# Table of Contents

- Welcome/Instructions .................................................................................................................. 3
- General Guidelines/Expectations/Policies .................................................................................. 4
- Mission and Vision Statements .................................................................................................. 7
- Identification of a Patient ........................................................................................................... 8
- AIDET ........................................................................................................................................... 9
- Assessment/Re-assessment of Patient ......................................................................................... 10
- Abbreviations ............................................................................................................................. 13
- Medication Administration ......................................................................................................... 15
- Monitoring for Blood Transfusion Reactions .............................................................................. 20
- Event and Close Call Reporting .................................................................................................. 22
- Patient Rights ............................................................................................................................. 23
- PAIN: Assessment, Management & Documentation ................................................................... 26
- Advance Directives ..................................................................................................................... 31
- Ethics and Compliance ............................................................................................................... 32
- Age-related Risk Hazards .......................................................................................................... 33
- Disability Services ....................................................................................................................... 38
- Restraint Use: Acute Med/Surg Care ......................................................................................... 41
- Safety Data Sheets ..................................................................................................................... 46
- Emergency Codes/Fire Safety ..................................................................................................... 47
- Security Tips ............................................................................................................................... 48
- No Smoking Policy ....................................................................................................................... 49
- Confidentiality and HIPAA ......................................................................................................... 50
- Infection Control, Hand Hygiene, Isolation Precautions .............................................................. 51
- Electrical Safety, Body Mechanics and Lifting, Radiation Safety ............................................... 57
- Inmates ....................................................................................................................................... 60
- Fall Prevention ............................................................................................................................ 61
- 2017 CMC Patient Safety Goals .................................................................................................. 62
- Hospital Orientation Quiz, HIPAA Quiz ...................................................................................... 65
- Confidentiality and Security Agreement ...................................................................................... 71
- Faculty Orientation Checklist ..................................................................................................... 74
Welcome

Coliseum Medical Centers welcomes you to our facility. It is our desire to provide you with a meaningful and enjoyable clinical rotation. This manual has been developed to help facilitate your experiences here in conjunction with your instructor-led orientation on site.

Orientation Instructions & Requirements
Please save a copy of the online manual that you can refer to when needed. You will need to print a copy of the Environment of Care/Hospital Safety Module Quiz Blank Answer Sheet and the HIPAA Quiz Blank Answer Sheet at the end of the manual and complete the post tests. A minimum score of 85% is required to demonstrate your cognitive knowledge prior to your first clinical day. You will also need to print the Confidentiality Security Form, fill in the appropriate information, and give to your instructor with both quiz answer sheets for grading. A physical orientation to your assigned clinical area will be facilitated by your clinical instructor prior to or on the first day of clinical rotation.
General Guidelines, Expectations and Policies

1. When you are in your clinical setting, you are expected to adhere to the facility’s policies and procedures. All policies and procedures may be found online on each unit for easy reference via the CHS Intranet home page under PolicyStat.

2. Every patient is under the direct care of a CMC RN. Students under the supervision of a clinical instructor may contribute to this care according to hospital policies. A consent form for care/treatment to be rendered by supervised students is signed by the patient on admission.

3. Students are expected to wear a school issued ID badge whenever in the hospital.

4. Students will arrive and leave as scheduled. All changes in schedules will be communicated to the clinical nurse managers by the instructor.

5. Abide by the Patient Rights guidelines, including pain assessment, and report any suspected abuse to clinical instructor/unit manager (See Patient Rights).

6. Document status of patient’s Advance Directive and insure a copy of the document is in the patient’s chart (See Advance Directives).

7. Utilize ethical considerations in problem solving ethical dilemmas and report all ethical issues to clinical instructor/unit manager (See Ethics & Compliance).

8. Complete routine assigned patient care with considerations of age, spiritual, special needs, culture and values keeping the assigned CMC RN
aware of patient care progress and any patient related problems as they occur (See Age-Related Risk Hazards).

9. Give a detailed, current report on your assigned patient(s) to the appropriate nurse responsible for the patient BEFORE LEAVING THE UNIT.


11. Ensure patient safety and welfare while providing patient care by adhering to all Environment of Care guidelines and related policies/procedures:
   
   a. Report chemical hazards/spills and handle hazardous chemicals in accordance with the SDS’s (Safety Data Sheets) maintained in every work area and found on Hospital INSIGHT under References (See Safety Data Sheets).
   b. Report malfunctioning equipment.
   c. Recognize and be able to report hospital “Codes” (See Emergency Codes).
   d. Observe radiation precautions.
   e. Practice safe ergonomic work habits to prevent injury.

12. Identify self appropriately when answering the phone; do not accept phone/verbal orders from physicians or other providers.

13. Park only in designated parking areas as instructed by your clinical instructor. Students should park in the Centreplex Parking lot on the outside of the hospital fence where hospital employees park. Students
should not park in the areas near the buildings. These spaces are for patients and visitors.

14. Our hospital is a non-smoking facility. No smoking is allowed anywhere on our campus.

15. Maintain patient confidentiality according to HIPAA standards (See Confidentiality).

16. Adhere to infection control policies and Standard Precautions policies (See Infection Control).

17. Students and Faculty are NOT eligible for any discounts that hospital employees receive in the cafeteria.

18. Students may not transport blood from the Lab.

19. Nursing students may not draw blood, start IV’s or administer any injections unless under the direct supervision of their nursing instructor. They may not perform these actions with the hospital preceptors.
MISSION, VISION and VALUES
COLISEUM HEALTH SYSTEM

MISSION:
Above all else, we are committed to the care and improvement of human life.

VISION:
We strive to be the most exciting, innovative health system in middle Georgia providing a signature customer experience.

VALUES:
We do this through our Values and Commitments “CARES”
Compassion
Accountability
Respect
Excellence/Empathy
Service

Attention to patient safety is consistent with our mission and values and our commitment to putting patients first.
IDENTIFICATION OF PATIENT

All patients will have a hospital issued identification band.

ARMBAND INFORMATION
Armbands will include the patient’s full name, billing number, date of birth, location (room #) and medical record number. Patients must use the same name from pre-op, through registration and hospital stay.

Aliases: Patients may not use an alias or modified version of their name. This is to assure that the patient’s medical record is consistent and information can be retrieved from a single medical record. Patients who are concerned about their identity should be encouraged to request “No Press – No Info”.

APPLICATION OF ARMBAND
Armbands will be placed on the patient as part of the registration process.
Identification bands should be placed on the wrist when possible except for special circumstances listed below.
Identification bands may be placed on the ankle of small children or infants.
Identification bands must remain on the patient until discharge.

Blood Bank
Additional armbands are used for patients who have had blood drawn for blood or blood products. The procedure for patient verification and identification are outlined in the Policy “Blood Administration”.

REMOVAL AND REPLACEMENT OF AN ARMBAND
It may be necessary to remove a patient identification armband because of interference with a medical test, treatment or procedure. Only someone, who was in the physical presence of the patient when the armband is removed, may replace the armband without repeating the verification process. Examples would be 1) A nurse removes an armband to begin an IV. She may then make a new armband and place it back on the patient. 2) The armband is removed by anesthesia pre-op, the nurse present at bedside when the armband was removed may place a new armband on the patient.

If a patient is found without an armband, the verification process must be repeated by asking the patient or present family member to state the patient’s name and birth date.
AIDET

A – Acknowledge – Cheerfully greet the patient and family. Call the patient by the preferred name. Use eye contact when speaking. Remember to smile.

I – Introduce – Introduce yourself and explain your role in the patient’s care. Wear your student ID badge at all times.

D – Duration – Communicate time expectations. Keep them informed of any delays.

E – Explanation – Explain what you are doing and why. Ask if they have questions.

T – Thank you – Thank the patient. Let them know you have enjoyed providing care for them. Ask if there is anything else you can do before you leave.
ASSESSMENT and REASSESSMENT

The goal of the patient assessment is to determine what kind of care is required to meet the needs of the patient initially as well as their needs as they change in response to care. In order to provide the patient with the right care at the time it is needed, qualified individuals in the hospital assess each patients care needs beginning with the admitting process and continuing through the discharge.

Those disciplines providing patient assessment and reassessment at Coliseum Medical Centers possess specialized knowledge and consider the relevant patient history, biophysical, psychosocial, behavioral, spiritual, environmental, educational, self-care and discharge planning needs of the patient. Judgment and skill derived from medical sciences is used in planning for the patients assessed needs. Under the auspices of Coliseum Medical Centers, health care professionals from varying disciplines function collaboratively as part of an interdisciplinary team to plan patient care based on an analysis of the findings from the assessment process in order to achieve positive patient outcomes.

Initial Assessment

During the initial assessment the staff members need to find out the reason why the patient was admitted. They must take into account the patient’s immediate and emerging needs and consider not only the physiological status but also the psychological and social concerns. During this initial assessment the staff determines what care the patient needs as well as any further assessments required.

The process begins with collecting data about each patient’s physical and psychosocial status and health history. Because the patient’s cultural and family/significant other contexts and individual background are important factors in his or her response to illness and treatment, it is important to include them in the assessment process. The data are analyzed in order to produce information about each patient’s care needs, and to identify additional information required. Care decisions are based on information developed about each patient’s needs.

The type of data collected, assessed, and analyzed are:

- Demographic
- Allergies
- Developmental stage
- Religion
- Ability to communicate
- Physical findings
At Coliseum Medical Centers, we recognize that there may be special needs for dying patients. For this population, an assessment is made of the social, spiritual, and cultural variables that influence the perceptions and expressions of grief by the individual, family members, or significant others.

The information gathered at the first patient contact may indicate that the patient needs further assessment. This will depend on the patient’s diagnosis, the care he or she is seeking, the care setting, and the patient’s response to any previous care, his or her consent to treatment, and the anticipated length of stay.

During the initial assessment the Registered Nurse ask screening questions for other disciplines in order to determine if further assessment is needed. Those screening questions that would lead to further assessment by those disciplines were developed by each department and deemed appropriate and approved by an interdisciplinary documentation team. These specialties may include, but are not limited to Nutrition, Rehabilitation, Speech Therapy, Case Management, and Physical Therapy.

Pain is assessed in all patients. In the initial assessment, those patients experiencing pain are identified. A more comprehensive assessment is performed when warranted by the patient’s condition (See Pain Policy).
A qualified member of the medical staff with appropriate clinical privileges completes the Medical History and Physical within 24 hours of admission.

Reassessment

In addition to the specified time intervals for reassessment, the patient will be reevaluated to determine response to specific treatment, or when a significant change occurs in the patient’s condition or diagnosis. Reassessment shall occur at least as follows:

- During and following any invasive procedure
- Following a change in the patient’s condition or level of care
- During and following the administration of blood and blood products
- Following any adverse drug reaction or allergic reaction
- During and following any use of physical restraints
**ABBREVIATIONS**

Precise communication is necessary for the safe use of medical abbreviations and documentation.

It is the responsibility of all staff members to only execute orders which are legible and whose content, including the use of symbols or abbreviations, is within the policies and practice of the hospital and are implicitly understood. Any abbreviation or entry that is not clear must be clarified with the practitioner responsible.

**DECIMAL POINTS**

Decimal points must be used correctly. (correct = 0.125 / incorrect = .125)
Never use a zero after a decimal point. (correct = 2 mg / incorrect = 2.0 mg)

**APOTHECARY SYMBOLS may not be used**

*The internet provides multiple reliable sources for commonly accepted medical abbreviations.*

http://www.medilexicon.com/medicalabbreviations.php
## UNACCEPTABLE ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (for unit)</td>
<td>Mistaken as zero, four or cc.</td>
<td>Write &quot;unit&quot;</td>
</tr>
<tr>
<td>IU (for international unit)</td>
<td>Mistaken as IV (intravenous) or 10 (ten).</td>
<td>Write &quot;international unit&quot;</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd QOD, Q.O.D., q.o.d., (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an &quot;I&quot; and the &quot;O&quot; can be mistaken for &quot;I&quot;.</td>
<td>Write &quot;daily&quot; and &quot;every other day&quot;</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg), Lack of leading zero (.X mg)</td>
<td>Decimal point is missed.</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)</td>
</tr>
<tr>
<td>MS, MSO₄, MgSO₄</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write &quot;morphine sulfate&quot; or &quot;magnesium sulfate&quot;</td>
</tr>
</tbody>
</table>
MEDICATION ADMINISTRATION

Medications are administered to patients only upon an order from a physician who is a member of the Medical Staff. They may be administered by Physicians, Registered Nurses, Licensed Practical Nurses and Respiratory Therapists. Radiology technicians may administer oral contrast media. Nuclear medicine technicians may administer radioactive contrast media. Student nurses, therapists or technicians from affiliated schools under the supervision of appropriately licensed instructors may administer medications.

Non-physicians (e.g., Registered Nurses, LPNs, Radiology Techs, and Nuclear Med Techs) who administer IV medications shall require specialized training to be qualified to administer IV medications. Until competency skills for administering IV medication have been performed, staff administering IV medication shall only administer IV meds under the supervision of one who has completed specialized training and IV medication skills have been validated. IV medication administration skills are validated and evaluated by competency skills checklist.

Routine drugs are administered as ordered by the physician according to an assigned schedule. All administered medications must be entered into the patient's record. This includes medications that are administered in error and medications administered by physicians.

The order will include the name of the drug, the dosage and the frequency of administration, the route of administration and the date, time and signature (or electronic signature in Meditech) of the prescriber. Orders for drugs should be written by the prescriber. Verbal orders for drugs shall be given only to individuals so authorized by law and hospital medical staff, and only by a person lawfully authorized to prescribe, and will be recorded promptly in the patient's medical record, noting the name of the individual receiving the order.

Individuals allowed to take verbal orders are listed below:
1. Registered Nurse
2. Licensed Practical Nurse
3. Physical Therapist for physical therapy orders
4. Respiratory Therapist for respiratory therapy orders
5. Dietitians for diet orders
6. Pharmacist for pharmaceutical orders

Routine drugs are administered as ordered by the physician according to assigned schedule. In administering analgesic drugs documentation will include:
1. Need
2. Location of administration (right deltoid, left deltoid, etc.)
3. Location of pain (operative side, right shoulder)
4. Evaluation of effectiveness
STAT – Medication is administered within 15 minutes of order written.

ROUTINE - Medication is administered within 1 hour before and 1 hour after the scheduled dose time.

New Medication – Medication is administered at the next scheduled dose time; as soon as possible.

Delayed and omitted medications can be determined as justified when:
- Patient was NPO
- Patient was temporarily absent from the patient care unit (scheduled procedure)
- Patient refused doses
- The reason for the delay or omission of a medication will be documented on the MAR

All medications will be administered after verifying the 6 patient rights:
1. Right Patient
2. Right Route
3. Right Medication
4. Right Time
5. Right Dose
6. Right Patient Teaching

In addition to verifying the 6-Rights:
1) The person administering the medication remains with the patient until the medication is administered.
2) Administration is within 1 hour of the scheduled time for administration;
3) Prior to administration, patient identity is verified using 2 identifiers (one of which cannot be the room number).
4) The medication’s stability is verified based on visual examination.
5) Contraindications are reviewed.
6) The patient or family is advised of potential clinically significant adverse reactions or other concerns regarding new medication.
7) Unresolved, significant concerns about the medication is discussed with the patient’s physician and other relevant staff involved in the patient’s care.
IV Medications, IV Fluids, Blood and Blood Components

Only Registered Nurses who have demonstrated competency may:

- Perform Venipuncture
- Regulate IV fluids
- Administer IV Medications
- Start IV Fluids
- Administer Blood and Blood Products
- Administer IV fluids containing medications

Additional training and competencies are required to administer Chemotherapeutic agents. These agents are administered by IV infusion.

The Registered Nurse may elect not to administer a particular IV medication due to her professional judgment.

1. The nurse may determine the patient has very difficult veins.
2. The nurse may regard the particular drug as being extremely potent and of a serious enough nature to warrant help in the administration, either from the administrative supervisor or the physician.

Administration Times

Each practitioner who prescribes medication must clearly state the administration times or the frequency of doses. The terms "prn" and "on call" must be qualified (i.e. q 4 h prn pain and on call to OR) so that there is no question as to the intent of the prescriber.

The standard hours for medication administration with set time of administration will be approved by the Medical Staff. Unless otherwise designated by the physician’s order, a nurse or pharmacist may make adjustment of the times to:

1. accommodate administration of multiple medications,
2. prevent food-drug/drug-drug interactions,
3. coincide with the time the patient routinely takes the medication at home,
4. enhance the safe, effective, and/or efficient use of the medication.
Patient Allergies

Before dispensing medications, the Pharmacy must be notified of any allergies the patient may have or indicate that there are no allergies or NKA (no known allergies). This information must be sent to the Pharmacy as soon as possible after admission. Before administering any medications, the patient must be questioned regarding allergies and the chart checked for documentation of known medication allergies/sensitivities.

Medication Errors

(See Hospital Wide Policy for Medication Management)

Adverse Drug Reactions

1. Definition

An adverse drug reaction (ADR) is: "Unintended, undesirable, and/or unexpected effects of prescribed medications or of medication errors that require discontinuing a medication or modifying the dose; require initial or prolonged hospitalization; result in disability; require treatment with a prescription medication; result in cognitive deterioration or impairment; are life threatening; result in death; or in congenital abnormalities.

A significant adverse drug reaction requires discontinuation of the medication, adjustment of the dose, or the requirement of additional medication as treatment. Examples include:

a. Symptoms suggesting an allergic reaction: rash, pruritus, anaphylaxis, edema, wheezing, or laryngospasm,
b. Severe GI disturbances: vomiting, diarrhea,
c. Severe skin or mucosal changes: ulcers, Stevens-Johnson syndrome,
d. Changes in mental status: hallucinations, confusion, anxiety, etc.
e. Systemic changes: hypertension, hypotension, respiratory distress, hematologic
f. CNS, cardiovascular, or respiratory instability,
g. An adverse event that is potentially life threatening or actually results in death.

An ADR resulting in death, paralysis, coma or other major permanent loss of function may qualify as a sentinel event and must be reported to Risk Management.

Medications – Refusal to Administer:

The nurse has the right to refuse to give any drug he/she feels is inappropriate for him/her to administer. The Nursing Supervisor must be notified.
Needle Disposal:

Entire used needle and syringe are disposed of in an impervious needle disposal box. All patient rooms are equipped with these boxes. It is the responsibility of Nursing Department employees to replace boxes as they become filled. This used container is then placed in the “red” bag.

Emergency Medications:

Emergency medications are available, controlled and secure on patient care areas.

Multi-dose Vials:

The contents of multi-dose vials expire 28 days after use unless otherwise specified by the manufacturer. The expiration date must be placed on the multi-dose vial when punctured for the first use. If a multi-dose vial is discovered opened and undated or the date opened is illegible, it should be discarded and a new vial obtained.
MONITORING FOR BLOOD TRANSFUSION REACTIONS

A Registered Nurse must remain with the patient for the first fifteen minutes during the transfusion and observe closely for any adverse reactions. Vital signs are to be documented and the patient assessed by the RN in fifteen minutes. An RN should care for the patient during the entire transfusion.

Signs and/or symptoms of adverse reaction

- Fever with or without chills, defined as 1 degree C (2 degrees F) increase in body temperature
- Shaking chills with or without fever
- Blood pressure changes, usually acute, either hypertension or hypotension
- Respiratory changes
- Nausea with or without vomiting
- Flushing, itching, urticaria, or localized or generalized edema
- Circulatory shock in combination with fever, severe chills, hypotension and high output cardiac failure
- Pain at infusion site, chest, abdomen and/or flanks
- Urine color changes

In the event of a possible reaction:

- Stop the transfusion immediately.
- Keep IV open with slow saline drip.
- Check for agreement of all identifying names and numbers on donor unit, transfusion record and patient armband.
- Notify attending physician and the Blood Bank at once and describe symptoms.
- Monitor vital signs every fifteen minutes.
- Send the following to the Blood Bank STAT: EDTA tube drawn to avoid hemolysis. Remove needles and tie off remainder of unit. Leave IV set attached and off. Keep Issue/Transfusion card attached to unit.
- At the request of the Blood Bank, send the first voided urine marked “Post Transfusion” to the lab.

Order Transfusion Reaction workup in Meditech completing all required fields and/or queries.
STUDENTS DO NOT TRANSPORT BLOOD FROM THE LAB
EVENT and CLOSE CALL REPORTING

Definitions:

Event:
A discrete, auditable and clearly defined occurrence

Adverse Event:
Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Events include errors, preventable adverse events, and hazards.

Error:
Failure of a planned action to be completed as intended or use of a wrong plan to achieve and aim. Errors can include problems in practice, products, procedures, and systems.

Close Call:
Events or situations that could have resulted in an adverse event (accident, injury, illness), but did not, whether by chance or through timely intervention. These may also be referred to as “near miss” incidents.

Reporting of Event:
Meditech is the HCA-designated system used to report events and close calls. All reports should be treated as confidential and should be completed as soon as possible after the event, but no later than the end of the shift.
Patient Rights

1. **Considerate and Respectful Care:**
   Ethical, high-quality, safe and professional care without discrimination
   Free from abuse and harassment
   To be treated with consideration, respect and recognition

2. **Information Regarding Health Status and Care:**
   To be informed of health status in understandable terms
   To participate in the development and implementation of their plan of care
   To be informed of the names and functions of all physicians and caregivers
   To be informed of continuing health care requirements after discharge from hospital
   To receive assistance in arranging for required follow up as appropriate
   To be informed of any risks, benefits and side effects of all medications and treatments
   To be informed of appropriate alternative treatment procedures
   To be informed of the outcomes of care, treatment and services
   Appropriate assessment and management of pain
   To be introduced to students. Patients may refuse to allow a student to participate in their care.

3. **Decision Making and Notification:**
   May choose healthcare representative/decision maker.
   May have family member, representative, personal physician notified promptly of admission
   May request or refuse treatment
   Must be informed and give consent if experimental research is part of their treatment
   May formulate advance directives
   May leave healthcare facility against physician advice to the extent permitted by law

4. **Access to Services:**
   To receive as soon as possible the free services of a translator/interpreter, telecommunications device or any necessary services to facilitate communication between patient and hospital personnel
   To bring a service animal into the facility except where prohibited
   May have pastoral counseling and take part in religious/social activities while in the hospital unless against medical advice
   Safe, secure and sanitary accommodations
   May access people outside the facility by means of verbal or written communication
5. **Access to Medical Records:**
   - All parts of the medical record must be kept confidential.
   - May have access to their medical record within a reasonable time frame.
   - The patient may decide who may receive copies of the records except as required by law.
   - The patient has the right to obtain copies of their medical record after discharge.

6. **Ethical decisions:**
   - May participate in ethical decisions

7. **Protective Services:**
   - To access protective and advocacy services
   - To be free from restraints
   - Additional rights by any state law for patients receiving treatment for mental illness or disability
   - To all legal and civil rights
   - To have alleged violation of rights reviewed
   - To have impartial review of hazardous treatments if requested
   - To expect emergency procedures to be carried out without delay
   - To give consent for treatment
   - Will not be required to work for the facility unless work is part of treatment
   - May file a complaint with Department of health or other quality improvement, accreditation or certifying body for concerns about patient abuse, neglect or misappropriation of patient property

8. **Payment and Administration:**
   - To receive an explanation of their hospital bill regardless of ability to pay
   - To be informed of Medicare eligibility prior to treatment
   - To receive a reasonable estimate of charges for medical care prior to treatment
   - To be informed in writing about the facility policies and procedures for reporting a complaint

9. **Additional Patient Rights:**
   - Must be given the full explanation for reason if being transferred to another facility
   - May initiate contact with the media
   - May get another physician’s opinion if they request and are paying for it
   - May wear personal clothing and religious or symbolic items if it does not interfere with their care and treatment
   - May request to be moved to another room if being disturbed by a patient/visitor
   - May request pet visitation if allowed by facility policy

**PATIENT RESPONSIBILITIES:**
- Must provide accurate and complete information about their health status and medical history
- Report perceived risks
- Ask questions if they do not understand. Report comprehension of instructions
- Follow plan of care
- Keep appointments
- Must be responsible for their actions if they refuse treatment or do not follow orders
- Must meet their financial responsibilities
- Must follow hospital policies and rules
- Must be considerate of other patients and hospital staff
Must respect property of others
Must communicate about their pain
Must inform facility of violation of patient rights or safety concerns

Visitation Rights:
Must be informed of their visitation rights and any limitations
May designate visitors
May be visited by their attorney, physician or clergy at any reasonable time
May refuse visitors
PAIN: Assessment, Management, and Documentation

Pain can be a common part of the patient experience and unrelieved pain has adverse physical and psychological effects. The patient’s right to pain management is respected and supported. Services for patients are provided in such a way as to respect and foster their sense of dignity, autonomy, positive self-regard, civil rights and involvement in their own care. The ethical obligation to manage pain and relieve the patient’s suffering is at the core of a health care professional’s commitment. The health care professionals of Coliseum Medical Centers utilize an interdisciplinary approach to the management of pain in order to minimize or eliminate pain throughout the continuum of care.

Patients of all ages and settings have the right:
A. to express their pain and have that expression accepted and respected as the most reliable indicator of pain,
B. to have their pain assessed systematically and thoroughly,
C. to have their pain managed according to the most currently accepted methods,
D. to receive a prompt response to unrelieved pain, and
E. to be informed and involved in decisions regarding aspects of their pain care including their roles in managing pain as well as the potential limitations and side effects of pain treatments.

PROCESS:
A. Patients/families/caregivers will be informed at the time of the initial interview/assessment that effective pain relief is an important part of their treatment, that their report of unrelieved pain is essential, and that staff will respond quickly to their report of pain.

B. Behaviors observed by nurses to assist in determining pain intensity:

<table>
<thead>
<tr>
<th>Movement</th>
<th>Verbal Cues</th>
<th>Facial Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless</td>
<td>Crying</td>
<td>Grimacing</td>
</tr>
<tr>
<td>Immobility</td>
<td>Moaning</td>
<td>Wincing</td>
</tr>
<tr>
<td>Decreased Movement</td>
<td>Whimpering</td>
<td>Strained look on face</td>
</tr>
<tr>
<td>Agitation</td>
<td>Screaming</td>
<td></td>
</tr>
<tr>
<td>Afraid to move</td>
<td>Grunting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotion cues/mood</th>
<th>Positioning</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Guarding</td>
<td>Diaphoretic</td>
</tr>
<tr>
<td>Fear</td>
<td>Fetal Position</td>
<td>Increased BP</td>
</tr>
<tr>
<td>Angry</td>
<td>Holding self rigid</td>
<td>Increased heart rate</td>
</tr>
<tr>
<td>Irritable</td>
<td>Splinting site of pain</td>
<td>Pupil dilation</td>
</tr>
<tr>
<td>Labile emotion</td>
<td>Tense</td>
<td></td>
</tr>
<tr>
<td>Apprehension</td>
<td>Stiff</td>
<td></td>
</tr>
</tbody>
</table>
Restlessness Jumps when touched

C. When patients are taught to use the pain rating scale, they will be asked to set a comfort (pain relief) goal. The comfort goal is articulated in terms of function and quality-of-life parameters. The comfort goal and related patient teaching will be documented in the patient’s medical record.

D. At the time of initial evaluation and at least once every shift patients will be asked about the presence and intensity of pain. Patients with pain initially or surgical patients will be re-evaluated as needed. The initial pain assessment will include pain intensity and quality including character, frequency, location, onset and duration, aggravating and alleviating factors, effects of pain on function and quality of life, and response to past interventions. The scope of assessment and treatment is based on the care setting and services provided. A more comprehensive assessment is performed when warranted by patient condition.

E. A pain rating greater than the patient’s comfort goal will trigger an appropriate pain relief intervention.

F. Pain intensity will be assessed within one (1) hour after medications are administered.

G. Pain ratings that are persistently above the comfort goal will trigger an interdisciplinary review of the pain management plan.

H. Staff will recognize that the elderly are at particular risk for both under and over treat and that they report pain differently and may metabolize medications differently.

I. Staff will be aware of visual, hearing and motor impairments in all age groups that may impede the use of some tools in the assessment of pain.

ASSESSMENT:

Tools:
A. Wong Baker Faces Pain Rating Scale
   1. Considerations
      a. This pain scale will be used for patients with impaired cognition and communication through observation of facial characteristics OR asking the pediatric patient (recommended for 3 years or older) to describe which face compares with how they feel.
      b. This pain scale consists of 6 faces ranging from 0 = smiling face, no pain, progressing to 10 = a tearful face for excruciating pain.
   2. Procedure
      Explain to the patient that each face is for a person who feels happy because he has not pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he does not hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you do not have to be crying to feel this bad. Ask the patient to choose the face that best describes how he or she is feeling.
B. 0 -10 Numeric Pain Distress Scale
1. Considerations
   a. This pain scale will be used to assess a patient’s pain level if they display appropriate cognitive and verbal skills.
   b. The Visual Analogue Pain Scale consists of a straight line with end points identified as 0=no pain and 10=worst pain imaginable.
2. Procedure
   Explain to the patient that the scale ranges from 0 No Pain to 5 Distressing Pain to 10 Unbearable Pain. Ask the patient to choose the numeric value that best describes how he or she is feeling.

C. Neonatal Infant Pain Scale
1. Considerations
   a. The NIPS tool is used to assess behavioral parameters related to pain in infants
   b. The maximum score is 7
   c. Non-pharmacological methods such as sucking, swaddling, and lullaby music, etc., should be used prior to or in conjunction with pharmacological interventions.
   d. The absence of overt responses may indicate that the infant is too ill to respond, or is sedated pharmacologically.
2. Procedures
   a. Using the NIPS scale the RN/LPN evaluates the infant on each of the six indicators and add the score.
   b. Scoring is done by utilizing the table as an Apgar scoring system. Determine a score for each of the 6 categories (note only “Cry” has the ability for a “2” score.)
   c. Scores greater than 4 indicate the infant is experiencing pain and requires intervention.
   d. The infant will be re-scored after the intervention to assess for the effectiveness of the intervention.
**DOCUMENTATION:**

Pain assessment and reassessment will be documented on admission and throughout the patient’s hospitalization. This documentation may be found on the admission assessment, shift assessment,
or the process intervention screens. If pain is present a pain goal will be established. Continued reassessment will occur, at least every shift, before and after medication administration and before and after non-pharmacological pain relief measures.
ADVANCE DIRECTIVES

A patient has the right to consent to, refuse, or alter treatment plans and the right to formulate advance directives.

DEFINITION:
An Advance Directive is a document in which the patient either states choices for medical treatment or designates one who shall make treatment choices if the patient should lose or not wish to exercise decision-making capacity.

PATIENT WITH AN ADVANCE DIRECTIVE UPON ADMISSION
A copy should be dated and signed by the patient and placed on the patient's medical record and the original returned to the patient.

PATIENT WITHOUT AN ADVANCE DIRECTIVE ON ADMISSION
- If the patient does not have an Advance Directive and does not express a desire to have one, this should be documented on the Conditions of Admission or Consent for Outpatient Services Form.
- If the patient does not have an Advance Directive and wishes to have information, the admitting clerk will provide the “Georgia Advance Directive Form for Healthcare.”
- If the patient requests additional information, the admitting clerk should contact Case Management (ext. 4104) who will provide assistance to the patient once they are in their room.

MAINTENANCE OF THE ADVANCE DIRECTIVE
- A copy of the Advance Directive will be made for the patient's medical record. This copy will be dated and authenticated for the current admission.
- The original advance directive will be returned to the patient.
- The advance directive copy will always remain in the same record, not to be "thinned out" if the record should become voluminous.
Ethics & Compliance Program

Mission and Values and the Ethics and Compliance Program
The HCA Mission and Values Statement is as follows:

*Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we will strive to deliver high quality, cost-effective healthcare in the communities we serve. In pursuit of our mission, we believe the following value statements are essential and timeless:*

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity, and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect, and dignity.

Through the Ethics and Compliance Program, Coliseum Health System will create and maintain a culture that promotes the highest standards of Ethics and Compliance. Such standards are designed to ensure that the system, including all hospital facilities and colleagues, operates in a manner that complies with legal and programmatic requirements of federal, state, and private payer health care programs. Furthermore, such a culture will ensure that the system meets the obligations set forth in our mission and values statement and affirmed in our fundamental commitment to stakeholders.
AGE-RELATED RISK HAZARDS

NEONATAL (Age 0 – 1 Year)

1. A parent or responsible adult should remain with a child that requires supervision and does not have independent safety skills.
2. Infants should be placed in a crib when appropriate accept when an adult is at the bedside and directly facing the infant.
3. Light plastic wrappings are never permitted on sheets and pillows
5. Encourage parents to require identification from anyone entering the room.
6. Cords and tubing should be secured to prevent strangulation
7. When a small child has finished eating, his/her feeding equipment should be removed and he/she should be returned to his/her crib immediately.
8. Toys should be suitable for the age and condition of the child.
9. Children should not be given any toys made of glass or having sharp edges, flaking paint or parts that can be detached and swallowed.
10. Toys should never be left in the cribs of sleeping children; they should be stored in proper storage areas and never left on the floor.
11. Use oral routes for medication administration
12. Heightened vigilance about monitoring infants for adverse drug reactions including allergy. Infants can have very sensitive responses to small amounts of medication.
13. No cleaning supplies are to be left in a pediatric patient room or left unattended by Environmental Services.
PEDIATRIC PATIENTS (1 – 12 Years)

1. A parent or responsible adult should remain with a child that requires supervision and does not have independent safety skills.
2. Infants should be placed in a crib when appropriate except when an adult is at the bedside and directly facing the infant.
3. Side rails should remain up on all beds used for pediatric patients. Beds should remain in the lowest position. Electric beds must have child protection feature.
4. Pillows may not be used in cribs. If used for older children, they should be firm and offer support.
5. Light plastic wrappings are never permitted on sheets and pillows.
7. Use oral routes for medication administration as often as possible when appropriate.
9. Respond promptly to meet the child’s needs.
10. Encourage parents to require identification from anyone entering the room.
11. Cords and tubing should be secured to prevent strangulation.
12. When a small child has finished eating, his/her feeding equipment should be removed and he/she should be returned to his/her crib immediately.
13. Toys should be suitable for the age and condition of the child.
14. Children should not be given any toys made of glass or having sharp edges, flaking paint or parts that can be detached and swallowed.
15. Heightened vigilance about monitoring infants for adverse drug reactions including allergy. Infants can have very sensitive responses to small amounts of medication.
17. Toys should never be left in the cribs of sleeping children; they should be stored in proper storage areas and never left on the floor.
18. No cleaning supplies are to be left in a pediatric patient room or left unattended by Environmental Services.
**ADOLESCENT PATIENTS (13 – 18 Years)**

1. Reassure and support a positive self-image
2. Offer education and training within their capacity. It may be necessary to educate parents at a different location to support adolescent responsibility.
3. Provide counseling on the dangers of physical injury and general safety
5. Respect privacy and confidentiality
6. Avoid conflicts in authority. Create an environment where the adolescent is willing to listen to instruction and cooperate with healthcare workers.
7. Watch for signs of depression or suicidal considerations.
ADULT PATIENTS (19 – 65 Years)

1. Adults, like all age levels should be assessed for their level of knowledge and capacity to understand their diagnosis and treatment. Physical stature and incapacity may warrant consideration of additional safety measures.
2. Bedside rails should remain up for patients with altered level of consciousness. These patients shall be observed closely when sitting in chairs or wheel chairs.
3. Rooms and halls should be kept clear of furniture or equipment.
4. Floors are to be kept clean and dry and clear of towels or obstructions.
5. Adult patients may not acknowledge restrictions their current health condition places on their mobility. Emphasize the importance of obtaining assistance when going to the bathroom or ambulating.
6. Patients should be instructed in safety measures to prevent falls.
7. Patients should be questioned frequently for needs, especially bathroom privileges. Bedside commodes should be utilized when warranted.
8. Provide education about the disease processes and medication. Warn patients of the dangers of non-compliance and self-medication.
9. The patient's glasses should be stored within reach when not being worn.
GERIATRIC PATIENTS (Over 65 Years)

1. Bedside rails (top two) should remain up for patients with altered level of consciousness. These patients shall be observed closely when sitting in chairs or wheel chairs.
2. Offer frequent meals of the patient's choosing to promote adequate nutritional intake.
3. Rooms and halls should be kept clear of furniture or equipment.
4. Floors are to be kept clean and dry and clear of towels or obstructions.
5. Handrails must be available in showers and baths.
6. Patients should be instructed in safety measures to prevent falls.
7. Patients should be questioned frequently for needs, especially bathroom privileges. Bedside commodes should be utilized when warranted.
8. Watch for patient hypersensitivity to medications.
9. Application of hot or cold should be monitored closely.
10. Teach patients about the use of assistive or adaptive devices.
11. The patient's glasses should be stored within reach when not being worn.
12. Notations are to be made on the call system if patient is unable to hear or speak.
13. Night lights should be left on when the room is dark.
DISABILITY SERVICES

BLIND OR LOW VISION

A. Auxiliary Aids
   1. Room and elevator signs in Braille
   2. Audible fire alarm system
   3. Large page magnifying glasses located in Plant Operations
   4. Patients should sign the Notice of Auxiliary Services form and waiver if they do not wish to have auxiliary services or materials

B. Accommodation
   1. Indicate on the Care Plan and chart that the patient is visually impaired.
   2. All individuals entering the room should introduce themselves.
   3. Any written materials/instructions should be read aloud as many times as the patient needs for understanding.
   4. Care should be taken not to disturb the location of objects in the patient’s room.

DEAF OR HARD OF HEARING

A. Auxiliary Aids
   2. TDD – Can be plugged into any phone outlet. Available at the Switchboard and in the Emergency Department
   3. State of Georgia Relay System for the Hearing-Impaired: A system which can translate a voice message to a TDD machine which can be read by a hearing impaired individual. The opposite can also be accomplished by translating a written TDD message to a voice message.
   4. Wireless Doorbell – bundled with the TDD. The receiver is magnetic and can be attached to the door frame. When activated, a light will flash in the patient’s room alerting them.
5. Amplified Phone – Can be installed by Building Services Has adjustable volume control and indicator light which blinks to let the patient know the phone is ringing.

6. Deaf Interpreter Services - Confirm that the patient uses American Sign Language (ASL) and wants an interpreter. There is a form for patients to sign.

7. It may be prudent to coordinate all services requiring the interpreter, including those provided by a physician. It is important to remember that accommodating a disability must be done with the same expectations as a non-disabled person.

8. Utilize Language Services Associates as primary American Sign Language (ASL) 1–800-305-9673

9. Video Remote Interpreting Service (via Portable Computer Station located in Nursing Administration)

B. Accommodation
   1. Indicate the disability on the Care Plan.
   2. When possible, patients should be placed in rooms which have fire alert/strobes.
   3. If the patient reads lips, remember to face them when speaking and talk in a natural voice.
   4. Indicate on the intercom that the patient is deaf/mute and that the patient signal will have to be answered in person.
   5. Provide paper and pencil at bedside.

LIMITED ENGLISH PROFICIENCY

A. Auxiliary Aids
   1. Use the “I speak…” reference card to identify the language.
   2. It may be prudent to coordinate all services requiring the interpreter, including those provided by a physician. It is important to remember that accommodating a disability must be done with the same expectations as a non-disabled person.
3. Access Language Services Associates. Carts are located in the Emergency Department and Nursing Administration. Language Line Services – 800–305-9673

SERVICE ANIMALS

Accommodation

1. Service animals may be dogs or miniature horses.
2. Do not inquire about the disability but ask if the animal is required due to a disability and what tasks the animal has been trained to perform.
3. Patients are required to provide care for their animal. This includes food, water, and exercise.
4. Service animals may be walked outside on the property.
5. Do not interact or feed a service animal.
6. In the event the patient cannot care for the service animal, they must be provided an opportunity to arrange alternative care.
HCA is dedicated to fostering a culture that supports a patient’s right to be free from restraint or seclusion. Restraint use will be limited to clinically justified situations, and the least restrictive restraint will be used with the goal of reducing, and ultimately eliminating, the use of restraints.

**PROCEDURE:**

1. **Assessment for Risk for Restraint**
   a. The Registered Nurse (RN) performs an assessment for risk for restraint or seclusion when a patient exhibits behavior that may place the patient at risk for restraint or seclusion. This risk assessment includes:
      1) Does the patient have a medical device?
      2) Does the patient understand the need to not remove the device?
      3) Is the patient required to be immobile?
      4) Does the patient understand the need to remain immobile?
      5) Is the patient exhibiting aggressive, combative or destructive behavior?
      6) Does this behavior place the patient/staff/others in immediate danger?

   b. The assessment for the risk for restraint also includes:
      1) Patients who arrive in restraint.
      2) Patients in restraint who have recovered from the effects of anesthesia and are awaiting transfer to a bed.

      **Note:** Patients in the NICU and nursery are excluded from the assessment for risk for restraint.

2. **Alternatives to Restraint or Seclusion**
   Patients that are determined to be at risk for restraint will have alternatives initiated promptly. Appendix B contains a listing of alternatives to restraint or seclusion.

3. **Determination That Alternatives to Restraint Have Failed**
   The RN determines that alternatives to restraint or seclusion have failed and that the patient will be safer in restraints than continuing without restraint.

4. **Second Tier of Review**
   A member of nursing administration/management (e.g., nursing supervisor, manager/director, CNO, charge nurse, etc.) will review the need for restraint or seclusion with the RN who has determined that the patient requires restraint or seclusion. The second tier review will occur with the initial application of restraint or seclusion. The review includes:
   a. Alternatives attempted
   b. Reason for restraint or seclusion
   c. Least restrictive type of restraint
   d. Staff’s knowledge of the cause of patient behavior (physiological, psychological, environmental, medication)
   e. Appropriate restraint for vulnerable patient populations
f. Staffing available for monitoring

g. Affirmation of partnering to meet the patient needs with safety and compassion

*Note:* In an emergency application of the restraint, the above review will be done immediately after the application of restraint.

5. **Order for Restraint or Seclusion**
   a. An order for restraint must be obtained from an LIP/physician who is responsible for the care of the patient prior to the application of restraint or seclusion. The order must specify clinical justification for the restraint, the date and time ordered, the duration of use, the type of restraint to be used and behavior-based criteria for release.
      1) An order for restraint may not be written as a standing order, protocol or as a PRN or “as needed” order.iii
      2) If a patient was recently released from restraint or seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order is required.iv
   b. If a telephone order is required, the RN must write down the order while the physician is on the phone and read-back the order to verify accuracy.v The order must specify clinical justification for the restraint, the date and time ordered, the duration of use, the type of restraint and behavior-based criteria for release.

6. **Application of Restraints**
   a. Restraints are applied by staff with demonstrated competence in restraint application.
   b. The patient is informed of the purpose of the restraint and the criteria for restraint removal.
   c. The patient’s family is informed of restraint or seclusion use, the purpose of the restraint or seclusion and the criteria for removal.

7. **Monitoring the Patient in Restraints**
   a. Patients are assessed by an RN immediately after restraints are applied to assure safe application of the restraint.
   b. An RN will assess the patient at least every 2 hours. The assessment will include:
      1) Signs of injury associated with restraint, including circulation of affected extremities
      2) Respiratory and cardiac status
      3) Psychological status including level of distress or agitation, mental status and cognitive functioning
      4) Needs for range of motion, exercise of limbs and systematic release of restrained limbs are being met
      5) Hydration/nutritional needs are being met
      6) Hygiene, toileting/elimination needs are being met
      7) The patient’s rights, dignity, and safety are maintained
      8) Patient’s understanding of reasons for restraint and criteria for release from restraint
      9) Consideration of less restrictive alternatives to restraint
   c. More frequent monitoring and notification of the ordering physician or LIP occurs when:
      1) Patient’s medical and emotional needs and health status change
      2) The type and design of the device or intervention poses increased risk
      3) The level of patient agitation/distress at being placed in restraint as evidenced by an escalation of behavior
4) Evidence of injury related to use of restraint

d. A trained staff member monitors each patient in restraint at least 3 times an hour for safety, and to confirm that the patient’s rights and dignity are maintained. This check will be documented in the electronic record.

e. Monitoring is based on the individual needs of the patient. Variables of the patient’s condition, cognitive status, risks associated with the chosen intervention may require more frequent evaluations.

f. For patients under continuous audio, video or in-person observation, care is rendered in real time, but documentation that safety, rights, and dignity were maintained for the defined period of time may be entered at end of the shift.

g. Any change in physical or psychological response will be reported to the RN. The RN will determine if medical intervention is required or if criteria for release have been met.

8. Documentation Requirements:
The medical record contains documentation of:

a. Assessment for risk for restraint
b. Restraint alternatives employed
c. Determination of effectiveness/ineffectiveness of restraint alternatives
d. Second tier review of need for restraint
e. Order for restraint and any renewal orders for restraint
f. Restraint application
g. Family notification of restraint use
h. Patient and family education regarding restraint use
i. Assessment of the patient in restraint/seclusion
j. Monitoring of the patient in restraint/seclusion
k. Medical and behavioral evaluation for restraint management of violent or self-destructive behavior
l. Modifications of the plan of care
m. Physician notification of changes in patient condition
n. Restraint removal
APPENDIX B: ALTERNATIVES TO RESTRAINT

A. Psychosocial Alternatives
   - Diversion
   - Family interaction
   - Orientation
   - Pastoral visit
   - Reassurance
   - Reading
   - Relaxation techniques
   - Interpreter services
   - Personal possessions available
   - Quiet area
   - One-on-one discussion
   - Decreased stimulation
   - Change in environment
   - Re-establishing communication
   - Setting limits

B. Environmental Alternatives
   - Commode at bedside
   - Decreased noise
   - Music/TV
   - Night light
   - Room close to nursing station
   - Call light within reach
   - Bed alarm in use
   - Specialty low bed
   - Sensory aids available (glasses, hearing aid)
   - Decreased stimulation
   - Providing a quiet area
   - Physical activity
   - Orientation

C. Physiological Alternatives
   - Toileting
   - Fluids/nutrition/snack
   - Positional devices
   - Pain intervention
Assisted ambulation
Re-positioning
Rest/sleep
Providing assistance
Additional warmth
Decreased temperature
Check lab values
Pharmacy consult
SAFETY DATA SHEETS

DEFINITION
Safety Data Sheets are produced by the manufacturer to provide the following information to the users of their product.

SDS INFORMATION
- Name of the Product
- Ingredients (Scientific name) and percent representation in the product.
- Handling and storage
- Identification of product risks (Carcinogenic, vapor risk, flammable) Precautions to be taken by users
- Treatment for accidental exposure to the product

HOW TO ACCESS SDS:
Go to: Insight, Applications, Coliseum Medical Centers, Safety Data Sheets. (Listed as MSDS)

MASTER INDEX
There is a master index of all SDS used in the hospital. These are located in Building Services and Emergency Services and on the CMC Intranet site.
EMERGENCY CODES/FIRE SAFETY

CODE BLUE  
Cardio Pulmonary Arrest and Resuscitation - Adult

CODE BLUE PALS  
Cardio Pulmonary Arrest and Resuscitation - Child

CODE RED  
Fire (Remember: RACE)

CODE GREY  
Security/Combative Situation/Person

CODE ORANGE  
Hazardous Materials Spill

CODE TRIAGE  
Mass Casualty Disaster

CODE PINK  
Infant/Child Abduction

CODE SILVER  
Person with a Weapon/ Active Shooter

CODE B  
Bomb Threat

WEATHER CODE  
Weather Watch/Warning

CODE GREEN  
Decon Team Activation

CODE E  
Emergency Situation/Accident

COD S  
Stroke Alert

CODE SEPSIS ALERT  
Signs and Symptoms of Sepsis

Rapid Response  
Early and Rapid Intervention Needed

CODE STEMI  
STEMI Alert

CODE LIFT  
Lifting Help Needed

TO REPORT AN EMERGENCY CODE: DIAL 4222 for Coliseum Medical Centers.
For Behavioral Health, dial 4222 (announced in CMC Building) and Extension 79
(announced in Behavioral)

FIRE RESPONSE
R……………………………………..RESCUE
A…………………………………..ALARM
C…………………………………….CONTAIN/CONFINE
E…………………………………….EXTINGUISH/EVACUATE

FIRE EXTINGUISHER OPERATION
P…………………………………….PULL THE PIN
A…………………………………..AIM AT BASE OF FIRE
S…………………………………….SQUEEZE THE TRIGGER
S…………………………………….SWEEP BACK AND FORTH
Security Tips

The safety and security of students while on campus is of the utmost importance. Students should engage in activities that promote personal safety and security:

- Do not bring pocketbooks or other valuable to the clinical area as space to securely store may not be available.
- Lock any valuable and personal items in the trunk prior to arriving at the hospital. This includes pocketbooks, CD’s, cell phones, etc that might be visible in your vehicle.
- Only carry minimal cash on your person.
- Leave jewelry at home.
- Always be aware of your surroundings and alert for any suspicious activities or individuals.
- Park only in assigned/designated areas.
- When entering or leaving the hospital in the early morning or late evening when it is dark: Park in well-lit areas
- Use a buddy system or call security, do not walk in and out alone.
- Have your keys ready to unlock your car.
- Be mindful of and notify Security for the following:
  - Doors propped open or having locks disabled
  - Unattended vehicles parked at front entrances or loading docks
  - Unattended packages, back packs or suitcases left in public areas
  - Unauthorized individuals in non-public areas
  - Individuals piggy-backing through doors for entrance to facility
NO SMOKING POLICY

PURPOSE
In an effort to reduce the risks of smoking, including possible adverse effects on treatment, reduce risks of passive smoking for others, and reduce the risk of fire, Coliseum Medical Centers prohibits smoking by patients, visitors, and staff throughout the hospital and on the campus. This includes students and faculty.
CONFIDENTIALITY and HIPAA

Quality medical care is related to the patient’s freedom to disclose detailed personal information and the healthcare professionals pledge to protect it. All patient information is considered confidential and may be released only to individuals designated by the patient or healthcare providers on a need to know basis. Patient information should not be released or discussed unless it is necessary to serve the patient or required by law. You should never disclose confidential patient information that violates the privacy rights of our patients. Patient information will only be released to persons authorized by law or by the patient’s written consent.

HIPAA stands for Health Insurance Portability and Accountability Act. It is mandated by federal law.

STEPS TO ASSURE PRIVACY/CONFIDENTIALITY

A. All interviews with the patient/family should be conducted in an area without threat of being overheard. Usually, closing a door will accomplish this.

B. Consultation or discussion involving the patient will be conducted discreetly.

C. Only individuals designated by the patient will be allowed to participate in decision-making processes.

D. The medical record including electronic should be assessable and read only by individuals directly involved in their treatment or in the handling of records.

E. All information pertaining to payment are confidential.

F. Patients have the right to access their record, amend their record and opt out of the dictionary.

G. A passcode is required to release information to a family member.

H. A visitor who asks for a patient by name may receive name, location and patient general condition unless the patient is No Press – No Info.

NO PRESS - NO INFO

A. Patients may request a "No Press - No Info" status for admission. No information related to the patient may be released including name, confirmation of hospitalization, or condition.

B. All Behavioral Health patients and inmates are considered No Press - No Info.

INFORMATION SECURITY

A. Always log off computers after use. Keep screen out of view of visitors.

B. Never share your password with anyone.

C. When sending a fax, always use a cover sheet.

D. Protected Health Information (PHI) must be kept secure and disposed in document destruction bins.
INFECTION CONTROL

STANDARD PRECAUTIONS

Standard Precautions combine the major features of Universal Blood and Body Fluid Precautions (designed to reduce the risk of transmission of bloodborne pathogens) and Body Substance Isolation (designed to reduce the risk of transmission of pathogens from moist body substances) and applies them to all patients receiving care in the hospital regardless of their diagnosis or presumed infection status.

STANDARD PRECAUTIONS APPLY TO:

- All Body Fluids and Secretions except sweat (regardless of whether or not they contain visible blood)
- Non-intact skin
- Mucous Membranes

Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in the hospital by use of the following fundamental infection control measures.

FUNDAMENTALS OF STANDARD PRECAUTIONS

Handwashing and Hand asepsis:
Handwashing is recognized as the single most effective infection control practice known to reduce the risk of transmission of infectious agents. Handwashing is to be performed frequently and is mandatory before and after contact with each patient. Handwashing should be performed as part of routine hygiene practice regardless of job category. Hands must be washed with soap and water whenever visibly soiled. Alcohol-based hand rubs are provided in addition to soap and water for hand sanitation. Hands should be washed and/or sanitized at a minimum, upon presentation for work, after restroom usage, before and after eating, and prior to leaving the work environment. Additionally, hands should be washed or sanitized whenever there is contact with an obviously unclean surface or whenever the hands have become contaminated from the environment. Hands should be washed or sanitized before and after each patient contact and after removing gloves. Alcohol-based hand sanitizers are available in addition, but not as a replacement for, soap and water handwashing.

Gloves: Gloves are worn for 3 important reasons in the hospital:
To provide a protective barrier and to prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin.
To reduce the likelihood that microorganisms present on the hands will be transmitted to patients, and to reduce the likelihood that hands contaminated with microorganisms from a patient or a fomite, transmit these microorganisms to another patient.
Gloves are required when working with patients. Gloves should be donned at bedside and removed at bedside. They should be worn when handling patient items or when attending the environment if contamination is
expected. Gloves provide protection from patient contact and also reduce the transfer of organisms through absent-minded touching. Gloves are never a substitution for handwashing. Because organisms multiply quickly under gloves and may be introduced through small tears in the glove, hands must be thoroughly washed when gloves are removed. Gloves should never be worn outside of a patient’s room and should never be reused for any purpose.

**Gowns/Protective Apparel:**
Various types of gowns and protective apparel are worn to provide barrier protection by preventing contamination of clothing and to protect the skin from blood/body fluid exposure. Gowns/aprons treated to make them impermeable to liquids provide greater protection to the skin when splashes or large quantities of infective material are present or anticipated. Gowns are worn during the care of patients infected with drug resistant microorganisms to reduce the opportunity for transmission of pathogens from patients or items in their environment to other patients or environments. When gowns are worn for this purpose, they are removed before leaving the patient’s environment. Even protective apparel which becomes contaminated is not an infectious risk itself. It is not until the microorganisms are picked up on the hands and transferred to other areas of the body or another patient that transmission occurs. For this reason, gloves should be worn outside of the gown sleeve and removed prior to exiting the patient’s room. Additionally, hands must be washed after glove removal.

**Mask/Goggles:**
Often masks and goggles are worn together. Appropriate usage is dictated by the type of isolation precautions utilized from patient to patient. Disposable masks should be discarded after each use. Masks are not to be worn around the neck or into the hallways. Goggles may be reused and may be washed with soap and water after usage. Prescription eyeglasses do not take the place of goggles. Goggles should be utilized for all personnel in situations where aerosolizing or splashing is anticipated.

**Sharps Disposal:**
Accidental needlesticks carry the highest risk of disease transmission in the hospital. When handling needles or other sharp instruments, care should be taken to perform slowly and deliberately. Safe Medical Devices must be activated at the point of usage. Hastily handled sharps are often the cause of injury – all sharps (safety or traditional sharps) should be placed in proper disposals immediately after usage. All needles and sharps must be placed in puncture resistant containers - this applies to all contaminated needles. This must be labeled at the time it is used for such. The box should be sealed & removed for disposal before it is too full to allow needles to fall unobstructed into the box (75% full). Sharps disposal systems are available in all patient care areas and all patient rooms. They are placed in a location which allows immediate disposal of sharps following usage. There should be no manipulation of any needle including bending, breaking, or clipping. Safety devices with hinged sharps covers or sheaths are to be used whenever possible. The cover must be put in place at the point of usage and then disposed of into the nearest sharps disposal. If safety devices are not available and a traditional needle is required, it is the policy of this hospital to practice “NO RECAPPING” of needles prior to disposal.
HAND HYGIENE

PURPOSE: Hand washing/hygiene is to reduce or prevent the transfer of microorganisms by direct or indirect spread to patients and personnel in health-care settings. Hand hygiene is the single most important activity for preventing the spread of infection. It is known that improved hand hygiene can result in the decrease of patient’s severity of illness and death from nosocomial (facility-acquired) infections.

A. Indications for Handwashing and Hand Antisepsis
1. When hands are visibly dirty or contaminated with protein type material or are visibly soiled with blood or other body fluids/organic material, Wash hands with soap and water.
2. If hands are not visibly soiled, an alcohol-based hand rub may be used to routinely decontaminate hands in all clinical situations. If alcohol based hand rub product is unavailable, wash hands with antimicrobial soap and water. This includes all indicators for number 3 – 10 that follow.
3. Decontaminate hands before having direct contact with patients.
4. Decontaminate hands prior to donning sterile gloves when inserting IVs and/or indwelling intravascular devices.
5. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure, prior to donning of gloves and PPE.
6. Decontaminate hands after contact with a patient’s intact skin (e.g., when taking a pulse or blood pressure, lifting a patient, etc.)
7. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, & wound dressings if hands are not visibly soiled.
8. Decontaminate hands if moving from a contaminated body site to clean body site during patient care.
9. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
10. Decontaminate hands after removing gloves.
11. Before eating and after using a restroom, wash hands with a non-antimicrobial or an antimicrobial soap and water.
12. Wash hands with non-antimicrobial or an antimicrobial soap and water if exposure to C. Difficile spores or Anthrax spores is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other common antiseptic agents have poor activity against spores.
B. Hand Hygiene Technique
1. When decontaminating hands with alcohol-based hand rub, apply a dime size portion of the product to palm of one hand and rub hands together covering all surfaces of hands and fingers. Rub until hands are dry.
2. When washing hands with soap and water, wet hands first with water, apply a quarter size amount of product to hands, and rub hands together vigorously for at least 15 seconds. Cover all surfaces of the hands and fingers including wrist areas. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off faucet. Avoid using extremely hot or cold water as repeated exposure to extreme temperatures may increase the risk of dermatitis.
3. Liquid, bar or powdered forms of plain soap are acceptable when washing hands with non-antimicrobial soap and water. If bar soap is used, a setup that facilitates drainage should be used or the bar should be discarded after use.
4. Multiple use or roll type cloth towels are not to be used in the facility.

C. Surgical Hand Antisepsis
1. Please see Operating Room Specific Policies

D. Other Aspects of Hand Hygiene
1. Artificial fingernails, extenders, wraps, tips, etc. are not to be worn by direct caregivers, support staff, or front-line disaster responders. This aspect of the hand hygiene policy includes, but is not limited to, all employees with Bloodborne Pathogen risk designated category I as set forth in the facility Exposure Control Plan.
2. Natural nail tips are to be kept less than ¼ inch from fingertip and should never impede the protective quality of glove usage.
3. Wear gloves when contact with blood, body fluids and non-intact skin is anticipated.
4. Remove gloves at bedside after single use. Do not care for more than one patient with the same pair of gloves. Do not wash gloves between uses. Gloves are protective equipment when utilized in the intended manner (single use, disposable item). Change gloves during patient care when moving from a contaminated to a clean body site.
5. Standard Precautions apply in all clinical situations. When certain epidemiologically significant diseases occur, isolation protocols may be utilized in addition to Standard Precautions.
6. Approved hand lotion that is to be used with the current hand antisepsis is provided to minimize the occurrence of irritant contact dermatitis. Do not use petroleum or mineral oil based hand lotions as they interfere with antisepsis efforts.
7. Encourage patients and families to remind healthcare providers at all levels to decontaminate their hands.
8. With any product change, the evaluation is to include the effects and possible interactions of the hand antisepsis and lotion.
ISOLATION PRECAUTIONS
IN ADDITION TO STANDARD PRECAUTIONS

AIRBORNE PRECAUTIONS
1) Private Room that has:
   - Monitored negative air pressure
   - 12 air changes per hour
   - Discharge of air outdoors or HEPA filtration before air is recirculated
   KEEP THE ROOM DOOR CLOSED AND THE PATIENT IN ROOM
2) Respiratory Protection: Wear an N95 respirator mask.
3) Standard precautions apply in addition to Airborne Precautions.
4) Limit the movement/transport of patients from room to essential purposes only. If transport is required, minimize the spread of droplet nuclei by placing a surgical mask on the patient. Limit elevator access to patient and transport personnel only.
5) Adult only visitation allowed. Adults with underlying chronic medical conditions and immunocompromised adults should be discouraged from visiting. Visitors must check in at nursing station and agree to wear surgical mask during visitation. Mask should be discarded in anteroom when leaving.

Diseases requiring Airborne Precautions:
Tuberculosis, Chicken Pox, Measles, SARS/Avian Flu

DROPLET PRECAUTIONS
1) Private Room: A true isolation room may be used if available.
2) Mask (Surgical) required when entering room.
3) Limit the movement/transport of patients from room to essential purposes only. During transport, minimize the spread of droplets by placing a surgical mask on the patient. Limit elevator access to patient and transport personnel only.
4) Standard precautions apply in addition to Droplet Precautions.
5) On adults may visit the patient on Droplet Precautions. For patient and visitor safety, adults with underlying medical conditions and immunocompromised adults should be discouraged from visiting.

Diseases requiring Droplet Precautions:
Flu, Meningitis, Sepsis, Diphtheria, Pertussis

**CONTACT PRECAUTIONS**

1) Private Room
2) Standard Precautions apply in addition to Contact Precautions.
3) Use disposable equipment when possible. Dedicate non-critical patient care equipment to a single patient. Keep medicine carts 3 feet from the patient. All equipment must be decontaminated after use before it can be used on another patient.
4) Use red bag disposal for blood and body fluids.
5) Strict hand hygiene adherence required. After glove removal and handwashing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient’s room to avoid transfer of microorganism to other patients or environments. Use alcohol hand cleaner as you exit the room.
4) Wear a clean non-sterile cover gown if you anticipate that your clothes will have contact with the patient, environmental surfaces, or items in the patient’s room or if the patient has any of the following:
   * Incontinence
   * Diarrhea
   * Colostomy
   * Ileostomy
   * Wound Drainage not contained by a dressing
   Remove gown before leaving the patient’s environment.
6) Limit the movement/transport of patients from room to essential purposes only. During transport, ensure that all precautions are maintained at all times.
7) All solid surfaces surrounding the patient should be decontaminated at the completion of each shift with an appropriate germicidal wipe.
8) Adult only visitation allowed.
Diseases requiring Contact Precautions:
VRE, MRSA, RSV, Herpes, Shingles, Impetigo, Scabies, Lice
C. Difficile Infection requires Enteric Precautions and Contact Precautions

**MODIFIED CONTACT PRECAUTIONS**

*Apply only to Rehab and Behavioral Health Adult and Senior Center*

1) Private Room: When a private room is not available, cohort with patient(s) who has active infection with the same microorganism but with no other infections.
2) Standard Precautions in addition to Modified Contact Precautions
3) Patients are allowed to leave their room for therapy sessions and must always use proper hand hygiene before leaving their room.
4) All solid surfaces surrounding the patient should be decontaminated with the appropriate germicidal wipe at the completion of each shift.

Requiring Modified Contact Precautions:
MRSA+ Surveillance Screen (MRSA Colonization) for in-patient Rehab patients and Behavioral Health Patients
ENTERIC PRECAUTIONS

1) Private Room
2) Wash hands with soap and water. Hand sanitizer is not effective.
3) Use disposable gown if soiling likely.
4) Wear gloves.
5) Bag reusable articles. Discard infectious trash.
6. Use bleach wipes for cleaning solid surfaces near patient and equipment.
ELECTRICAL SAFETY

A. Be aware of the dangers which may result from unsafe use of electricity include shock, fire, explosion, burns, disabling injuries and even death. Precautions are essential in the prevention of injuries related to electricity.

B. All plugs should be hospital grade and should have been approved by the Engineering Department. Childproof plugs should be used in pediatric areas.

C. Plugs and sockets should fit firmly requiring some force for insertion or removal.

D. Unplug and tag any plugs or sockets that are warm to the touch when connected.

E. Grasp the plug to remove it, never pull the cord.

F. Electrical devices should be properly grounded. Do not place 3-prong plugs into 2-prong plug cheaters.

G. Check cords for wear and fraying. Keep cords away from oil, grease, or any other material which causes deterioration.

H. Avoid using extension cords. Extension cords are prohibited.

I. Space heaters or portable comfort devices are not permitted.

J. In the case of an electrical fire, turn off the machine by unplugging it. Never use water to extinguish an electrical fire.

K. In the case of an electrical shock, turn off the power before touching the affected person.
BODY MECHANICS AND LIFTING SAFETY

A. There are six basic steps to followed in any type of lifting procedure:
   1. Position yourself as close as possible to the object about to be lifted.
   2. Bend at the knees, keeping the spine in proper alignment.
   3. Lift the object with the weight distributed evenly between both hands.
   4. Feet should be shoulder width apart with one foot slightly forward for balance.
   5. Remember to use your legs when lifting, not your back.
   6. Keep the weight close to the body at all times.

B. Never lift too much; make heavy lifting a teamwork job. Discretion is the only acceptable attitude.

C. When lifting with another person, do smoothly to avoid strain produced by jerky movements. Count to "3" before beginning lift.

D. Prior to lifting a patient, be sure the patient knows what you are about to do.

E. While back belts do not replace good body mechanics, consider wearing a properly fitted back belts if provided by your department as a reminder to use good body mechanics when lifting.

F. Use lifting equipment or other appropriate aides when working with heavy loads or at heights.

G. Do not stand under loads being handled by hoists.

H. When working on ladders where lifting is involved, have a helper.

I. When carrying or lifting heavy loads remember to PIVOT - DO NOT TWIST.

J. When moving equipment or a cart, always PUSH the cart. DO NOT pull the cart.
RADIATION SAFETY

Always stand at least six feet from an x-ray machine when an image is being made.

Always wear a leaded apron when working near C-arms or portable x-ray machines.

Never stand in the direct beam of the x-ray.

If caring for patients who have received radioactive material, find out what special precautions are needed.

Do not enter Zones 3 and 4 in the MRI area.
INMATES

Inmates (prisoners) are always No Press/ No Info.
Remain professional at all times.
There will be two correctional officers with the inmate at all times.
Refrain from personal conversations with inmates.
Do not leave anything in the room unattended that could be used as a weapon.
Report any concerns about the inmate or the corrections officers immediately.
FALL PREVENTION

An RN will complete the fall risk assessment on admission and each shift. Patients at risk for falling will have a yellow blanket, yellow armband and yellow non-skid socks. There is a yellow door magnet that is placed outside the patient’s room to show that they are at risk for falling. Patients are taught to call for assistance when they need to get up.
## 2017 NATIONAL PATIENT SAFETY GOALS

<table>
<thead>
<tr>
<th>GOAL</th>
<th>REQUIREMENT</th>
<th>IMPORTANT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify Patients Correctly</td>
<td>Use <strong>two identifiers</strong> to make sure that each patient gets the correct medicine and treatment.</td>
<td>Patient Identifiers at CMC: 1. Patient Name 2. Date of Birth</td>
</tr>
<tr>
<td></td>
<td>Containers used for blood and other specimens should be labeled in the presence of the patient.</td>
<td>• You never use the room # to identify a patient</td>
</tr>
<tr>
<td></td>
<td>When a patient receives a blood transfusion, make sure the right patient gets the correct blood.</td>
<td>• When using eMAR, you must scan the patient’s armband. Use the Final Check:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Look at the patient armband and the barcode on the medication or specimen label. Make sure the last three numbers of the medical record number are the same.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Read them out loud.</td>
</tr>
<tr>
<td>Improve Communication</td>
<td>Get important test results to the right staff person on time.</td>
<td>Critical test results may include lab values, radiology reports, respiratory and cardiology results.</td>
</tr>
<tr>
<td>Use Medications Safely</td>
<td>Before a procedure, label all medications. This includes medicines in syringes, cups and basins.</td>
<td>Labeling applies even if there is only one medication being used and should occur when any medication or solution is transferred from the original packaging to another container.</td>
</tr>
<tr>
<td></td>
<td>Take extra care with patients who take medicines to thin their blood.</td>
<td>Medication or solution labels include:</td>
</tr>
<tr>
<td></td>
<td>Record and pass along correct</td>
<td></td>
</tr>
</tbody>
</table>
information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor or hospital.

<table>
<thead>
<tr>
<th>Prevent Infection</th>
<th>Use the hand cleaning guidelines from CDC or WHO. Use proven guidelines to prevent infections that are difficult to treat. Use proven guidelines to prevent infection of the blood from central lines. Use proven guidelines to prevent infection after surgery. Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.</th>
<th>Medication Name Strength Quality Diluent and Volume Expiration date when not used within 24 hours Expiration time when expiration occurs in less than 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDROs include MRSA, c. difficile, VRE, and multi-drug resistant gram-negative bacteria. Patients who are infected or colonized with a multi-drug resistant organism and their families should be educated about health care associated infection prevention strategies. Patients and their families should be educated on central line associated bloodstream infections prior to insertion of a central venous catheter. Educate surgery patients and their families about surgical site infection prevention.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use Alarms Safely</th>
<th>Ensure that alarms on medical equipment are heard and responded to on time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify Patient</td>
<td>Find out which patients are Suicide prevention</td>
</tr>
<tr>
<td>Safety Risks</td>
<td>most likely to commit suicide.</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Prevent Mistakes in Surgery</td>
<td>Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body. Mark the correct place on the patient's body where the surgery is to be done. Pause before the surgery to make sure that a mistake is not being made.</td>
</tr>
</tbody>
</table>
Hospital Orientation Quiz
Coliseum Medical Centers
(Student/Faculty)

NAME ___________________________________________ DATE_________________________
SCHOOL ________________________________ FACULTY __________________________

1) Match the following:

______ CODE BLUE  
A. Decon team report to decon area  
______ CODE RED  
B. Emergency Situation/Accident  
______ CODE TRIAGE  
C. Hazardous Material Spill  
______ CODE SILVER  
D. Patient in Septic Shock  
______ CODE E  
E. Cardiac/Respiratory Arrest  
______ CODE PINK  
F. Mass Casualty Disaster  
______ CODE ORANGE  
G. Patient with Signs of Stroke  
______ RAPID RESPONSE  
H. Security/Combative Situation/Person
______ CODE B  
I. Person with Weapon/Active Shooter  
______ CODE GREY  
J. Bomb Threat  
______ CODE GREEN  
K. Early and Rapid Intervention Needed  
______ CODE S  
L. Infant Abduction  
______ SEPSIS ALERT  
M. Fire

2) To report an emergency code, dial ext. __________.

3) When using a fire extinguisher, the PASS system stands for:

P  ______________________
A  ______________________
S  ______________________
S  ______________________
4) The cornerstone of the hospital fire program is RACE which stands for:

R __________________________
A __________________________
C __________________________
E __________________________

5) TRUE or FALSE:

_______ Safety Data Sheets, commonly referred to as SDS, provide detailed information on a chemical and its hazards.

_______ Disposable needles/syringes are to be immediately placed in the disposal box after being recapped, bent, clipped, or removed from the syringe.

_______ The definition of an adverse event is any deviation from usual medical care that causes an injury to the patient or poses a risk of harm.

_______ Staff/students are not permitted to smoke anywhere on campus.

_______ Attention to patient safety is consistent with our mission and values statement and to our commitment to putting patients first.

_______ The patient has the right to refuse treatment to the extent permitted by law.

_______ Handwashing remains the single most effective method known to reduce the risk of transmission of infectious agents.

_______ It is permissible to wear artificial nails as long as they are less than ¼ inch from the tips of the fingertips and kept well manicured.

6) Isolation categories are:

__________________________
__________________________
__________________________
7) Circle the number that shows the appropriate order for proper lifting:
   a. Bend Knees
   b. Bring objects close to the body
   c. Keep legs shoulder width apart
   d. Lift with the legs

   1. a, c, b, d
   2. c, a, b, d
   3. d, a, b, c
   4. b, a, c, d

8) If you found a back-pack lying in a corner of the back hallway on first floor you would:
   a. Pick it up and take it to the nearest nurse station
   b. Pick it up and take it to the switchboard
   c. Walk by it and assume that someone will eventually come after it
   d. Call Security immediately and report a suspicious package

9) AIDET stands for:
   a. Acknowledge, Introduce, Duration, Explanation, Time
   b. Assist, Interview, Debrief, Explain, Thank
   c. Acknowledge, Introduce, Duration, Explanation, Thank you
   d. Annoy, Ignore, Duration, Examine, Time of next medication

10) Behaviors that may be observed to assist in determining pain intensity include:
    a. Agitation
    b. Grimacing
    c. Restlessness
    d. All of the above

Rev. 4/06; 9/11, 08/12, 01/13, 01/14, 02/16, 01/17
ENVIRONMENT OF CARE/HOSPITAL SAFETY MODULE QUIZ
ANSWER SHEET- Give completed form to Faculty Instructor

Coliseum Medical Centers (Student/Faculty)

1) ______

6) ____________________
   ____________________
   ____________________
   ____________________
   ____________________

7) ______

8) ______

9) ______

10) _____

2) ____________________

3) ____________________
   ____________________
   ____________________
   ____________________

4) ____________________
   ____________________
   ____________________
   ____________________

5) ______
   ______
   ______
   ______
   ______

   Date____________________
   ______
   ______
   ______
   ______
   ______
   ______

   Name____________________
   ______
   ______
   ______
   ______
   ______

   School____________________
   ______
   ______
   ______
   ______
   ______
   ______

   Faculty____________________
HIPAA/CONFIDENTIALITY QUIZ
Coliseum Medical Centers
(Student/Faculty)

NAME __________________________________ DATE ________________________________

SCHOOL ______________________________ FACULTY ____________________________

1. HIPAA is mandated by:
   a. State Law
   b. JCAHO
   c. Federal Law
   d. CMS (Center for Medicare and Medicaid Services)

2. The following are responsible for protecting patient information:
   a. Students
   b. Physicians
   c. Hospital Employees
   d. All of the above

3. It is appropriate to share information with the following without patient authorization:
   a. Former physician of the patient’s who is concerned about the patient
   b. Colleague who needs information about the patient to provide proper care
   c. Friend of patient
   d. Pharmaceutical salesman offering fee for list of patients names

4. HIPAA prevents which of the following:
   a. Whiteboards at nursing units
   b. Patient sign in sheets
   c. Overhead paging of patients and family members
   d. None of the above
5. Patient’s have the right to:
   a. Access their records
   b. Amend their records
   c. Opt out of the Directory
   d. All of the above

6. The following is required for release of information from the nursing unit:
   a. Patient’s Social Security Number
   b. Passcode
   c. Patient's Medical Record Number
   d. Full Name of Patient

7. A visitor who asks for a patient by name may receive the following except for:
   a. Patient name
   b. Patient condition in general terms
   c. Patient location
   d. Patient Diagnosis

8. Good privacy practices include:
   a. Never discussing patient information in public places
   b. Creating a “hard to guess password”
   c. Logging off of locking your terminal when away from your work station
   d. All of the above

9. When faxing information, you must:
   a. Remove patient identifying information before sending
   b. Call the recipient before sending to be sure they are at the receiving fax
   c. Include a HIPAA compliant cover sheet
   d. Be sure to get a fax confirmation sheet

10. Protected Health Information:
    a. Must be disposed of in secured trash bins designated for appropriate destruction
    b. Must never be left lying around in places where visitors and patients have access
    c. Should not be posted where anyone can view
    d. All of the above
Confidentiality and Security Agreement

I understand that the HCA affiliated facility or business entity (the “Company”) for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, “Confidential Information”).

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

**General Rules**

1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company’s policies.

**Protecting Confidential Information**

4. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
5. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
6. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
7. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
8. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
9. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

**Following Appropriate Access**

10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient’s record or Company information, I am affirmatively
representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

**Using Portable Devices and Removable Media**

12. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards.

13. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (e.g., Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
   a. Require the use of only encryption capable devices.
   b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
   c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes company data regardless of it being a Company or personally owned device.
   d. Remotely "wipe" any synchronized device that has been lost, stolen or belongs to a terminated employee or affiliated partner.
   e. Restrict access to any mobile application that poses a security risk to the Company network.

**Doing My Part – Personal Security**

14. I understand that I will be assigned a unique identifier (e.g., 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.

15. I will:
   a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
   b. Use only approved licensed software.
   c. Use a device with virus protection software.

16. I will never:
   a. Disclose passwords, PINs, or access codes.
   b. Use tools or techniques to break/exploit security measures.
   c. Connect unauthorized systems or devices to the Company network.

17. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.

18. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
   a. my password has been seen, disclosed, or otherwise compromised;
   b. media with Confidential Information stored on it has been lost or stolen;
   c. I suspect a virus infection on any system;
   d. I am aware of any activity that violates this agreement, privacy and security policies; or
   e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

**Upon Termination**

19. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.

20. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
21. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

<table>
<thead>
<tr>
<th>Employee/Workforce Member Signature</th>
<th>Facility Name and COID</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee/Workforce Member Printed Name</td>
<td>Business Entity Name</td>
<td></td>
</tr>
</tbody>
</table>

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

<table>
<thead>
<tr>
<th>Employee/Consultant/Vendor/Office Staff/Physician Signature</th>
<th>Facility Name and COID</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coliseum Medical Centers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee/Consultant/Vendor/Office Staff/Physician Printed Name</th>
<th>Business Entity Name</th>
</tr>
</thead>
</table>

**HIPAA/CONFIDENTIALITY MODULE**

**QUIZ ANSWER SHEET**

*Give completed form to Faculty Instructor*

Coliseum Medical Centers (Nursing Student/Faculty)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) ____

Date_____________________
Name_____________________
School____________________
Faculty____________________
Faculty Hospital Orientation Checklist

It is expected that faculty will submit to the Education Department this completed form, all signed Confidentiality Statements and Attestation Forms, a student roster, and the instructor’s name/phone numbers no later than the close of the first clinical practice experience for each clinical rotation.

In signing this form, the faculty agrees that:

- The following information has been provided to the nurse manager and education department:
  - List of instructors and phone numbers
  - Schedule of students; list of names
  - Clinical rotation schedule
  - Name/phone number/fax number of person who holds copies of all information indicated on individual attestation forms:
    ________________________________________________________________
    ________________________________________________________________
    ________________________________________________________________

- Students/Faculty have received a unit orientation for the following (as appropriate):
  - Location of fire extinguishers and fire pulls
  - Emergency codes and appropriate response
  - Documentation process
  - eMAR
  - IV/Therapy procedure/Glucometer competence
  - Other policy and procedure/equipment review as appropriate

_________________________________________  ______________________
Faculty Signature                     School                     Date

_________________________________________  ______________________
Unit Manager Signature                Unit                         Date

---

1 HCA Best Practice
2 HCA Best Practice
3 TJC PC.03.05.05; CMS §482.13(e)(6)
4 TJC PC.03.05.05; CMS §482.13(e)(6)
5 TJC NPSG.02.01.01