procedures

OSHA requires that healthcare facilities follow lockout and tagout procedures when equipment may be unsafe or damaged. (See policy *Lock Out/Tag Out #8310.1028*)

If followed, the lockout and tagout procedures should keep faulty equipment from being connected to a power source until the machine is tested and then put back in working order.

These procedures prevent electrical injury to employees, maintenance workers, and patients who would not otherwise realize that the machine might harm someone if reconnected to a power source.

The OSHA lockout procedure works as follows: When a piece of electrical equipment requires repair, its power source must be turned off, and the equipment must be disconnected from the power source. The electrician uses a lockout device to prevent others from turning on the equipment or reconnecting the equipment to a power source; otherwise, workers doing repairs could be electrocuted.

Once an electrician has disconnected equipment that needs to be repaired from its power source, he or she attaches a tag and a lock to the equipment's power source or plug, indicating to all employees that the equipment is under repair and should not be restarted under any circumstances. The tag lists the date, the time, and the person locking out the equipment. The tag is signed by the electrician and can be removed only by the same electrician. Likewise, the lock should only have one key and can only be removed by the electrician who installed it.

By following lockout/tagout procedures and other rules governing the use of electrical equipment, and by reporting any potential electrical hazards that you observe, you are contributing to the safety of patients, visitors, and employees of your healthcare facility and fulfilling a crucial job responsibility.

UTILITIES

Maintaining functional and appropriate utility systems is an important part of maintaining a safe environment. The key thing that staff' need to know is what to do in the event of a utility failure.

(See policy: *Utility Systems Management Plan 8310.1002*) which includes the following:

- Boiler & Steam
- Communication Systems
- Electrical Distribution
- Elevator
- Emergency Power
- HVAC
- Medical Gas
- Plumbing
- Pneumatic Tube System
- Vacuum Systems
- Water / Sewer

Plant Operations will be available on a 24-hour a day basis to respond to emergencies involving utility systems disruption. During normal business hours, the Plant Operations Staff can be contacted directly by telephone. During evenings, nights, weekends and holidays, contact the on-call Plant Operations Staff through the Medical Center's telephone operators.

Emergency Receptacles and Wall Outlets

It is important for every employee to be able to recognize and understand the color coding of outlets used for emergencies and those for regular use.

Receptacles and wall outlets are coded in the following manner:

- Red: emergency power outlets, typically 120 volts
- Ivory: normal power outlets, typically 120 volts

EMERGENCY PREPAREDNESS

Critical Areas of Emergency Planning

We have developed specific policies, plans, and procedures to address six critical areas of emergency preparedness:

- Communication during an emergency (*see policy SYS:SEC007 Emergency Communication Plan*)
- Managing resources and assets
- Managing utilities
- Managing security and safety
- Managing staff
- Managing patients and clinical activities

Emergency Preparedness Plan

Because you can't always predict the nature of an emergency, organizations – including ours – establish an emergency preparedness plan that allows us to respond effectively regardless of the nature of the emergency. *(See policy SYS:SEC008 Emergency Operations Plan (EOP) General Guidelines)*

EMERGENCY RESPONSE CODES

Below are the color codes recommended by the Kansas Hospital Association. Plain language or clear talk will be used as a way to alert staff as well as visitors and patients of incidents that are occurring at the hospital.
For ALL emergencies – dial **777**

Code Name	DESCRIPTION	OVERHEAD ANNOUNCEMENT	CORRESPONDING POLICY
Fire Alarm Report	Fire Safety Plan	"Fire Alarm Reported at _____ (location)"	SYS:SEC011
Code Blue	Cardiac arrest, medical emergency	"Code Blue room ____"	C111
Child Abduction Alert	Infant or Child abduction	"Child Abduction Alert"	AA111
Code Black	Bomb Threat	Not paged overhead.	AA104
Hazardous Material	Hazardous Material Incident	"Hazardous Materials release ____. (location)"	AA103
Code Strong (not a KS standardized code)	Criminal Behavior A combative or potentially combative person or security event	"Code Strong _____. (Area)	SS108
Armed Intruder Alert	Active shooter	"Armed intruder ____ (location)" and description if available	SS116

Specific Emergency Response Procedures

Our organization conducts a **Hazard Vulnerability Analysis** (HVA) in cooperation with the State of Kansas Emergency Management and Reno County Emergency Management to identify specific types of emergencies or disasters that we are likely to face. Emergencies or disasters are classified by four main causes or hazard groups: Natural Disasters, Technological Disasters, Civil Disruption or Violence (Human), and Long-Term or Ecological changes.
The table below lists the most likely types of emergencies our organization will face, and what staff are expected to prepare or respond to them. (See Emergency Operations Plan General Guidelines SYS:SEC008)

Types of Emergency	Corresponding Policy
Emerging Infectious Disease	GG135 & GG183
Tornado/Severe Weather Plan or Earthquake	AA102 & SYS.SEC006
Fire Safety Plan	SYS:SEC0011
Safety Management Plan	SYS:SEC019
Communication Failure (Emergency Communications Plan)	SYS:SEC007
Patient Surge	AA100
Mass Fatality/Casualty	AA106
Armed Intruder or Workplace Violence	SS116 & SYS:SEC010
Hazardous Materials Management Plan	SYS:SEC020
Bomb Threat	AA104
Utility Failure	8310.1008
Guideline for PPE Usage During Supply Shortages	SYS:IP001

Your Role in Emergency Management

As an HRHS employee, you will learn more about your role during an emergency through information provided by your department and through direct participation in required drills and special emergency management training. Specific exercise with different components will be organized to improve our emergency preparedness, response, recovery, and mitigation in the face of various disasters.

In order to provide proper care to our patients and the community we serve, in emergencies or disaster situations all employees will report to unit management or (faculty if a student) to await specific instructions regarding either an internal or external disaster.

Disaster Privileges for Volunteer Licensed Independent Practitioners AA116

DO NOT SELF REPORT OR RESPOND……When the emergency management plan has been activated by the Chief Executive Officer, Chief of Staff or their designee(s), privileges may be granted to individuals deemed qualified and competent for the duration of the disaster situation. The hospital administration will inform the HRHS Volunteer Coordinator that the emergency management plan has been activated and that disaster privileging will be required. The individuals will be screened and given temporary privileges. Once privileged, they will report to the personnel pool at a place designated by the Incident Commander based on the type of incident. (See policy *Disaster Privileges for Volunteer Licensed Independent Practitioners AA116*).

Physicians, & Volunteer Licensed Independent Practitioners will be referred to in all emergency response plans as either Doctor, Physician, Provider, Staff, or Employee. The response plans outline staff duties and responsibilities. Further guidance will be distributed by the Incident Commander based on the type of event and the response needed to address the event.

Volunteers Practitioner AA111

To provide Hutchinson Regional Medical Center (HRHS) staff with guidance in the event that the volunteer practitioners that are not licensed independent practitioners, are needed to provide assistance when the Emergency Operation Plan has been activated and the hospital is unable to meet immediate patient needs.

Note: These volunteers could include, but are not limited to the following professions: RNs, Behavioral Health Professionals, EMTs & Paramedics, LPNs, Respiratory Therapists, Medical and Clinical Laboratory technicians, Diagnostic Medical Sonographers, Medical records and Health Information Technologists, and pharmacists.

When the Emergency Operation Plan is activated, the Chief Executive Officer (CEO) or the Incident Command Officer may activate the Volunteer Practitioner Request and Receipt Policy which provides the procedure with which we ensure to coordination and tracking of non-licensed volunteers.

The Incident Command Officer will be responsible for deciding what kind of volunteers are needed and appropriate staffing numbers. Non-Licensed Volunteers will be referred to in all emergency response plans as Staff, or Employee. The response plans outline staff duties and responsibilities. Further guidance will be distributed by the Incident Commander based on the type of event and the response needed to address the event.

DOWNTIME PROCEDURES

As part of our emergency operations plan, HRHS has a plan for downtime management. This includes documentation in the patients record as well as departmental policies and procedures. Providers and Nurses can access up to seven days of patient data on registered patients at the time of downtime using the 724 Access Viewer. (See policies: *Downtime Plan for Documentation A104, Registration and Ordering Downtime C119, & Emergency Operations Plan SYS:SEC008*).

PATIENT RIGHTS

PATIENT RIGHTS & RESPONSIBILITIES

Patients have a wide variety of rights. Our organization respects patient rights. Some of these rights include:

- Confidentiality and privacy of patient information
- Effective management of pain
- Right to refuse care
- Receive information about their care
- Having a support person with them when receiving care, treatment, or service
- Right to formulate an advanced directive
- Right to designate a representative to participate in their care decisions
- Right to have their representative, family or their own physician notified of their admission
- Right to receive the “Important Message from Medicare” within 2 days of admission and again within 2 days of discharge when the admission is longer than 2 days

Patients have the responsibility to:

- Provide information about their condition
- Follow organization policies
- Inform staff of changes in their condition

Patients receive written information about their rights and responsibilities at the time of admission or presentation for care. This may be accomplished by giving handouts, signage, etc.

EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) requires HRMC to:

- Provide an appropriate medical screening examination to any individual who comes to our dedicated emergency department;
- Provide necessary stabilizing treatment to an individual with an emergency medical condition (EMC) or an individual in active labor;
- Provide for an appropriate transfer of the individual if either the individual requests the transfer or the hospital does not have the capability or capacity to provide the treatment necessary to stabilize the EMC or the capability to admit the individual;
- Not delay the examination and/or treatment in order to inquire about the individual’s insurance or payment status;
- Obtain or attempt to obtain written and informed refusal of examination, treatment or appropriate transfer in the case of an individual who refuses examination, treatment or transfer.

INFORMED CONSENT

A patient signing the consent form is signifying that he or she has been provided with sufficient information to make an informed decision about the proposed treatment or procedure. If there is any question or concern, the patient's physician should be contacted.

Informed consent is usually provided by the physician or other practitioner involved in the performing the procedure. The patient signed form is an acknowledgement that the patient has been informed about the risks, benefits, alternatives, and other important information about the treatment or procedure. Informed consent must occur before the treatment or procedure begins. (See policy *Informed Consent KK117*).

ADVANCE DIRECTIVES

An advance directive is either a written or verbal statement by a patient or their authorized designee regarding care issues. Types of advance directives include:

- Living Wills
- Durable Power of Attorney for Healthcare

Patients are asked if they have an advance directive when they are admitted to the hospital.

If the directive is with them, a copy is placed in the record and the Physician is notified of the contents**.** If the copy is not available, the patient is asked to bring it in.

A directive can be changed at any time. This can either be done verbally or in writing. If a patient wishes to change their directive, the Physician should be notified.

DEATH, DYING AND END OF LIFE CARE

HRMC has established guidelines in place that involve patients, and when appropriate, their family members or surrogate decision makers, in every aspect of care related to the end of life. Our guidelines foster comfort, dignity and respect for all patients at the end of their life.

Every person should be able to fairly expect the following elements of care from physicians, Advanced Practice Providers, healthcare institutions and the community:

- The opportunity to discuss and plan for end-of-life care
- The opportunity to discuss scenarios and treatment preferences with the physician and healthcare proxy
- The chance for discussion with others.
- The chance to make a formal advanced directive and assistance in completing these forms.

If you have questions on end-of-life concerns, please contact social services or the hospital chaplain.
For reference: (see policy *End of Life KK118*)

TISSUE AND ORGAN DONATION

Tissue and organ donations save lives. HRMC partners with Midwest Transplant Network (MTN).
It is the policy of HRMC to ensure that families of all potential donors are made aware of the option of organ, tissue and eye donation. Discretion and sensitivity are encouraged with respect to the circumstances, views and beliefs of those families. The MTN, organ procurement agency designated by the Secretary of the Department of Health and Human Services, will be notified of all deaths. For specifics on the procedure, (see policy: *Tissue and Organ Donation PP100*).

PATIENTS' RIGHT TO ETHICAL CARE:

Our patients have the right to expect ethical care and treatment. If you have ethical concerns about the care or treatment of a patient, an ethics consultation can be requested through an electronic consult order or by speaking directly to the Chaplain, Director of Care Management, or any care manager or social worker.

INFORMING PATIENTS ABOUT ERRORS IN CARE

Our organization requires that patients be informed of significant errors in care. (See Policy *Clinical Patient Safety Events KK103*).
When an error in care occurs, the following actions should be taken:

- The patient is provided with whatever care is necessary to ensure they have their needs met and they feel safe.
- Any evidence regarding the error is saved for follow up investigation
- The Physician is informed
- An unusual occurrence or event report should be generated
- A formalized team response to stabilize the patient, disclose the event to the patient and family, and provide support for the patient and family as well as staff involved in the event.

PATIENT COMPLAINTS & GRIEVANCES

Both federal law and organization policy give patients the right to file a complaint or grievance. A complaint is usually something minor in nature and is resolved by staff present at the time the complaint is reported, while a grievance is something more serious – often involving a potential violation of a patient's rights. However, any complaint received in writing, no matter how seemingly minor, is considered a grievance**.** Ensure that you know the difference between a complaint and a grievance. These two issues are handled in a different manner from a compliance perspective. (See policy *Patient Complaint and Grievance Process QQ102*)

If a staff member becomes aware of a complaint or grievance, the following actions should be taken:

- If you are able to resolve the issue immediately, then do so.
- If you cannot resolve the issue immediately, then:
  - Report the complaint to your immediate Director, Manager or the House Supervisor.
  - The complaint will be investigated by the organization
  - The patient will be informed of the results of the investigation and any actions taken.
  - If the patient wants to file a formal complaint with the regulatory agencies, they are allowed to do so.

USE OF INTERPRETERS / SERVICES FOR THE VISUALLY OR HEARING IMPAIRED

Hutchinson Regional Medical Center (HRHS) recognizes that an individual patient, client or resident has the right to obtain information concerning diagnosis, treatment and prognosis, and their rights, in their native language. HRHS will make available the appropriate interpreter to the patient, client or resident at no charge; the patient, client or resident has the right to refuse this free service.

HRHS has contracted with a company to provide 24-hour service for remote video interpretation in Spanish and more than 200 other languages. This is HRHS preferred service since it provides the most immediate response for patients and families.

Each hospital floor, house supervisor, admissions, and facility have an assigned iPad for interpreter use.

The use of family members and/or friends to provide interpretive services for medically related care needs is strongly discouraged. Family may be used for non-medical related interpretive services (e.g. explaining visiting hours, orientation to the room environment, etc.).
(See policy *Interpreter Services SYS:SXC001*)

VISITATION

Patients have the right for visitors and to have a support person. Access to the hospital between 9:00 pm and 6:30 am is limited for the security and safety of the facility, patients, visitors and staff. All visitors entering the facility after 9:00 pm will be given a badge to identify the visitor's name, date, time in and the unit destination for safety. For the most up to date visitation allowance for COVID-19 patients – see policy.
For reference – (see policies: *Patient Visitation Rights A124 and Visitor Badging SS130*).

PATIENT CARE

ASSESSMENT & REASSESSMENT OF PATIENTS

Patients receive an initial assessment upon admission or when presenting for care. The scope and timeframe for completing the initial assessment varies depending on the discipline involved and the care setting.

Key Point

It is very important for staff to know the timeframes for conducting initial assessments for their discipline.

It is also important to know when it is necessary to contact other disciplines for specialized assessments.

While the scope and depth may vary depending on the care setting, initial nursing assessments include the following:

- Physical assessment
- Psycho-social assessment
- Victims of abuse screen / assessment
- Pain screen / assessment
- Nutrition screen / assessment
- Functional screen / assessment
- Fall risk screen / assessment
- Cultural and spiritual needs screen / assessment
- Communication needs screen / assessment
- Discharge planning screen / assessment

The frequency of reassessment varies depending on the care setting and the needs of the patient. In general, a patient is reassessed:

- When there is a significant change in condition
- The patient is transferred to a different level of care
- Due to the performance of treatments or procedures
- At regular intervals as determined by discipline / department specific policy or standards of care

(See policy *Admission Assessment and Re-assessment C101*)

ASSESSMENT & MANAGEMENT OF PAIN

Each inpatient will be assessed for the presence of pain upon admission or presentation for care. If the patient reports pain, then they receive a more comprehensive assessment. Patients are also usually screened for pain:

- After invasive treatments and procedures
- Routinely during care when vital signs are taken

If a patient reports pain, they should receive an assessment that addresses:

- Location, severity, and duration of pain
- What precipitates the pain
- What alleviates pain

We use patient age-appropriate pain scales to assess the level of pain. For example:

- 1 – 10 Pain Scale
- Wong-Baker Pain Scale (faces)
- Neonatal Pain Scale
- Non-verbal / non-communicative pain assessment tools

It is very important that pain be effectively managed. We employ a variety of treatment modalities to combat pain:

- Non-pharmacologic Pain Management, such as:
  - Relaxation techniques
  - Application of warm or cold
- Medication
- Patient Controlled Analgesia (PCA)

Use of Opioids in persons that have not had opioids before (Opioid naïve) or in patients with over sedation risk factors must be administered with caution. It is important to evaluate the patient for characteristics that place them at a higher risk for over sedation and respiratory depression with pain medications. For example:

- Sleep apnea or sleep disorder diagnosis
- Morbid obesity with high risk of sleep apnea
- Snoring
- Older age; risk is

- 2.8 times higher for individuals aged 61-70
- 5.4 times higher for age 71-80
- 8.7 times higher for those over age 80

- No recent opioid use
- Post-surgery, particularly upper abdominal or thoracic surgery that may impair breathing
- Increased opioid dose requirement or opioid habituation
- Longer length of receiving general anesthesia during surgery
- Receiving other sedating drugs, such as benzodiazepines, antihistamines, diphenhydramine, sedatives, or other CNS depressants
- Preexisting pulmonary or cardiac diseases or dysfunction or major organ failure
- Smoker

At HRMC we utilize the Michigan Opioid Safety Score (MOSS) to assess risk for over sedation and the Pasero Opioid-induced Sedation Scale to assess a person's level of sedation with the use of opioids.

Patients (and, when appropriate, their families) should be educated about their role in pain management. This includes the following:

- Importance of reporting pain
- The type of pain treatment they are receiving
- Techniques for managing pain

See Policy

(See policy *Pain Management C144*)

Key Point

Make sure that documentation of the following is complete in each medical record:

- Initial screen / assessment of pain
- Ongoing assessments of pain
- Pain interventions (i.e. medications given)
- Response to pain interventions
- Notation on the patient's plan of care

RESPONDING TO UNANTICIPATED CHANGES IN PATIENT CONDITION

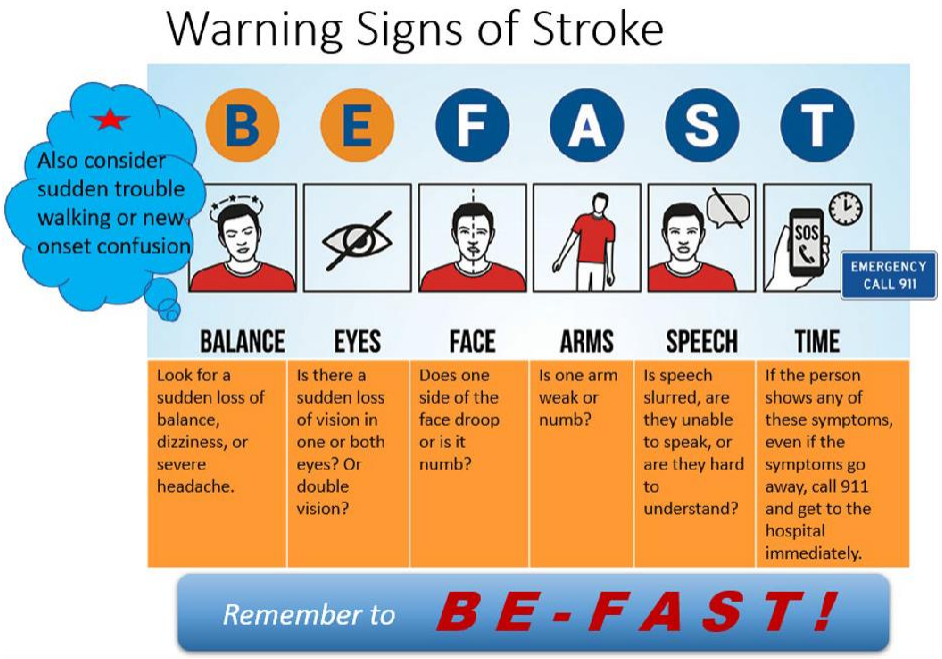
Patients may experience an unanticipated change in condition. The **Rapid Response Team** (RRT) will provide critical care expertise for urgent patient situations throughout the hospital, particularly to a patient showing signs of deterioration. The RRT assists staff to provide early and rapid intervention in order to promote better patient outcomes. The RRT is not meant to take the place of immediate consultation with the physician. For the RRT call the number **777**.
Examples of criteria that may prompt a call to the RRT for an adult patient include the following:

- Acute change in heart rate – less than 40 or greater than 130
- Acute change in systolic blood pressure – less than 90 mmHg
- Acute change in respiratory rate – less than 8 or greater than 28/minute
- Fall in oxygen saturation to less than 90% despite oxygen
- Acute change in mental status
- New onset of seizure activity
- Status epilepticus
- Signs/symptoms of stroke: BEFAST (sudden change in balance, vision, facial droop, speech, arm or leg weakness)
- Suspect sepsis, staff member, family member or visitor is worried about a deterioration in the condition

of the patient. (See policy *Rapid Response Team (RRT) C163)*

STROKE CARE

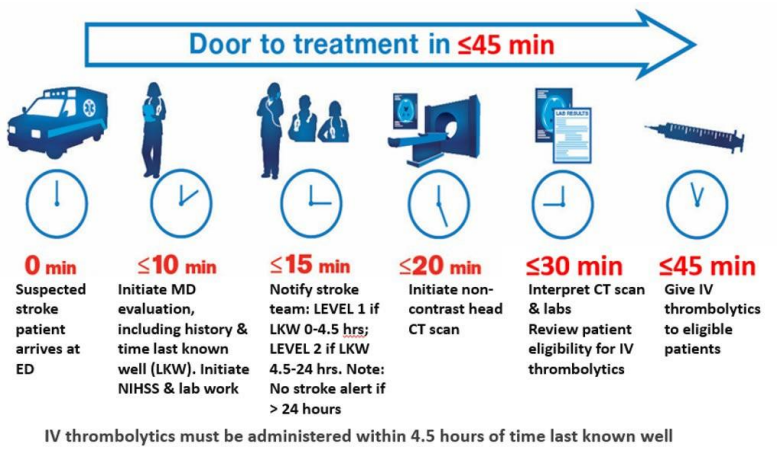
HRMC has certification from the Joint Commission as a Primary Stroke Center Program. Our mission is to provide rapid stroke & TIA treatment for the patients of the Hutchinson Regional Medical Center. HRMC has developed policies and procedures to align the care that we provide to patients with stroke and stroke-like symptoms. Standardized PowerPlans are utilized for guiding stroke patient care upon arrival to the Emergency Department, admission into one of our designated stroke care units (ICU or Telemetry), and discharge. (See policy *Stroke Alert C211*)



ED Stroke Alert

This is a process to alert multiple disciplines within the hospital setting to assist in the rapid assessment and treatment of stroke symptoms in patients of HRMC. To activate the Stroke Alert – Dial "7-7-7" then state the need for a **Stroke Alert** with department and patient room number.

Time Goal for patient assessment and treatment:



VICTIMS OF ABUSE, NEGLECT AND HUMAN TRAFFICKING

Patients are screened upon admission to the organization or upon presenting for care. This screen is conducted by qualified staff' (usually the physician or nurse). Patient care staff is trained on recognizing specific types of abuse.

Examples of abuse, neglect and exploitation include, but are not limited to:

- Physical abuse
- Sexual abuse/assault
- Neglect (failure to provide medical treatment or adequate food, clothing or shelter to a minor by a person responsible for child's care or to an elderly or disabled person by the person's caretaker, family member or other individual who has ongoing relationship with the elderly or disabled person).
- Exploitation (Financial or Human Trafficking)
- Abandonment
- Family violence if a child was involved or witnessed incident
- Human Trafficking – sexual or labor trafficking

Resources:

- Policies:
    - Mandatory Reporting (Child Abuse, Neglect or Sexual Abuse) SYS:GEN010
    - Mandatory Reporting (Adult Abuse, Neglect or Exploitation) SYS:GEN009
    - Human Trafficking
- Sexual Assault Nurse Examiner (call hospital operator to have them paged)

CARE PLANNING

Care planning is interdisciplinary in nature. Each discipline may identify care problems as the result of their assessment activities; however, nursing must have a documented plan of care.

The care plan must meet the required regulatory standards including but not limited to the following:

The criteria (in order of priority) are:

- Life threatening conditions
- Patient safety issues
- Care needs to enable the patient to be discharged
- Patient education needs

Care needs are communicated among the various disciplines through:

- Shift to Shift report – hand off reports
- Patient car rounds
- Documentation in the medical record

(See policy *Interdisciplinary Plan of Care C133*)

KEY POINT

Make sure that all identified patient care problems are documented on the plan of care, and that care plans are reviewed and updated as required by policy

PATIENT BOARDING

Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The Joint Commission recommends that boarding timeframes not exceed 4 hours in the interest of patient safety and quality of care. At HRMC, the Emergency Dept goal is to prevent boarding and provide timely care, treatment and services to our patients. However, to the extent boarding occurs, we will analyze and assess our processes relating to patient flow to seek improvements to reduce the length and frequency of boarding. It is everyone's responsibility to improve patient flow across units and departments throughout HRMC. (See policy *Boarding of Patients in the Emergency Department EDT114*).

PATIENT DIET & FOOD STORAGE

Inpatients are provided a diet designed to maximize their recovery. Diets – including supplements – are ordered by the physician or individual responsible for the patient's care.

HRMC Registered Dieticians have privileges to write orders for medical nutrition therapy (see policy *Registered Dietician (RD) Order Writing Privileges C213*) RDs can also independently change the texture of a diet.

If the patient or family wishes to bring in food, it must be consistent with the ordered diet. Any food brought in for the patient should be identified with the patient's name, date provided, and appropriately stored.

Any food left in refrigerators must be covered and dated when opened. Food must be discarded by the expiration date listed on the container.

PREVENTING PATIENT FALLS (See policy *Fall Prevention C124*)

All patients will be assessed for risk of falls upon admission, during shift assessment and with any change in health status using the Morse Fall Scale. A personalized plan will be developed to decrease the risk for falls.

- Inpatients identified as a fall risk will have a specific plan of care developed to address his or her risk issues. The plan of care will outline applicable safety interventions such as;
  - Visually identifying the patient as a fall risk
  - Communicating the fall risk to members of the healthcare team
  - Increasing the frequency of observation and assistance to the patient for care needs and ambulation
  - Implementing actions to prevent falls or to reduce the potential severity of a fall
  - Determining if the patient would be a good candidate for the Telesitter Program
- A Physical Therapy Consult will be autogenerated if it is identified on the assessment that the patient has fallen within the previous 3 months of the current admission.
  - A Physical Therapist will evaluate the patient and contribute to the patient's plan of care

Monitoring and Interventions for Fall Prevention based on Morse Fall Scale:

- Standard Fall Preventions :
  - Provide fall prevention education (use of call light, encourage not to get up without help) to patient and patient/visitors*. (Attachment C)
  - Write the number of assists on care board (whiteboard)*.
  - Non-slip footwear.
  - Bed in low position.
  - Bed locked*.
  - Room free of clutter and trip hazards.
  - Personal items in reach (cell phone, trash can, bedside table, other possessions).
  - Adequate room lighting
- Morse Fall Scale 45 (**High Fall Risk**) or greater:
  - All interventions listed above
  - Yellow Fall Risk Arm Band
  - Yellow Light outside of room*
  - Document the Interdisciplinary Plan of Care (IPOC).
- Morse Fall Scale 65 (**Extremely High Fall Risk)** or greater:
  - All interventions listed above
  - Bed alarm unless contraindicated*
  - Consider 1:1 observation or telesitter*, refer to C220 Tele-Sitter/Patient Observer Policy and Telesitter/Patient Observer Workflow.

Post-Fall Monitoring and Intervention:

After a patient falls, assess patient according to the Post Fall Assessment. If the patient has an injury that needs medical attention, notify the provider immediately. Following a fall, a patient assessment will be completed.

- After a patient fall, assess the patient for injury, change in status, fall risk and additional fall risk interventions that should be initiated.
- Notify the physician/provider of patient fall/injuries.
- Notify the family of patient fall/injuries*.
- Document the following in the EHR:
  - Post Fall Evaluation.
- Complete an Event Report.
- At handoff, inform all clinical team members about the fall, and any changes to the plan of care.

PATIENT & FAMILY EDUCATION

- Our patients/families receive education necessary to allow them to effectively participate in their care. Patients are assessed for education needs as part of the assessment activities. Needs include, but are not limited to knowledge of disease, medication use, equipment uses, rehabilitative techniques, diet, and access to community resources.
- Barriers to learning include language, education level, speech or hearing difficulties, cultural influences, and a

patient's readiness to learning as well as the language they prefer when receiving their healthcare information.
- If you are responsible for patient education, you should clearly document both the education provided in the patient's medical record, as well as whether or not the patient comprehended the education in their medical record.

DE-ESCALATION TECHNIQUES

- Did you know that in most cases you can prevent escalation of disruptive behavior with your own nonverbal behaviors?
- The ability to organize your thinking and calmly respond are effective de-escalation techniques that can help you avoid a potential crisis.
- Personal space, body language and listening skills can help effectively de-escalate the disruptive behavior of those in your care.
- Usually people listen to respond, instead we should listen to hear and understand.
- The ability to listen with empathy may be the most important attribute of interveners who succeed in gaining the trust and cooperation of parties to intractable conflicts and other disputes with high emotional content.

Top 10 De-Escalation Tips

- Be empathetic and nonjudgmental
- Respect personal space
- Use nonthreatening nonverbals
- Avoid overreacting
- Focus on feelings
- Ignore challenging questions
- Set limits
- Choose wisely what you insist upon
- Allow silence for reflection
- Allow time for decisions

We cannot control what happens in the world. We can control how we respond to it.

AVOID	DO
Argue	Remain calm
Power struggles	Validate
Contradict delusions	Offer choices
Use of leading questions	Ask the question
Judgmental stance	Provide information
Lack of caring	Know your limits
Negative body language	Give space with observation
Labeling of patient	Provide limits
	TRUST Your Gut

USE OF RESTRAINT AND SECLUSION (see policy *Restraint and Seclusion C165*)

- Patients have the right to be free of restraint or seclusion. We believe that the use of restraint or seclusion is a last resort only after other clinical interventions have been considered or attempted.
- Use must be limited to clinically justifiable situations only and never for convenience, punishment, or coercion. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member or others and must be discontinued at the earliest possible time.
- Use the least restrictive restraint for the least amount of time.
- Restraints are used as a LAST resort when all other alternatives have been tried and failed. Restraints are used to manage behavior that is either violent and self-destructive or non-violent and protection of a medical device.
- HRMC does not allow simultaneous use of restraint and seclusion.
- If there is concurrent use of physical restraints and a chemical restraint both requirements must be met for monitoring.

Clinical Justification for Use of Restraints or Seclusion

There are two basic reasons to place someone in restraint or seclusion:
- Non-violent / non-self-destructive behavior such as:
    - Pulling out tubes, drains, or lines necessary for medical care (if restraints are used for these or any other reason, please document well to show why the restraints was implemented)
- Violent / Self destructive behavior such as:
    - Harming self, staff or others
    - Attempting to mutilate or harm self (if restraints are used for these or any other reason, please

document well to show why the restraints were implemented.

Alternatives to Restraints and Seclusion

The use of restraint or seclusion is limited to those situations for which there is adequate and appropriate clinical justification.

- The use of restraint or seclusion is based on the assessed needs of the patient. Restraint or seclusion may **only** be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member or others from harm.
- De-escalation - all interaction is treatment from the start – recognize and respond to at-risk-behaviors.
- The use of restraint or seclusion occurs only after alternatives to such use have been considered and / or attempted as appropriate. Such alternatives may include, but are not necessarily limited to:
    - Assessing for medical reason for behavior/actions
    - Diversional activities
    - Frequent bathroom privileges
    - Modify environment
    - Pain/comfort addressed
    - Verbal reminders
    - 1:1 supervision
    - Adjusting therapies
    - Disguise tubes and lines
    - Reorient to surroundings
    - Move patient closer to nurses' station

Orders for Restraint & Seclusion

If a patient needs to be placed in restraint or seclusion, an order must be obtained. If it is an emergency, staff can place the patient into restraint or seclusion and then obtain the order immediately afterwards**.** PRN orders are NEVER allowed.

**** Note that the "trial removal" of restraint or seclusion is considered a PRN use and is not permitted ****

Physicians, Physician Assistants and Advanced Practice Nurses authorized to order restraint or seclusion by hospital policy in accordance with Kansas State Law must have a working knowledge of the hospital policy regarding the use of restraint or seclusion.

An order for restraints must be obtained from the Physician, Physician Assistant or Advanced Practice Registered Nurse who is responsible for the care of the patient. The order must specify:

- The clinical justification for the restraint or seclusion
- The duration of use
- The type of restraint to be used
- The criteria for release
- The date and time ordered

The attending physician must be consulted as soon as possible if the patient's attending physician does not order the restraint or seclusion.

Restraint orders for **non-violent or non-self-destructive** behavior are good for the duration of the restraint.

Restraint or seclusion orders for **violent or self-destructive** behavior must be re-ordered:

- Every 3 hours for an adult
- Every 2 hours for a child age 9 - 17
- Every 1 hour for a child under the age of 9

After 24 hours, and before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, the provider must see and assess the patient to determine if continuation of restraint or seclusion is warranted.

When a restraint is ordered for violent behavior, a 1-hour face-to-face assessment is required. This may be completed by the provider ordering the restraint or a trained RN who has completed a competency to do so. This assessment includes the following:

- The patient's immediate situation
- The patient's reaction to the intervention
- The patients' medical and behavioral condition
- The need to continue or terminate the restraint
    - When the face-to-face is completed by an RN – he or she is required to consult with the attending physician or other provider responsible for the care of the patient as soon as possible after the evaluation (within one

hour).

What is Considered Physical Restraint?

A restraint is a mechanical device that is intended to restrict a patient's movement or access to their body. In general, the following are considered restraint:

- Mitts
- Limb immobilizers
- Soft wrist or limb
- Velcro limb
- Use of all 4 side rails in the raised position (certain exceptions apply)
- Bed sheets tucked so tightly that the patient cannot move
- Physical or manual Hold

Monitoring of the Patient Placed in Restraint/Seclusion

- The patient placed in non-violent/non-self-destructive behavior restraints will be monitored hourly or more frequently based on patient's condition and nursing judgement.
- The patient placed in violent/self-destructive behavior restraints will be monitored every 15 minutes.

Chemical Restraints (please see policy *Chemical Restraint D101*)

Definitions:
Chemical Restraint - A medication used as a restriction to manage the patient's behavior when they become violent or in danger of hurting themselves, staff, and others – or to restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Administration of this medication would result in:

- Restricting the patient's movement
- NOT be used as a standard treatment for the patient's medical or psychiatric condition

Standard Treatment – medications that are used as part of the patient's standard medical or psychiatric treatment, and are administered within the standard dosage for the patient's condition. Criteria for "standard treatment":

- Doses/indications must be within pharmaceutical parameters approved by FDA
- Follows national practice standards established or recognized by the medical community
- Use of the medication is based on the patient's symptoms, overall clinical situation, and provider's knowledge of that patient's expected and actual response to the medication

It is the expectation that the standard use of a drug or medication to treat the patient's condition **enables the patient to more effectively or appropriately function in the world around them** than would be possible without the use of the medication.

Monitoring of The Patient Given A Chemical Restraint:
A patient who has been chemically restrained must be continuously observed by a staff member who is:

- In the immediate physical presence
- In the same room, and
- Trained to monitor restrained patients

The observations must be documented at 15-minute intervals up to two (2) hours after the medication has been administered.

When medications are ordered as a Chemical Restraint – it is important for the provider to specify that it is for Chemical Restraint in the order.

If the order is being used to treat a medical condition – that condition and/or diagnosis should be documented with the order (i.e. delirium, psychosis, dementia, withdrawal…etc.)

USE OF MODERATE / DEEP SEDATION (see policy *Moderate Sedation/Analgesia (Conscious Sedation) Guidelines ANES 100.10*)

We have established clear requirements for caring for patients receiving moderate or deep sedation.

- A patient must receive a pre-sedation assessment to assure that he/she is an appropriate candidate for the use of sedation.
- Informed consent for the use of sedation is required.
- Only someone qualified to administer anesthesia may administer deep sedation.

- Emergency equipment must be readily available.
- The Physician or a qualified RN throughout the procedure must monitor the patient's cardiovascular and respiratory status.
- The patient must be recovered using the same standard of care used to recover patients from anesthesia.
- Only qualified staff may monitor and recover a patient from moderate or deep sedation.
- An unusual occurrence or incident report should be generated for any patient that requires the use of a "reversal agent" or suffers an untoward effect as the result of sedation.

DISCHARGE PLANNING / CONTINUUM OF CARE (See policy *Discharge Planning Process (QQ114)*

Our organization assures that patient's receive appropriate care during and after their stay by providing the following:
- Transfer and referral agreements exist with other healthcare organizations to assist the patient if it is more appropriate for care needs to be met elsewhere.
- Discharge planners, case managers, and social workers are available to assist with post-care needs.

Patients with the same care needs receive the same level of care regardless of location. This is done by:
- Establishing common policy and procedure
- Establishing similar competencies and training of staff
- Communicating and coordinating care among the various disciplines

MEDICATION USE

STORING & SECURITY OF MEDICATIONS- Medication Storage (See Policy *Control of Medication #3201)*

We have developed specific policies to assure that medications are appropriately stored. These policies require that:

- Internal and external medications should not be mixed together.
- Medications requiring refrigeration must be stored in refrigerators. The temperature of the refrigerator must be monitored in accordance with policy.
- Store medications that are light sensitive appropriately.
- Medications are made available in the most "ready to use" form as possible.
- Medications are provided in unit dose form whenever possible.
- Pharmacy staff' makes routine inspections of medication storage areas to assure compliance with policy.
- "Look alike" and "sound alike" medications are stored with special precautions to alert staff to the potential for retrieval errors.
- Check medication storage areas for expired drugs and return them to pharmacy for disposal.

Medication Security (See Policy *Medication Access and Security D154)*

We have developed a specific policy to assure that medications are appropriately secured. This policy requires that:
- All medications, biologicals and information are secured and not accessible to unauthorized personnel.
- A Pyxis machine or other locked cabinetry will be utilized for medications on nursing units and in clinical departments.
- Nurse Server medication drawers will be locked at all times when unattended.
- Department personnel and pharmacy will review secured storage areas to ensure proper control and storage of all medications and biologicals.
- Access to medication, biologicals and information storage areas is limited to personnel who are authorized to work in the areas.

ORDERING OF MEDICATIONS (See policy *Receipt of Physician Orders by Clinical Staff (C151*) and *Medication Administration (D121)*)

Medications may only be administered upon an order by the physician or other authorized prescriber. Medication orders must be written clearly and with sufficient information to staff so that the order can be implemented safely and appropriately.
- PRN orders must have the indication for use written as part of the order (e.g. "PRN for pain").
- Duplicate therapy (e.g. two or more PRN orders for the same clinical indication) must be written in a manner that provides sufficient direction to staff to determine which medication or the order of medications to be given. Therapeutic duplication orders are not permitted without meeting these criteria.
- Orders that direct the implementation of a protocol must specifically state that the protocol is to be used (e.g. "Start

Dopamine drip per protocol").

- Titration orders must note the parameters for titration.

Medication orders that are unclear or not written appropriately should be clarified with the prescriber prior to administration.

LABELING OF MEDICATIONS (See policy *Labeling Medications #3417*)

Medications must be labeled anytime they are prepared but not immediately administered. All medications prepared must be correctly labeled with the following:

- Name and location of patient
- Medication name, strength and amount (if not apparent from the container).
- Beyond-use date and time
    - Route of administration
- The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas.
- Multi-dose vials must be dated with 28 days from initial puncture or by the manufacturer's expiration date; whichever comes first.

ADMINISTRATION OF MEDICATIONS (See policy *Medication Administration D121*)

We have developed specific policies to guide staff in administering medication. Key steps to safely administering medication include:

- Wash your hands.
- Correctly identify the patient using two patient identifiers.
- Verify that you have the correct medication/dose/route against both the drug label and the medication order.
- Check the expiration date on the drug to make sure it is still good. Do not use if the drug has expired.
- As appropriate, visualize the medication for stability (i.e., color, clarity, presence of particulate matter). Do not use if the medication appears to be compromised.
- Check the patient's medical record to make sure there are no contra-indications to giving the medication.
- Verify that you are giving the medication at the proper time.
- Advise the patient of the purpose of the medication, and, as appropriate, of any potential adverse reactions or side effects.
- If it is the first time the patient is receiving the medication, be prepared to describe how you monitor the patient's reaction.

If you have any questions or concerns regarding the medication, discuss them in advance with the physician or call the pharmacist for assistance.

MEDICATION ERRORS/ADVERSE DRUG REACTIONS (See policy *Adverse Drug Events D152*)

Do you need to administer any of the following: Flumazenil, Phytonadione, Dextrose 50%, Glucose, Naloxone, or Diphenhydramine? If so you most likely treated an adverse drug reaction. Respond according to the policy D152.

The following strategies have been developed to spot potential adverse drug reactions:

- Pay particular attention to the first time a patient receives a medication.
- Monitor for allergic reactions such as fever, rash, anaphylaxis.
- Monitor for hypersensitivity to a drug such as changes in vital signs, acute or severe manifestations of side effects.
- Look for drug intolerance – a lowered threshold to the normal pharmacological effect of the drug.
- Look for idiosyncratic reactions – an uncommon response by a patient to a drug given at normal doses.

Staff should take the following actions when there is a suspected adverse drug reaction or medication error:

- Support the patient. Assess the patient for untoward effects. Notify the patient's attending physician.
- Notify a pharmacist to report the reaction.
- Complete an event report.
- Document the pertinent facts in the patient's medical record.

PATIENT'S OWN MEDICATIONS (See policy *Patient's Home Medication, Utilization, Storage, and Destruction D125*)

Patients may only use their own medication if it is a medication not on the hospital formulary, or the medication is an oral contraceptive or injectable allergenic extract. If a patient is permitted to use their own medication, staff is to do the following:

- Medication needs to go to pharmacy with a tamper evident tape placed over the cap of each medication in the presence of the patient. Both the patient – or patient's representative – and the nurse will date and initial the tape.
- Place meds in a bag labeled with the patient's identification information and take to pharmacy by either the nurse or a pharmacy representative.
- The medication will be listed on the medication administration record as the "patient's own supply".
- The pharmacy will dispense each dose of drug as ordered.

MANAGEMENT OF HIGH-RISK MEDICATIONS (See *High Alert Medications; Concentrated Electrolytes Policy D155 and Medication Administration Policy D121)*

There are certain medications that the organization has determined to be of high risk. The list below identifies those classes of medications and summarizes steps that have been taken to safely manage them. See the "HALT" High Alert Look Twice Medication List for medications that require an independent double check prior to administration and at shift change.

"HALT" (High Alert Look Twice) Medication List Requiring TWO PROVIDER Check

- **Insulin**
  - Infusion, intravenous push
- **Opioids**
  - Epidural continuous infusions
  - Fentanyl continuous infusions
  - HYDROmorphone (PCA only)
  - Morphine (PCA only)
- **Antithrombotic Agents**
  - Heparin infusion
  - Alteplase (not declot PICC line alteplase)
  - Eptifibatide
  - Tenecteplase
- **Chemotherapy/antineoplastic agents**
- **Magnesium**
  - Large volume or continuous infusion (>500 ml)
- **TPN and Intralipids**
- **EPINEPHrine**
  - Infusion and boluses
- **Neuromuscular Blockers**
  - Cisatracurium
  - Rocuronium
  - Succinylcholine
  - Vecuronium
- **Moderate Sedation Agents**
  - Midazolam infusion
  - Propofol infusion
  - Lorazepam Infusion
  - Ketamine Infusion
  - Dexmedetomidine Infusion

MANAGEMENT OF HAZARDOUS MEDICATIONS (See policy *Chemotherapy/Hazardous Medication Administration and Handling D102)*

There are certain medications that the organization has deemed to be hazardous. The tables below list those medications.

Generic Name - Oral	Brand Name
Abacavir/lamiVUDine/Zidovudine	Trizivir
Acitretin	**Soriatane**
Ambrisentan	Letairis
Anastrozole	**Arimidex**
AzaTHIOprine	Imuran
Bicalutamide	**Casodex**
Bosentan	Tracleer
Capecitabine	**Xeloda**
CarBAMazepine	Tegretol
ClomiPHENE	**Serophene, Clomid**
ClonazePAM	Klonopin
Colchicine	**Colcrys**
CycloSPORINE	Neoral, Gengraf, SandIMMUNE
Divalproex	**Depakote**
Dronedarone	Multaq
Dutasteride	**Avodart**
Erlotinib	Tarceva
Estradiol	**Estrace, Minivelle, Climara, Vagifem**
Estradiol/Norethindrone	Combipatch
Estrogens, conjugated	**Premarin**
Estropipate	Ortho-Est
Exemestane	**Aromasin**
Finasteride	Proscar
Fingolimod	**Gilenya**
Fluconazole	Diflucan
Hydroxyurea	**Hydrea**
Leflunomide	Arava
Letrozole	**Femara**
MedroxyPROGESTERone	Provera
Megestrol	**Megace**
Mercaptopurine	Purinethol
MethIMAzole	**Tapazole**
Methotrexate	Rheumatrex
Methylergonovine	**Methergine**
MiSOPROStol	Cytotec
Mycophenolate	**Cellcept, Myfortic**
OXcarbazepine	Trileptal
Paliperidone	**Invega**
PARoxetine	Paxil
Phenytoin	**Dilantin**
Progesterone	Crinone, Prometrium
Raloxifene	**Evista**
Rasagiline	Azilect
RisperiDONE	**Risperdal**
Sirolimus	Rapamune
Spironolactone	**Aldactone**
Tacrolimus	Prograf
Tamoxifen	**Soltamox**
Temazepam	Restoril

Temozolomide	**Temodar**
Tofacitinib	Xeljanz
Topiramate	**Topamax**
Tretinoin	Accutane
ValGANciclovir	**Valcyte**
Valproate	Depakene
Voriconazole	**Vfend**
Warfarin	Coumadin
Zidovudine	**Retrovir**
Ziprasidone	Geodon
Zonisamide	**Zonegran**

Generic Name – Non-oral, Non-chemo	Brand Name
Fosphenytoin	Cerebyx
Ganciclovir	**Cytovene**
Liraglutide	Victoza
MedroxyPROGESTERone	**Depo-Provera**
Methylergonovine	Methergine
Oxytocin	**Pitocin**
Paliperidone	Invega Sustenna
Pamidronate	**Aredia**
Testosterone Cypionate	Depo-Testosterone
Valproic acid	**Depacon**
Voriconazole	Vfend
Ziprasidone	**Geodon**
Zoledronic Acid	Zometa

Generic Name – Non-oral, Chemo	Brand Name
Atezolizumab	Tecentriq
AzaCITIDine	**Vidaza**
Bevacizumab	Avastin
Bevacizumab-awwb	**Mvasi**
Bevacizumab-bvzr	Zirabev
Bevacizumab-maly	**Alymsys**
Bleomycin	Blenoxane
Bortezomib	**Velcade**
Brentuximab	Adcetris
CARBOplatin	
CISplatin	
Cladribine	
Cyclophosphamide	Cytoxan
Cytarabine	
Dacarbazine	
Daratumumab-Hyaluronidase-fihj	**Darzalex Faspro**
Decitabine	Dacogen
Degarelix	**Firmagon**
DOCEtaxel	Taxotere
DOXOrubicin	**Adriamycin**
Durvalumab	Imfinzi
Etoposide	**Toposar**
Fluorouracil	Adrucil
Fulvestrant	**Faslodex**

Gemcitabine	Gemzar
Goserelin	**Zoladex**
IDArubicin	Idamycin PFS
Ifosfamide	**Ifex**
Irinotecan	Camptosar
Leuprolide	**Eligard/Lupron**
Lurbinectedin	Zepzelca
Methotrexate	**Rheumatrex**
MitoMYcin	Mutamycin
MitoXANTRONE	**Novantrone**
Oxaliplatin	Eloxatin
PACLitaxel protein bound	**Abraxane**
PACLitaxel	Taxol
Panitumumab	**Vectibix**
PEMEtrexed	Alimta
Pertuzumab	**Perjeta**
RiTUXimab	Rituxan
RiTUXimab-abbs	**Truxima**
Topotecan	Hycamtin
Trastuzumab	**Herceptin**
Trastuzumab-anns	Kanjinti
Trastuzumab-dkst	**Ogivri**
VinCRIStine	Vincasar PFS
VinBLAStine	**Velban**
Vinorelbine	Navelbine

Table 5 provides general guidance for some of the possible scenarios that may be encountered in healthcare settings where hazardous drugs are handled, but it cannot cover all possible situations.

Abbreviations and footnotes. BSC = Class II biological safety cabinet; CACI = compounding aseptic containment isolator; CSTD = closed system drug-transfer device; HIPEC = hyperthermic intraperitoneal chemotherapy.

*This guidance applies to the drugs in Tables 1–3. For more detailed information on safe-handling practices, see the reference list [NIOSH 2004; ASHP 2006; ONS 2011; USP 2016; OSHA 2016].

†For nonsterile preparations, a ventilated engineering control such as a fume hood or Class I BSC or a HEPA-filtered enclosure (such as a powder hood) is sufficient if the control device exhaust is HEPA filtered or appropriately exhausted to the outside of the building. It is recommended that these activities be carried out in a control device, but it is recognized that under some circumstances, it is not possible. If the activity is performed in a ventilated engineering control that is used for sterile intravenous preparations, a thorough cleaning is required following the activity.

‡Required if patient may resist (infant, unruly patient, patient pre-disposed to spitting out, patient who has difficulty swallowing, veterinary patient) or if the formulation is hard to swallow.

§Sterile gloves are required for aseptic drug preparation in BSC or CACI.

¶Intravenous tubing already attached and primed.

Table 5. Personal protective equipment and engineering controls for working with hazardous drugs in healthcare settings*

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
All types of hazardous drugs	Receiving, unpacking, and placing in storage	no (single glove can be used, unless spills occur)	yes, when spills and leaks occur	no	yes, when spills and leaks occur	no
Intact tablet or capsule	Administration from unit-dose package	no (single glove can be used)	no	no	no	N/A
Tablets or capsules	Cutting, crushing, or manipulating tablets or capsules; handling uncoated tablets	yes	yes	no	yes, if not done in a control device	yes†
	Administration	no (single glove can be used)	no	yes, if vomit or potential to spit up‡	no	N/A

(Continued)

Table 5 (Continued). Personal protective equipment and engineering controls for working with hazardous drugs in healthcare settings*

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
Oral liquid drug or feeding tube	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes†
	Administration	yes	yes	yes, if vomit or potential to spit up†	no	N/A
Topical drug	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes†, BSC or CACI (Note: carmustine and mustargen are volatile)
	Administration	yes	yes	yes, if liquid that could splash†	yes, if inhalation potential	N/A
Subcutaneous/ intra-muscular injection from a vial	Preparation (withdrawing from vial)	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes, BSC or CACI
	Administration from prepared syringe	yes	yes	yes, if liquid that could splash†	no	N/A
Withdrawing and/or mixing intravenous or intramuscular solution from a vial or ampoule	Compounding	yes§	yes	no	no	yes, BSC or CACI; use of CSTD recommended
	Administration of prepared solution	yes	yes	yes; if liquid that could splash†	no	N/A; CSTD required per USP 800 if the dosage form allows

(Continued)

Table 5 (Continued). Personal protective equipment and engineering controls for working with hazardous drugs in healthcare settings*

Formulation	Activity	Double chemo-therapy gloves	Protective gown	Eye/face protection	Respiratory protection	Ventilated engineering control
Solution for irrigation	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes, BSC or CACI; use of CSTD recommended
	Administration (bladder, HIPEC, limb perfusion, etc.)	yes	yes	yes	yes	N/A
Powder/solution for inhalation/ aerosol treatment	Compounding	yes	yes	yes, if not done in a control device	yes, if not done in a control device	yes, BSC or CACI
	Aerosol administration	yes	yes	yes	yes	yes, when applicable
	Administration	yes	yes	yes, if liquid that could splash†	yes, if inhalation potential	N/A
Drugs and metabolites in body fluids	Disposal and cleaning	yes	yes	yes, if liquid that could splash	yes, if inhalation potential	N/A
Drug-contaminated waste	Disposal and cleaning	yes	yes	yes, if liquid that could splash	yes, if inhalation potential	N/A
Spills	Cleaning	yes	yes	yes	yes	N/A

LOOK ALIKE OR SOUND ALIKE MEDICATIONS (See policy *Look-Alike, Sound Alike Medication Management #3215*)

Medications that look or sound alike carry a high risk for errors. Our organization has selected combinations of drugs that look or sound alike. The table below lists these drug combinations and the strategies we have taken to prevent errors. Tall man lettering gives an alert that a look-or sound-alike drug is being dispensed or administered.
The following is the most current HRMC approved list of look-alike, sound-alike medications:

Look-Alike/Sound-Alike Medication List

amlodipine and amiloride
amphotericin B liposomal and amphotericin B
atomoxetine and atorvastatin
buPROPion and buSPIRone
carbamazepine and oxcarbazepine
CARBOplatin and CISplatin
chlordiazepoxide and chlorproMAZINE
clonazepam and clozapine
clonazepam and clonidine
clonidine and clozapine
DTaP (Daptacel) and Tdap (Adacel)
DAUNOrubicin and DAUNOrubicin lipid based
DAUNOrubicin and DOXOrubicin
DOXOrubicin and DOXOrubicin lipid based
DOBUTamine and DOPamine
ephedrine and epinephrine
fentanyl and sufentanil
folic acid and folinic acid
glipiZIDE and glyBURIDE
guaifenesin and guanfacine
hydrALAZINE and hydrOXYzine
hydrALAZINE and hydroCHLOROthiazide
hydroCLOROthiazide and hydrOXYzine
HYDROmorphone and morphine
lamictal and terbinafine (lamisil)
levetiracetam and levofloxacin
levothyroxine and liothyronine
medroxyPROGESTERONE (Depo-Provera) and medroxyPREDNISolone (Depo-Medrol) and medroxyTESTOSTERone (Depo-Test)
metformin and metronidazole
metoprolol succinate and metoprolol tartrate
morphine liquid and morphine concentrated liquid
niCARdipine and NIFEdipine
niCARdipine and niMODipine
niMODipine and NIFEdipine
oxycodone controlled release and oxycodone immediate release
Insulin products Humalog and Humulin Novolog and Novolin Humulin and Novolin Humalog and Novolog Novolin 70/30 and Novolog Mix 70/30 Insulin lispro Insulin human regular Insulin aspart Insulin NPH **Insulin aspart and protamine 70/30** Insulin human regular and NPH 70/30
K-Phos Neutral and Neutra-Phos-K
paclitaxel and paclitaxel protein-bound particles
pentobarbital and phenobarbital
PrenisoLONE and predniSONE
quiNIDine and quiNINE
rifampin and rifaximin
rimantadine and ranitidine
risperiDONE and ROPINirole
saxagliptin and sitagliptin
sufentanil and fentanyl
sulfADIAZINE and sulfasalazine
Sumatriptan and zolmitriptan
valacyclovir and valganciclovir
vinblastine and vincristine

HRMC MEDICATION DISPOSAL GUIDELINES (See Medication *Waste Policy D151)*

HUTCHINSON
REGIONAL MEDICAL CENTER

HRMC Medication Disposal Guidelines

White bin/blue lid	Trash can	Sink	Red sharps box	Black bins	Yellow bins
					
All medications except for inhalers All IV fluids and tubing that contain medication except for salt/electrolyte solutions, chemo, and insulin bags Controlled substances wasted from a syringe and fentanyl patches	All empty bags & empty tubing except insulin All empty syringes All empty vials All empty insulin vials	IV solutions containing salts and electrolytes including: *Potassium chloride *Potassium phosphate *Sodium phosphate *Calcium *Sodium bicarbonate *Dextrose *Sodium chloride *Sterile water	Needles or syringes with needles attached Broken glass vials /ampules	Insulin bags and tubing with any insulin in it Insulin vials with medication remaining in it	All empty chemotherapy products including oral medication packaging Trace protective personal equipment (PPE)

REVIEW OF MEDICATION ORDERS BY PHARMACY

Our policy requires that Pharmacy review all new medication orders before staff may give the first dose. That means that staff cannot take the medication from stock until Pharmacy has reviewed the order. There are some exceptions:

- The Physician is in control of the medication process such as during surgery, invasive procedures, etc.
- There is a clinical emergency and there is no time for Pharmacy to review the order (i.e. Code Blue, impending cardiovascular or respiratory failure, etc)

IV ADMIXTURE OUTSIDE OF PHARMACY

It is expected that the admixture of IV medications occurs in the pharmacy.
- Only staff who have been trained and deemed competent to perform IV admixture may do so
- The admixture must be done in a functionally clean and designated area using aseptic technique

ANTIMICROBIAL STEWARDSHIP PROGRAM (AMS) (see policy *Antimicrobial Stewardship Program D145*)

The key objectives of this program for HRMC includes implementation of directed antimicrobial use optimization, providing antibiotic expertise and educational guidance, and to monitor and report on antimicrobial prescription trends, thus reducing inappropriate antimicrobial use and improving patient care outcomes by limiting adverse consequences of antimicrobial use.

ANTICOAGULATION COMMITTEE/PROGRAM (see policy *Anticoagulation Management for Adults D157*)

All adults admitted to HRMC will be assessed for venous thromboembolism (VTE) risk and shall receive appropriate VTE prophylaxis unless contraindicated. (See policy *VTE Risk Assessment Intervention C208*)

Patients receiving anticoagulant therapy will have medications ordered, prepared, dispensed, administered and monitored. The following requirements govern the overall approach to managing patients on anticoagulant therapy.
- There must be a clear and appropriate indication for use.

- The particular type of anticoagulation used shall be the most appropriate and clinically indicated for the condition or reason for use.
- Where appropriate, patient's laboratory values will be monitored while on anticoagulant therapy.
- Pharmacy will review orders for anticoagulation therapy against normative and patient specific information regarding indications for use, dosage, route, frequency, contraindications, duplicative therapy, and drug/drug interactions. Issues or concerns will be brought to the attention of the prescribing practitioner for appropriate resolution (unless emergent situations) before the medication is dispensed.

For reversal of or management of bleeding with anticoagulants, HRMC has an Emergent Anticoagulation Reversal Guidelines (see Anticoagulation Reversal Guidelines D150-G).

The purpose of this committee in coordination with medical staff, is to develop comprehensive anticoagulation protocols based on best practices or evidence-based guidelines are to reduce the likelihood of patient harm.
The Anticoagulation management program includes the following:

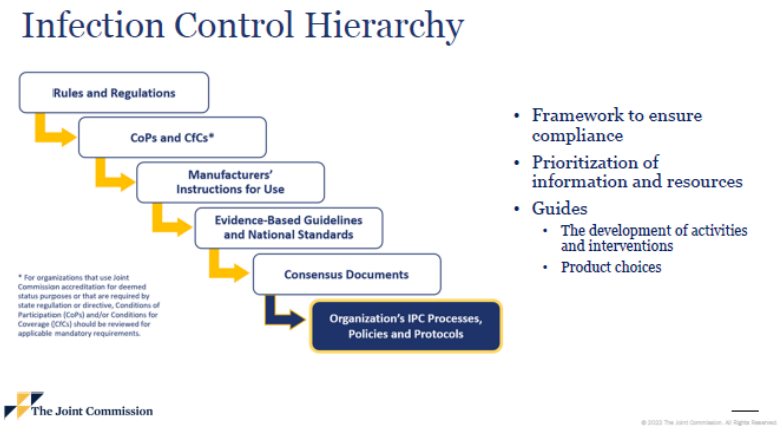
1. Protocols and evidence-based guidelines:
    a. Anticoagulation Guidelines for Neuraxial Procedures
    b. Anticoagulant Transitions
    c. Atrial Fibrillation
    d. Emergent Anticoagulation Reversal
    e. Heparin Induced Thrombocytopenia Treatment
    f. Thromboembolism Treatment
    g. Valvular Heart Disease and Peripheral Arterial Disease
    h. Periprocedural Management of Anticoagulants
2. Anticoagulant medications will be ordered by indication or have an indication specified on the order.
3. The role of the pharmacist in managing anticoagulant therapy is based on medical staff approved hospital protocols.

INFECTION CONTROL

INFECTION PREVENTION AND CONTROL RESOURCES

Each area of the facility has distinct and varied needs pertaining to infection prevention. However, there are standards and guidelines that all patient and non-patient care areas must follow to prevent the spread of infections to our patients, visitors and staff. All employees, physicians, volunteers, and students are required to complete a comprehensive system wide general orientation program for infection prevention. Each employee is required to complete HealthStream training modules pertaining to infection prevention, as appropriate for their job duties and as part of system orientation. This training is completed annually, and anytime his/her job assignment changes and more training is required.

Policy resources for specific infection prevention measures include:
- *Infection Prevention Guidelines GG103*
- *Exposure Control Plan GG106*
- *Isolation/Transmission Based Precautions GG108*
- *Hand Hygiene GG111*
- *Standard Precautions GG137*
- *Isolation for New Novel Virus Infections GG190*
- *Isolation for SARS CoV 2 (COVID 19) Virus GG183*



USE OF ISOLATION

Certain patients may require isolation. The table below lists the various types of isolation used in our organization and the specific precautions that must be taken: ****Note: Best practice guidelines such as the CDC should be followed*****

Isolation Precautions for Select Infections and Diseases
(policy *Isolation/Transmission Based Precautions GG108*)

This is a list of infections and diseases that are frequently encountered in healthcare. Patients suspected of having any of these infections or diseases should be placed in precautions until the infection is ruled out.

NOTE: Airborne and Droplet precautions now require gown and gloves. Contact precautions with Airborne and/or Droplet are no longer indicated, unless they meet the guidelines for Contact as well as airborne or Droplet.

Infection/Disease	Isolation Precaution	Duration of Isolation
Abscess, Major wounds or draining wounds *Required if no dressing, dressing requires changing* *more than 3 times per day, or wound is being irrigated.*	**Contact**	Duration of condition
Bed Bugs	**Special Precautions**	Duration of Hospitalization
Carbapenem-resistant Enterobacteriaceae (CRE)	**Contact**	Duration of Hospitalization
C.difficile and other infectious diarrhea	**Contact Plus**	Antibiotic Therapy must be completed. Formed stools for 48 hours.
Covid-19, SARS CoV 1, MERS CoV, and all novel viruses	**Respiratory Precautions**	Duration of illness
Extended Spectrum Beta- lactamase (ESBL positive)	**Contact**	Duration of Hospitalization
Hepatitis A, B C HIV/AIDS	**Standard Precautions**	Duration of illness
Lice (Pediculosis, Scabies)	**Contact**	24 hours after treatment
Measles (Rubeola)	**Airborne**	4 days after onset of rash, Duration of illness for the
Meningitis, bacterial	**Droplet**	24 hours after initiation of appropriate antibiotics
MRSA (Methicillin Resistant Staphylococcus aureus)	**Contact**	Duration of hospitalization
MRSA Pneumonia	**Droplet**	Duration of hospitalization.
Mumps (infectious parotitis)	**Droplet**	For 9 days after onset of swelling
Novel viruses, e.g. Monkeypox, and SarsC0V2 that does not require negative pressure	**Droplet Plus**	Duration of hospitalization, unless CDC requires different length of time
Rubella (German Measles)	**Droplet**	For 7 days after the onset of rash
Shingles (Varicella Zoster) Disseminated or localized in immunocompromised patients	**Airborne**	Until lesions have crusted
Shingles (Varicella Zoster) localized in normal patient	**Contact**	Until lesions have crusted

Tuberculosis (TB)	**Airborne**	Negative pressure required until TB ruled out or has three negative smears
VRE (Vancomycin Resistant Enterococcus)	**Contact**	Duration of hospitalization

NOTE: per standard precautions, any time a patient is coughing a mask should be worn when within three (3) feet of the patient, in addition or other isolation requirements.

Isolation Precautions for Positive Results on a Respiratory Panel

Place on precaution as soon as the Respiratory Panel is ordered. If the flu screen is negative, but the panel is still pending, maintain precautions until the panel results are available.

NOTE: with the change in Droplet Precautions requiring gown and gloves, Contact with Droplet and Contact with a mask has changed to Droplet.

Infection	Isolation Precaution	Duration of Isolation
Adenovirus Children and immunocompromised adults	**Droplet**	Duration of illness
Coronavirus: 229E, UKU1, NL63, OC43	**Droplet**	Five days after test collected provided afebrile and no cough
Covid-19, SARS CoV 1, MERS CoV, and all new novel viruses	**Respiratory Precautions**	Duration of illness
Human Metapneumonovirus	**Droplet**	Duration of illness
Rhinovirus	**Droplet**	Duration of illness
Enterovirus for diapered or incontinent children only	**Contact precaution**	Duration of illness
Influenza A Influenza B	**Droplet**	Five days from onset of symptoms, and afebrile for 24 hours (without fever reducing medications) whichever is greater.
Para Influenza 1 – 4	**Droplet**	Duration of illness
Respiratory Syncytial Virus (RSV) Children and immunocompromised adults.	**Droplet**	Duration of illness
Bordatella Pertussis	**Droplet**	Maintain isolation for five (5) days after initiation of antibiotics
Chlamydophila pneumonia	**Droplet**	Duration of hospitalization
Mycoplasma Pneumonia	**Droplet**	Duration of Illness

NOTE: per standard precautions, any time a patient is coughing, a mask should be worn when within three (3) feet of the patient, in addition or other isolation requirements.

See policy to determine the (*Type of Precautions for Communicable Diseases see GG179-G)*

Red Box Safe Zone (see policy *Isolation Precautions (using CDC's Transmission Based Precautions) & The Red Box Safe Zone GG108*)

If present, red tape will be placed on the floor at the time the isolation is initiated, past the threshold of the door. If the

red lines are present, PPE is not indicated provided the HCW stays within the red lines. When crossing the red line, must have appropriate PPE on including: gown, gloves, mask or mask with eye shield, as indicated by the isolation category. If there are no red lines on the floor, PPE is required to cross the threshold into the isolation room.

HAND HYGIENE (See policy *Hand Hygiene GG111*)

Washing your hands is the single most effective way of preventing the spread of infection among staff and patients. Our organization adheres to the CDC recommendations for good hand hygiene (soap or alcohol gel should cover all surfaces of hands and fingers, including thumbs and fingernails) :
Wash hands (for at least 20 seconds) or use the alcohol gel/foam sanitizer (rub hands until dry):

- Prior to entering the patient's room
- Before donning sterile gloves for procedures
- After contact with blood or body fluids
- After removing gloves
- When leaving the patient's room
- You must wash your hands with **soap and water** for any of the following:
    - Engaged in food preparation
    - After using the restroom
    - If your hands are visibly soiled
    - Caring for a patient with C-Difficile
    - At the start of your shift and before you go home after your shift

    Hand Hygiene compliance is monitored by direct observation.

CLEANING & DISINFECTING OF EQUIPMENT (See policy *Equipment Cleaning and Equipment Flagging GG125*)

It is important to assure that equipment and the patient's care environment is appropriately cleaned and disinfected. The cleaning agents routinely used in patient care areas (i.e. cleaning wipes) all carry what is called a "wet contact" or **dwell time**. This is the minimal amount of time that the surface being cleaned **must** remain visibly moist before it can be considered appropriately disinfected. Contact "dwell" time is noted on the chemical packaging label.

Staff' who are responsible for cleaning and disinfecting equipment and environmental surfaces must be aware of the wet contact time of the agents they are using and follow manufacturer instructions for use of the cleaning agents.

All clean equipment will be flagged with blue tape, or otherwise indicated as clean prior to being placed into storage locations. Be familiar with the policy and proper cleaning of equipment used in the area you will be working.

HIGH LEVEL DISINFECTION (HLD) (See policy *High Level Disinfection Pre-Cleaning and Transport GG179*)

All instruments that touch non-intact skin, mucous membranes, or used for invasive procedures will be HLD, or sterilized prior to use on another patient. Precleaning is applied at the point of use in the procedure room or Operating Room (OR) to remove blood, body fluids, and bioburden from items that are to be reprocessed based on the instructions for use from the manufacturer and evidence-based guidelines.

Staff that will be transporting instruments for sterilization and those who will be completing the HLD with the Trophon 2 will be trained in the HLD process.

HLD for sonography probes will be done utilizing the Trophon 2 HLD process. (see policy *High Level Disinfection (HLD) Using the Trophon 2 GG171*) The purpose of the Trophon 2 is to high level disinfect all ultrasound transducers according to a specified process. To prevent cross contamination, gel packaged for single use will be used on all patients. After each patient interaction, ultrasound probes will be low level disinfected with approved disinfectant. Those patients that meet semi-critical or critical classification, as defined in the policy, will be high level disinfected.

MANAGING MULTI-DRUG RESISTANT ORGANISMS (MDRO)

Our organization performs an annual risk assessment to identify the risk of acquisition and transmission of multi-drug-resistant organisms (MDRO). Based on this assessment, the organization has identified the following MDRO to be of epidemiologic significance:

- MRSA (*methicillin resistant Staphylococcus aureus*)
- VRE (*vancomycin resistant Enterococcus*),
- CDI *(Clostridioides difficile)*
- CRE (*Carbapenem Resistant Enterobacteriaceae*)
- ESBL (*Extended Spectrum Beta-Lactamase*)

To effectively reduce the risk of transmitting or acquiring an infection from these organisms, the following measures have been employed:

Use of Personal Protective Equipment

Gloves, gowns, and masks should be worn as appropriate to the specific communicable condition being treated. PPE are not to be worn out of the patient's room, see policy for exceptions. Consult appropriate infection control policy if you have any questions.
(Isolation/ Precautions and the Red Box Zone GG108)

Patient Transport

As much as possible, necessary treatments and procedures should be performed at the patient's bedside. If essential tests must be performed in another area, the department should be notified that the patient has an MDRO prior to transporting the patient to the department. Beds should not be used to transport patients our of their room, see exception in the isolation policy.

PREVENTING CENTRAL LINE INFECTIONS (See policy *Central Venous Catheters and Midline Management D134*)

It is the policy of our organization to implement practices consistent with evidence-based standards of care to reduce the risk of central venous catheter associated blood stream infections. These practices include, but are not necessarily limited to, the following:

Central Venous Catheter Insertion

Whenever a central venous catheter is inserted, the following shall occur:

- If possible, the procedure should be explained to the patient and family. Appropriate consent – if required – should be obtained for non-emergent need.
- Hand hygiene must be performed by all staff involved in the procedure prior to catheter insertion.

Maximum barrier precautions shall be deployed, including hair cover, masking, and sterile gowning/gloving of all personnel involved in the procedure, as well as sterile prepping and draping of the insertion site.

- If body hair needs to be removed, it should be clipped rather than shaved.
- An evidence-based antiseptic skin preparation shall be used.
- Catheters should not be inserted into the femoral vein unless other sites are not available.
- Catheters should be secured in place and a sterile occlusive dressing applied following insertion.
- Confirmation of proper placement (e.g. x-ray or another test) may be performed.

Accessing Central Venous Catheters

To reduce the risk of infection, hands will be washed thoroughly or disinfected with alcohol sanitizer then gloved prior to any manipulation of the IV infusion system or insertion site. Accessing central venous catheters should be limited to necessary use. Catheter hubs and injection ports must be appropriately disinfected (per policy) prior to use.

Dressing Changes

Dressing changes are to occur as required by policy.

Removal of Central Venous Catheters

Catheters should be evaluated routinely and removed as soon as the patient's clinical status and needs will allow. Non-essential catheters should be removed.

PREVENTING SURGICAL SITE INFECTIONS

We are committed to reducing the incidence of surgical site infections. Please note the following evidence-based practices:

Preparation of the Patient (See policy *Preps (Surgical Site) C193*)

Whenever possible, infections remote to the surgical site should be identified and treated before elective procedures. Elective procedures should be postponed – if necessary – until the remote infection has resolved.

Patients are instructed to shower with an antiseptic agent the night before and the morning of the operative day.

Hair should not be removed preoperatively unless the hair at or around the incision site will interfere with the operation. If hair must be removed, it should occur immediately before the operation, with electric clippers. Shaving is not an appropriate method for hair removal.

The area around the intended incision site should be thoroughly washed and cleaned to remove gross contamination before performing antiseptic skin preparation. Chlorhexidine-based, and iodine-based are acceptable for use as antiseptics. When an antiseptic agent is applied, the prepared area must be large enough to extend the incision or create new incisions or drain sites, if necessary.

Antisepsis for Operative Personnel (*See policy Surgical Hand Scrub Policy C191* and *Surgical Attire GG180)*

Nails should be kept short. Artificial nails should not be worn. Personnel should perform a preoperative surgical scrub for at least 2 to 5 minutes using an appropriate antiseptic. Hands and forearms should be scrubbed up to the elbows.

After performing the surgical scrub, hands should be kept up and away from the body (elbows in flexed position) so that water runs from the tips of the fingers toward the elbows. Hands should be dried with a sterile towel and staff should then don a sterile gown and gloves.

Postoperative Incision Care

For an incision that has been closed primarily, the site should be protected with a sterile dressing for 24 to 48 hours postoperatively. When a dressing must be changed, sterile technique should be deployed. Staff should follow appropriate hand hygiene practices when checking or changing dressings.

PREVENTING URINARY TRACT INFECTIONS (see policy *Prevention of Catheter Associated Urinary Tract Infections (CAUTI) GG113)*

Our organization has implemented evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI). We have implemented a process to insert indwelling urinary catheters according to established evidence-based guidelines that include:

- Limiting use and duration to situations necessary for patient care
- Using aseptic techniques for site preparation, equipment and supplies

*All urinary catheters will be inserted with a physician's written order that includes the indication for the catheter, if the order does not include an indication the catheter should not be placed until the physician is contacted to obtain the indication which is outlined in the policy (GG113).

Our process to manage indwelling urinary catheters according to established evidence-based guidelines address the following:

- Securing catheters for unobstructed urine flow and drainage
- Maintaining the sterility of the urine collection system
- Replacing the urine collection system when required
- Collecting urine samples

In order to evaluate our program, we measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas.

For females who are confined to bed for long periods of time, incontinent of urine or are unable to get out of bed to empty the bladder and do not meet criteria for an indwelling catheter, an external catheter (Purewick) may be an option. (See policy *Purewick Female External Catheter, Procedure for Use C215*).

When ordering a urine culture, the reason for the culture must be indicated. For patients with a catheter, the only recognized symptoms are fever, pelvic pain, and/or costovertebral pain. For patients with no catheter, dysuria, frequency, urgency are symptoms used. Cloudy or malodorous urine are not recognized symptoms for a UTI. If a catheter has been in place for fourteen days or longer, the catheter needs to be changed prior to collecting the urine specimen.

INFLUENZA VACCINATIONS (see policy *HRHS Influenza Vaccination SYS:GEN014 & Vaccination Policy D133*)

For the protection of patients and employees against influenza HRHS has a policy that is compliant with regulatory agencies. Our area's influenza season runs from October 1 to March 31. The season may be extended per direction

from the Centers for Disease Control. All current HRHS personnel will be required to get an influenza vaccination before December 1st each year. This includes employees, volunteers, Licensed Independent Practitioners (Physicians and Allied Health Practitioners), and students. Those declining will follow hospital policy.

COVID-19 VACCINATIONS

The Covid-19 Vaccination is mandated for Medicare and Medicaid certified healthcare facilities. This mandate requires all staff, licensed practitioners, students, volunteers and contracted staff, regardless of clinical responsibility or patient (or consumer) contact to take one of the following four actions to work at one of our facilities:

1. Provide proof of vaccination; or
2. Receive a Covid-19 vaccination; or
3. Apply for & receive a medical exemption; or
4. Apply for & receive a religious exemption.

It is recommended that all recommended booster doses be received. Please provide Employee Health with a record of all vaccines obtained.

MANAGEMENT OF INFORMATION & THE MEDICAL RECORD

CONFIDENTIALITY OF INFORMATION

Our goal is to protect the confidentiality of patient information. Actions that staff can take in this area include:

- Do not discuss patient information in public places or with individuals who are not involved in caring for the patient.
- Keep medical records secure. Do not leave the record out in public areas.
- Dispose of any paper waste containing patient information into the secure recycle bins. Do not throw into the normal trash.
- Do not leave patient identifiable information in ways that can be seen by visitors or unauthorized personnel. For example:
- Be aware of patients that have requested “no information” or “limited information”.

ABBREVIATIONS IN THE MEDICAL RECORD (see policy *Abbreviations in the Medical Record LL104*)

The following abbreviations, acronyms, symbols and dose designations are prohibited from use:

Unacceptable Abbreviations	**Intended Meaning**	**What is acceptable practice**
U or u	Unit	Write out “units”
IU	International unit	Write out “international units”
Q.D., QD, q.d., qd	every day	Write out “daily”
Q.O.D., QOD, q.o.d., qod	every other day	Write out “every other day”
Unacceptable Dose Expressions	**Intended Meaning**	**What is acceptable practice**
Zero after decimal point (X.0 mg)	1 mg	Do not use terminal zeros for doses expressed in whole numbers.
No zero before decimal dose (.X mg)	0.5 mg	Always use zero before a decimal when the dose is less than a whole unit.
		A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
Unacceptable Drug Name Abbreviations	**Intended Meaning**	**Use the complete spelling for drug names**
MS	morphine sulfate	Write out drug name
MSO4	morphine sulfate	Write out drug name
MgSO4	magnesium sulfate	Write out drug name

Narrative Documentation Abbreviations

Abbreviations that are widely recognized are acceptable for use in the medical record. For example, vital signs are written with abbreviations in a comprehensive manner for the content to be understood (T101, P26, BP 140/89), abbreviations of narrative notes are acceptable.

PHYSICIAN / PROVIDER ORDERS & VERBAL ORDERS (see policies *Receipt of Physician Orders by Clinical Staff C151*, *Physician/Provider’s Orders MSO 100.15, Protocol Orders & Provider Order sets D125)*

It is our policy that the use of verbal (including telephone) orders is discouraged and may be received only in emergent circumstances and are to be entered electronically and read back to the ordering physician/provider and signed by the ordering physician/provider. When possible, orders should be electronically entered by the practitioner providing the order. Only personnel authorized by policy may receive a verbal order. The person receiving the order must write down the order and then read the order back verbatim to the practitioner. The practitioner should then verbally confirm that the order is correct.

READ BACK OF ORDERS & TEST RESULTS

A “Read Back” process will be conducted by the individual receiving the order. The authorized hospital personnel receiving the order will read back to the physician/provider or authorized designee the order including the frequency

and/or all instructions for use in a non-abbreviated format. The ordering physician/provider or authorized designee will confirm the order is correct.

When a critical test result (i.e. lab value) is communicated to the physician or patient care area, the individual making the call should speak directly with the physician or nurse caring for the patient (whenever possible). The person calling should relate the test result and then ask the person receiving the result to read the result back to them.

ENTRIES INTO THE MEDICAL RECORD (see policy *The Medical Record LL105)*

Authorization to Make Entries into the Medical Record

Only members of the medical staff, allied health practitioners, organization employees, contract staff, and students - consistent with their job function - may make entries into the medical record. Other individuals may make entries into the medical record in special circumstances if approved by the Director of Health Information Management Services

Legibility of Entries

Entries into the medical record must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. A legible entry is defined as one that can be read and understood by at least two different clinical practitioners. Entries that are not considered legible should be re-written or clarified as warranted.

Authentication of Entries into the Medical Record

Authentication of medical record entries may include written signatures, initials, computer key, or other code. For authentication, in written or electronic form, HRMC has a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Signature stamps may not be used to authenticate entries in the medical record.

JOINT COMMISSION™

2026 Hospital National Performance Goals (NPGs)

Goal 1	The hospital ensures that the correct patient receives the correct care at the correct time.
Goal 2	The governing body and leadership team foster a culture of safety.
Goal 3	The hospital has an emergency management program.
Goal 4	The hospital prioritizes excellent health outcomes for all.
Goal 5	The hospital prioritizes infection prevention and control.
Goal 6	The hospital prioritizes pain management and safe prescribing practices.
Goal 7	The hospital respects the patient's right to safe, informed care.
Goal 8	The hospital reduces the risk for suicide.
Goal 9	The hospital develops and implements safe transplant practices.
Goal 10	The hospital performs waived testing in a safe and consistent manner. *Note: Waived tests are categorized by CLIA as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result." The Food and Drug Administration (FDA) determines which tests meet these criteria when it reviews a manufacturer's application for test system waiver. The list of FDA-approved waived tests can be accessed at the following link: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm.*
Goal 11	The hospital maintains workplace and patient safety.
Goal 12	The hospital is staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care.
Goal 13	The hospital safely performs imaging services.
Goal 14	The hospital has a medication management program that focuses on safety.

USE OF TWO PATIENT IDENTIFIERS

Our policy, (*Patient Identification C145*) requires using two patient identifiers prior to any invasive treatment/procedures, obtaining lab specimens, administering medications and/or blood products. The patient's arm band will be verified by checking two of the following:

- Full Name
- Date of Birth
- Financial Identification Number (FIN)
    - If the patient is unable to communicate or unresponsive patient's armband will be the means of checking the two identifiers.
        - Patient Identification Number, Full Name and/or Date of Birth will be on the armband

REPORTING OF CRITICAL RESULTS (See policy *Critical Test Result Reporting ADM:0005.5/C197*)

Critical results are to be managed and reported to the responsible licensed caregiver in a timely manner.

Physicians or his/her designee should be notified of Critical Lab Test Results within 60 minutes, unless the results are immediately life threatening, in which case the physician would be notified immediately. If more than one attempt is made, document each attempt.

The RN may use clinical judgment and knowledge of therapeutic ranges for the patient's condition, the specimen source or testing conditions to determine whether the physician should be notified. Some test results may be outside the normal variation but be clinically normal for the patient. Persistent, stable, critical results secondary to chronic conditions may be exempt from the notification.

Critical Radiology Results will be relayed from the Radiologist (either in-house, or teleradiology service) to the ordering or treating physician within 30 minutes of reviewing the case. Critical results may also be relayed from the Radiologist to the ordering physician by the imaging technologist or RN caring for the patient. When the critical results are delivered in this manner, the Technologist or RN will have an additional 30 minutes to contact the provider.

MANAGING THE FLOW OF PATIENTS

Managing the flow of patients throughout the hospital poses many potential patient safety risks including:

- Available supply of patient beds
- Throughput of areas where patients receive care, treatment, and services (ex: inpatient units, laboratory, operating rooms, telemetry, radiology, and the post anesthesia care unit)
- Safety of areas where patients receive care, treatment and services
- Efficiency of the nonclinical services that support patient care and treatment (such as environmental services and transportation)
- Access to support services (such as case management and social work)

Patients who are boarded in the emergency department also pose patient safety risks.

HANDOFF COMMUNICATION

- Handoff Communication – the transfer of essential information and the responsibility for care of the patient from one healthcare provider to another is an integral component in healthcare.
- Effective handoffs require an environment free of interruptions and distractions, allowing for the appropriate staff and or medical provider receiving the handoff to listen actively and engage in a discussion when necessary.

LABELING OF MEDICATIONS ON AND OFF A STERILE FIELD (See policy *Safe Medication Practices Surgical Services and LDRP C-section Suite D132)*

- Labeling must occur when any medication or solution is transferred from the original packaging to another container.
- Labels must include the drug name, strength, amount if not apparent from the container, expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours. Date and time are not necessary for short procedures lasting less than 12 hours.
- In perioperative, procedural and other settings both on and off the sterile field, medication or solutions must be labeled that are not immediately administered.
    - An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient and administers to that patient without any break in the process.
- Any medications or solutions found unlabeled are immediately discarded.

MEDICATION RECONCILIATION (See policy *Medication Reconciliation D110*)

The purpose of medication reconciliation is to create an accurate list of a patient's medications on admission and/or presentation for care, treatment, and service and to assure than an accurate and reconciled list of medications is, when required, provided to the patient upon discharge.

Reconciling medication means comparing the patient's home medication list with the medication that will be ordered and/or prescribed to the patient at the time of discharge. The purpose of medication reconciliation is to identify potential contraindications, duplications, omissions, or other discrepancies.

A key component of medication reconciliation is documenting the patient's home medications, including prescription medications, over the counter medications, herbal products and supplements accurately. Enter medication(s) just as the patient takes it, not necessarily how it was prescribed. For example, if the patient is taking once daily but it is prescribed as TID, this should be entered as once daily and a note in the comments section should reflect how it is prescribed.

MANAGEMENT OF BLOOD TRANSFUSIONS (See policy *Blood and Blood Product D106*)

The RN or anesthesia provider administering the blood must match the blood or blood component to the order and match the donor unit and the intended recipient in the presence of the patient prior to the start of the transfusion. Check the patient's hospital wristband and red blood bank wristband for name and medical record number and match this information to the unit of blood before administration by scanning the information into the "Bridge Transfusion" section in the EHR.

Note: If there is a computer downtime and documentation must be done on paper or if using the "Rapid Transfusion" option in Bridge, a second licensed nurse must match the blood or blood component to the order and match the donor unit and the intended recipient in the presence of the patient prior to the start of the transfusion.

If the blood bank wristband must be removed, immediately place back on the patient using a reattachment band.

- Two nurses should verify the patient's identification by patient's ID number, full name, and/or date of birth and verifying the blood bank wristband is current with blood bank.
- Replacement of blood bank wristband should be recorded in the patient record.

If the blood bank wristband is not in place on the patient's person, and can't be located, administration of the blood product must be deferred, and the patient redrawn for type and crossmatch.

Check the blood bank transfusion tag (form and barcode sticker) and match the data with the unit of blood:

- Recipient blood type and Rh type are compatible with donor blood type and Rh type.
- Blood unit number on blood match unit number on form.
- Check the expiration date and time on unit of blood.

Record verification is completed by scanning the patient's hospital armband, the patient's blood bank wristband, & the 2D barcode sticker on the back of blood product according to the Policy D106.

If any part of the double check does not match – STOP and notify blood bank immediately.

CLINICAL ALARM MANAGEMENT

Leaders have identified Clinical Alarms as a priority for patient safety. All clinical alarms must be customized with settings appropriate to the patient and the patient care area.

- Alarms must be sufficiently audible with respect to distance and competing noise within the patient care area.
- Clinical alarms will be re-evaluated with transfer of patient care and changes in patient condition.
- Any monitoring device in use (ex: telemetry, pulse oximetry, capnography, bedside cardiac monitors) will have alarms turned on at all times during patient use.
- Alarms should be age appropriate and customized to the patient. Upper and lower limits should be set on the basis of the patient's current clinical status.

All clinical alarms will undergo regular preventive maintenance and testing by the Clinical Engineering Department. (See Policies: *Clinical Alarms Management C210* and *Telemetry Monitoring C173*)

ASSESSING PATIENTS AT RISK OF SUICIDE (See policy *Mental Health Crisis Assessment, Prevention and Precautions C171*)

- A suicide risk screening and assessment will be done on all patients 6 and older upon entry into HRMC utilizing the C-SSRS.
- A suicide risk reassessment will be completed on all patients admitted with a suicide warning within 30 minutes of arrival, every shift and with any change in the patient's behavior using the C-SSRS.

- Patients that are assessed as at risk for suicide based on the C-SSRS score will have 1:1 observation by competently trained staff.

IMPROVING HEALTH CARE EQUITY

- Patient's health-related social needs (HRSN) are assessed and information is provided about community resources and support services. Examples of HRSNs may include:
    - Access to transportation
    - Difficulty paying for prescriptions or medical bills
    - Education and literacy
    - Food insecurity
    - Housing insecurity
- Health care disparities are identified in patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients.

UNIVERSAL PROTOCOL TO PREVENT WRONG PATIENT/WRONG-SITE PROCEDURES (See policy *Universal*

Protocol/Preprocedure Verification,

Site Marking and Time Out C112)

The organization has established, implemented and enforces a process to prevent the performance of a procedure on the wrong patient and/or a procedure on the wrong side/site of a patient.

The established process includes:
- A preprocedure verification process
- Marking the operative or procedure site if applicable
- A Time Out (final verification) which is performed immediately before starting the operation/procedure.

HUMAN RESOURCES & EDUCATION

ORIENTATION/TRAINING/COMPETENCY ASSESSMENT

New employees attend Hospital General Orientation when they begin employment and are provided Department Specific Orientation to job duties and responsibilities. Nursing employees attend a comprehensive orientation that is specific to nursing. Staff participate in ongoing education and training to maintain or increase competency. To ensure employees remain competent, ongoing education is offered throughout the year in HealthStream, classroom and other methods of learning.

Each employee receives a comprehensive assessment of competency when they first start working. Then, on an annual basis, staff members are assessed against key aspects of their job. (This includes contract staff when applicable)

DIVERSITY IN HEALTHCARE

Diversity in healthcare helps ensure all backgrounds, beliefs, ethnicities, and perspectives are adequately represented in the medical field. It's about providing the best possible care for all patients. Cultural competency is the ability to understand, appreciate, and interact with persons from cultures and/or belief systems other than one's own, based on various factors. Areas of cultural diversity include family organization, gestures, language, personal space, touching, eye contact, healthcare beliefs, spirituality, religion, sexual orientation and gender identification.

HEALTHCARE DISPARITY

Health disparities are differences in health outcomes closely linked with social, economic and environmental disadvantage and are often driven by the social conditions in which individuals live, learn, work and play. Eliminating health care disparities is essential to improve quality of care for all patients. To decrease/eliminate this inequality, it is important to assess for social determinants of health, which are the non-medical factors that influence health outcomes and shape the conditions of daily life.

STAFF AND MEDICAL STAFF IMPAIRMENT

It is important that we are able to recognize impairment in staff or medical staff members. Impairment is the inability of an individual to practice their profession with reasonable skill and safety as a result of a mental disorder, physical illness

or condition, or substance related disorders including abuse and dependency on drugs or alcohol.

Signs of possible impairment:

- Physical signs often manifest as fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, eating disorders
- Family stability disturbances
- Social changes may include withdrawal from outside activities, isolation from peers, inappropriate behavior, undependability and unpredictability, aggressive behavior and argumentativeness
- Physical signs often manifest as fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, eating disorders
- Drug use indicators may manifest as excessive agitation or edginess, dilated or pinpoint pupils, self-medication with psychotropic drugs, stereotypical behavior, alcohol on breath at work, uncontrolled drinking at social events, blackouts, and binge drinking

When to report:

- A report should be made when:
  - Diversion is suspected,
  - Notified by outside sources including family and/or law enforcement,
  - Making a self-report

How to report:

- Reports may be made using a number of internal and external mechanisms including:
  - Patient Care Supervisor (House Supervisor),
  - Unit/Area Manager or Director,
  - Any system executive,
  - Risk Management via the RL6 event system (anonymous report),
  - Placing a Compliance Hotline report by calling 855-998-9907 (anonymous report).

If you have concerns, please report them.
Policies for reference: (*Drug Diversion – Reporting SYS:GEN012* and *Drug Diversion Investigation and Response SYS:GEN013*), and the Employee Handbook.

FORENSIC STAFF (LAW ENFORCEMENT PERSONNEL)

Forensic staff consists of police, correctional officers, or other public safety personnel that may accompany a prisoner or patient who is under arrest. It is our responsibility to assure that forensic staff are oriented to at least the following:

- How to report a concern or conflict between forensic staff and hospital staff
- The difference between forensic and clinical restraint
- What to do in the event of an emergency (e.g. fire, disaster, etc.)

IMPORTANT NAMES AND NUMBERS

Role	Name	Phone
Compliance Officer	Julie Moore	620-665-2009
Infection Control Nurse Manager	Lisa Proffitt	620-513-3993
Information Security Officer	Chris Duskin	620-513-5003
Privacy Officer	Julie Moore	620-665-2009
Patient Advocate	Misty Harner	620-513-3866
Risk Manager & Patient Safety Officer	Anna Brown	620-665-2303

Hutchinson Regional Medical Center Reporting

HRMC is committed to provide safe patient care and would like to know immediately if you have a concern about the safety or quality of care provided. Internally you can enter an RL6, use the Compliance Hotline, or email. You may also directly contact the Chief of Staff, CEO, or Risk Manager. Other departments can be notified such as Medical Staff Office, Quality, Risk Management, Compliance, and Administration. You may also report your concerns externally to the Joint Commission and/or Kansas Department of Health and Environment. HRMC is committed to ensuring anyone can report concerns without fear of discipline or punitive action.

Concerns may include:

- Serious Quality of Care or Safety Concerns
- Abuse
- Neglect
- Threatening and intimidating behaviors
- Humiliation by one or more persons towards another
- Harassment or discrimination
- On-the-job drug or alcohol use
- Violations of company policy
- Violations of law
- Fraud, waste, and abuse
- Theft
- Behavior that is unethical
- Illegal activity
- Drug Diversion
- Violence or aggression

Report Concerns:

Enter an RL/ Midas Report or Direct Reporting

Email: compliancereports@hutchregional.com

Compliance: 620.665.2164

Risk Manager: 620.665.2303

CEO/Administration 620.665.2001

CoS/Medical Staff Office 620.513.5050

Hotline Service

855.998.9907

Email: reports@lighthouse-services.com

The Joint Commission

Online: Submit a NEW patient safety event or concern

Online: Submit an UPDATE or ASK a Question about your incident (You must have your incident number)

The Joint Commission no longer accepts faxed or emailed submissions.

The Office of Quality & Patient Safety
The Joint Commissions
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

KDHE

Kansas Department of Health & Environment at:

1000 SW Jackson, Suite 200, Topeka, KS 66612-1365 or call

1-800-842-0078

Date	Changes
10/5/2021	Added Robust Process Improvement to PI section, Updated the PI flow, deleted Tobacco free campus from Hospital Safety Section (duplicate), Add Emerging Infectious Diseases in type of Emergency and GG135, GG183.
1/7/2021	Updated Infection prevention section, updated Anticoagulation Committee info, updated Suicide Risk Section.
3/7/2022	Several changes made through the document regarding grammatical and typographical errors in addition to correcting policy number references that were incorrect.
1/22/2023	Updated with changes for 2023. Updated to 2023 NPSG, updated emergency code announcement section, updated Infection Prevention sections with current isolation precautions, updated hazard meds list and HALT med lists, verified all policies and numbers listed throughout document, updated fall prevention section removing the Fall Tips tool and adding interventions based on Morse Fall Score, added section for Healthcare Disparities.
1/12/2023	Updated QAPI diagram. Removed subcutaneous insulin from HALT list.
3/3/23	Updated “Important Names and Numbers” list to reflect organizational changes. Additionally, changed Emergency Codes to Clear Talk Codes.
3/21/2023	Updated “Important Names and Numbers” list to reflect organizational changes.
4/17/2023	Updated Privacy Officer and deleted employee health.
5/17/2023	Updated page numbers to match index.
7/13/2023	Update reporting information and National Patient Safety Goals.
9/11/2023	Updated to change Compliance Officer.
9/13/2023	Updated Joint Commission reporting instructions. Updated DMAIC chart, QAPI Program flow.
9/18/2023	Updated TJC Reporting guidelines, QAPI Structure, and changed the picture for Six sigma - KJ
9/25/2023	Updated to add information on how to request and ethics consult. - LP
12/4/2023	Changed to add “It’s Not OK” information and remove C360 Icon, adding Power DMS. Also added 2024 National Patient Safety Goals.
12/14/2023	Updated privacy officer to Alicia Hedlund.
09/9/2024	Updated privacy officer to Julie Moore, Information Security Officer to Chris Duskin and Compliance Officer to Nick Baldetti.
12/11/2024	Updated change all RL references to Midas. Update Mission, Vision and Values. Updated Medication Disposal Guidelines. Added Patient Safety Officer
12/24/2025	Updated with new National Performance Goals and to align with changes to policies on falls, IPOC, Assessment/Reassessment.
1/7/2026	Removed Nick Baldetti as Compliance Officer, replaced with Julie Moore.