PROVIDER ORIENTATION PACKET

Summit Health Credentials Verification Organization
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Created: January 2014
Instructions
After reviewing enclosed material, please print, sign and return the last page of this packet

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Our Vision
Summit Health will be the catalyst for improving the health of people living in communities within Franklin County and surrounding areas.

Our Care Promise
Summit Health is dedicated and committed to providing you with the highest quality and safest care. We strive daily to make sure all your needs are met. We believe it’s important for us to maintain open and honest communication.

Our Values
- Integrity
- Compassion
- Excellence
- Service
Respect for People
FOUNDATIONAL BEHAVIORS OF RESPECT

Our healthcare community is deeply committed to respect for all caregivers through equity, honesty, and kindness in support of the caregiver experience. To this end, we:

- Promote the well-being of
- Seek to enhance the confidence of
- And aspire to build trusting relationships of...ALL CAREGIVERS

TOP WAYS TO SHOW RESPECT

1. **Assume good intent.** Trust that teammates have good intentions. Believe that each person is doing their best and do your best to support them. Embody a spirit of collaboration and trust. Trust builds confidence and supports teamwork.

2. **Listen to understand.** Good listening means giving the speaker your full attention. Non-verbal cues like eye contact and nodding let others know you are paying attention and are fully present for the conversation. Avoid interrupting or cutting others off when they are speaking.

3. **Keep your promises.** When you keep your word you show you are honest and you let others know you value them. Follow through on commitments and if you run into problems, let others know. Be reliable and expect reliability from others.

4. **Be encouraging.** Giving encouragement shows you care about others and their success. It is essential that everyone understand that their contributions have value. Encourage your coworkers to share their ideas, opinions and perspectives.

5. **Connect with others.** Notice those around you and smile. This acknowledgement, combined with a few sincere words of greeting, creates a powerful connection. Practice courtesy and kindness in all interactions.

6. **Express gratitude.** A heartfelt “thank you” can often make a person’s day and show them you notice and appreciate their work. Share a story of “going above and beyond” at your next team meeting.

7. **Share information.** When people know what is going on, they feel valued and included. Be sure everyone has the information they need to do their work and know about things that affect their work environment. Sharing information and communicating openly signals you trust and respect others.

8. **Speak up.** It is our responsibility to ensure a safe environment for everyone; not just physical safety but also mental and emotional safety. Create an environment where we all feel comfortable to speak up if we see something unsafe or feel unsafe.

9. **Walk in their shoes.** Empathize with others; understand their point of view, and their contributions. Be considerate of their time, job responsibilities and workload. Ask before you assume your priorities are their priorities.

10. **Grow and develop.** Value your own potential by committing to continuous learning. Take advantage of opportunities to gain knowledge and learn new skills. Share your knowledge, skills, and expertise with others. Ask for and be open to feedback to grow both personally and professionally.

11. **Be a team player.** Great teams are great because team members support each other. Create a work environment where help is happily offered, asked for and received. Anticipate other team members’ needs and clearly communicate priorities and expectations to be sure the work is level loaded.
### EMERGENCY MANAGEMENT / SECURITY – Chambersburg Hospital

“The first priority in every event is the safety of YOU, OUR PATIENTS, AND OTHERS!”

At Chambersburg Hospital, call 5555 (hospital) to report all codes and (9) 911 at the Satellites.

<table>
<thead>
<tr>
<th>Purpose</th>
<th>To Activate {Satellites call (9) 911 and give conditions}</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fire</strong>&lt;br&gt;“Code Red”</td>
<td>RACE (Fire Procedure)&lt;br&gt;▪ Rescue those in danger&lt;br&gt;▪ Alarm – pull alarm, then call x5555 satellites call (9) 911&lt;br&gt;▪ Contain – close windows and doors&lt;br&gt;▪ Extinguish – use a fire extinguisher</td>
<td>· Security and Plant Operations will respond&lt;br&gt;PASS (Extinguishers)&lt;br&gt;▪ Pull the pin&lt;br&gt;▪ Aim the nozzle&lt;br&gt;▪ Squeeze the handle&lt;br&gt;▪ Sweep side to side at base of fire</td>
</tr>
<tr>
<td><strong>Cardiac Arrest/Medical Emergency</strong>&lt;br&gt;“Code Blue” or “Code Blue Junior” (Child)</td>
<td>✓ Call Ext 5555&lt;br&gt;✓ Say “Code Blue” or “Code Blue Junior”&lt;br&gt;✓ Give location</td>
<td>· ED Team responds w/ supplies&lt;br&gt;▪ If CPR qualified, start the CPR assessment&lt;br&gt;▪ Stay with the person until relieved</td>
</tr>
<tr>
<td><strong>Threatening/violent behavior</strong>&lt;br&gt;“Code Green”</td>
<td>✓ Call Ext. 5555&lt;br&gt;✓ Say “Code Green”&lt;br&gt;✓ Give location</td>
<td>· Security and Behavioral Health responds&lt;br&gt;▪ Avoid placing yourself in danger.</td>
</tr>
<tr>
<td><strong>Abduction/infant/child</strong>&lt;br&gt;“Code Pink”</td>
<td>✓ Call Ext 5555, &amp; (9)911&lt;br&gt;✓ Say “Code Pink”&lt;br&gt;✓ State victim’s 1st name, age, sex, dress, location&lt;br&gt;✓ Watch all exits</td>
<td>· Everyone must respond&lt;br&gt;▪ Look for a suspect with an infant or child&lt;br&gt;▪ DO NOT try to stop them&lt;br&gt;▪ Get suspect and vehicle description&lt;br&gt;▪ Report to the Command Post</td>
</tr>
<tr>
<td><strong>Bomb Threat</strong>&lt;br&gt;“Code Black”</td>
<td>✓ Call Ext. 5555&lt;br&gt;✓ Say “Code Black”&lt;br&gt;✓ Give location</td>
<td>· Security responds&lt;br&gt;▪ Keep caller on telephone-Ask questions, bomb details&lt;br&gt;▪ Listen for clues: background, caller accent, gender&lt;br&gt;▪ Notify a supervisor on site immediately</td>
</tr>
<tr>
<td><strong>Hostage/Weapon Situation</strong>&lt;br&gt;“Code Silver”</td>
<td>✓ Call Ext. 5555&lt;br&gt;✓ State location and description</td>
<td>· Security responds&lt;br&gt;▪ If you witness, keep safe: do not attempt to intervene.&lt;br&gt;▪ If you are the hostage, cooperate, hide ID, don’t bargain, expect a police response</td>
</tr>
<tr>
<td>Disaster</td>
<td>“Code Orange”</td>
<td>On-duty staff</td>
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<tr>
<td>---</td>
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<tr>
<td>Notify onsite supervisor of conditions</td>
<td>✓ Report to your department</td>
<td>✓ Wait for assignment</td>
</tr>
<tr>
<td>✓ Off-duty incoming staff</td>
<td>✓ Bring your ID badge</td>
<td>✓ Use North ground floor entrance - you’ll be directed where to report</td>
</tr>
</tbody>
</table>

- Examples: mass casualty, severe weather, utility failure, evacuation etc.
- The highest-ranking administrative person onsite is in charge of the event (Incident Commander)
- The Command Post location will be announced

<table>
<thead>
<tr>
<th>“Code Orange BC”</th>
<th>Disaster/Decon Team</th>
<th>Decontamination Team reports for duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological-radiological-chemical hazmat requires decontamination</td>
<td></td>
<td></td>
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</table>

- Ordered by the Incident Commander based on hazards
- Entrances/exits will be assigned by the Command Post
- Security will lock doors and place signs w/directions
- Standby for instructions or you hear “Lockdown All Clear”

<table>
<thead>
<tr>
<th>“Lockdown in progress”</th>
<th>(Facility)</th>
<th>✓ Report to all ground and 1st floor exit doors &amp; windows</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Do not open for anyone</td>
<td>✓ Standby until relieved</td>
<td></td>
</tr>
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</table>

- An event which places patients, other persons or facilities in imminent danger to health and well-being
- Ex: Chemical spill beyond your clean-up capabilities, severe
- Operator contacts the highest-ranking administrative person on-site

<table>
<thead>
<tr>
<th>“All clear”</th>
<th>Code ended</th>
<th>Resume duties</th>
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<table>
<thead>
<tr>
<th>Safety</th>
<th>(Nonemergency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Contact responsible department for correction asap</td>
<td>✓ Notify your supervisor</td>
</tr>
<tr>
<td>✓ Call OOPS (Ext 6677) if a patient is involved</td>
<td></td>
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</table>

- Examples of concerns/issues: torn carpet, wrong chemical spill kits being used, unusual odors or noises, equipment used on patient has rough edges, etc.
- *Report any condition, as deemed appropriate, to Safety Officer, Ext 7787

<table>
<thead>
<tr>
<th>Safety</th>
<th>(Emergency)</th>
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</thead>
<tbody>
<tr>
<td>✓ Notify the supervisor onsite</td>
<td>✓ Call Ext.5555</td>
</tr>
<tr>
<td>✓ Describe the situation</td>
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<table>
<thead>
<tr>
<th>Blue Phones</th>
<th>Telephone outage</th>
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<tbody>
<tr>
<td>Use blue “Bypass” phones located in priority areas. (e.g. nurses stations)</td>
<td></td>
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<tr>
<td>Directions posted by blue phones</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Security</th>
<th>(Non emergency)</th>
</tr>
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<tbody>
<tr>
<td>✓ Call Ext. 2222</td>
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</table>

- Report any suspicious behavior
- Unlock doors if you forget a key
- Escort workers to their vehicles after hours
- Report accidents
- Jumpstart vehicle
<table>
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<tr>
<th>Immediate Evacuation:</th>
<th>“Person in charge of area”</th>
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</thead>
</table>
| **E1** – one area to a “safe” zone (horizontal) | ✓ Call Ext. 5555  
✓ State “E” ___(number), unit location, and relocation area  
**All others:**  
✓ Report to your supervisor for assignment |
| **E2** – an entire floor or zone down or out of building (vertical) |  |
| **E3** – entire facility |  |

- Operator contacts highest-ranking administrative person onsite (Incident Commander)

**Order of move:**
- Move 1st – Visitors/ambulatory
- Next – Nonambulatory or require minimal assistance
- Final – Critically ill or require full assistance

- Charge person place tape across lower part of vacant room door frames
- Additional evacuation and relocation to be ordered by the Command Post

| External Evacuation | Lead person in your area takes charge of the unit:  
✓ Evacuate to new location and account for everyone |
|---------------------|--------------------------------------------------|
| Patient Care Floors 2, 3, 4, & 5 | ...
| All other depts. | ...
| Relocate to the Medical Office Building parking lot |

<table>
<thead>
<tr>
<th>Safety Officer</th>
<th>Vickie Negley, ext. 7787</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Safety Officer</th>
<th>Nancy Probst, ext. 7757</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Medical Assistance in Non clinical areas</th>
<th>Call 7800</th>
</tr>
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</table>

- May be used in lobbies and lecture rooms where clinical staff are not present. For example, when someone falls and needs help.

- register a complaint at Chambersburg Hospital, call (717) 267-7454.
- To file a complaint with the Pennsylvania Department of Health, Acute & Ambulatory Care Services, P.O. Box 90, Harrisburg, PA 17108-0090
EMERGENCY MANAGEMENT / SECURITY
Waynesboro Hospital

At Waynesboro Hospital, call 6666 (hospital) to report all codes.

I. All emergency codes, unless otherwise authorized, will be announced by the Switchboard Operator on a priority basis using the general overhead paging system.

II. Upon appropriate authorization, the Switchboard Operator will announce the requested Emergency Code (3) three times. The use of the term Administration includes Senior Management, Shift Administrator and Resource Nurse when acting as Shift Administrator.

III. The following are recognized hospital codes:

A. **Code Orange** – Used to initiate the Emergency Operations / Disaster Plan and is to be authorized by Administration. The Switchboard Operator, upon request, will announce “Code Orange is in effect” upon initiation and “Cancel Code Orange” upon termination. For more detailed information refer to the Environment of Care Policy and Procedures.

B. **Code Orange BC** – The Decontamination Team will be activated in the event of a biological, chemical or nuclear agent. The Switchboard Operator, upon request, will announce “Code Orange BC is in effect” upon initiation and “Cancel Code Orange BC” upon termination. For more detailed information refer to Decontamination, Radiation Emergency and Hazardous Spill policies.

C. **Code Red** – Used to initiate the Fire Plan and is to be authorized by any person making a verbal report of fire or smoke or a system initiated alarm. The Switchboard Operator will announce 3 times “Code Red (along with the location)” upon initiation and “Cancel Code Red” upon termination. For more detailed information refer to the Environment of Care Policies and procedures.

D. **Code Black** – Used to initiate the Bomb Threat and is to be authorized by Administration. The Switchboard Operator will announce, upon request, “Code Black is in effect” upon initiation and “Cancel Code Black” upon termination. For more detailed information refer to the Environment of Care Policy Manual.

E. **Code Pink** – Used to initiate the Infant/Child Abduction Plan and can be authorized by anyone witnessing a child abduction, Department Management or Administration. The Switchboard Operator will announce, upon request, “Code Pink is in effect” upon initiation and “Cancel Code Pink” upon termination. For more detailed information refer to the Environment of Care Policies and Procedures.

F. **Code Blue** – Used to activate the cardiac team and will be initiated upon receipt of either a verbal request or code blue alarm activation. The Switchboard Operator will announce, upon request, “Code Blue” (along with the location). For more detailed information refer to the Code Blue policy.

G. **Rapid Response Team** – Used to deploy the Rapid Response Team to prevent deaths in patients who are failing. The switchboard operator will announce, upon request, “Rapid Response Team (along with the location).” For more detailed information refer to the Administration Policy Manual.

H. **Code Green** – Used to deploy staff to respond to a patient, or a visitor, exhibiting violent behavior. The switchboard operator will announce, upon request, “Code Green (along with location).” For more detailed information refer to the Code Green policy in the Environment of Care policies and procedures.

I. **Code Silver** – Used to deploy a coordinated team to de-escalate and mitigate an event that a person is held against their wishes and/or is threatened. The switchboard operator will announce, upon request, “Code Silver (along with location).” For more detailed information refer to the Code Silver policy in the Environment of Care Manual.

IV. Switchboard Operators should refer to color coded Operator’s Quick Checklist for specific instructions and notifications.

V. While any emergency code listed in Section III, item A through F is in effect, all self-paging is to be suspended until the “cancel” is announced. All pages should be limited to essential requests through the Switchboard. Upon termination of these emergency codes, normal self-paging may be resumed.

VI. Any codes requested other than those authorized, should be referred to Administration to be resolved.
Rationale for Anticoagulants Training

All prescribers need to be educated on the use of anticoagulants

This is part of The Joint Commission National Patient Safety Goals on Anticoagulants

FDA Medwatch

The following content regarding Anticoagulants is cited from http://depts.washington.edu/anticoag
In This Issue: Anticoagulants

- Mistakes that involve blood coagulation modifiers ( BCMs) – anticoagulants, thrombolytic, and antiplatelet agents – have a greater potential for harm than errors involving other drugs, according to the Pharmacopeia (USP).

- During 2011, Dabigatran (PRADAXA) and Warfarin (COUMADIN) were the top two drugs associated with patient harm or death reported to the FDA, Medwatch 2012.

Heparin

Dosing:
- Dosing will vary greatly depending on the intended use and route of administration.

- Subcutaneous (SQ) Administration – 5000 – 10,000 units every 8 – 12 hours.

- Intravenous (IV) administration – calculated by weight, initial bolus does of 60-70 units/kg IV push then a continuous infusion 12-18 units/kg/hr.

Note: There are 2 heparin protocols with calculators on the intranet for Summit Health. One for DVT/VTE/PE and one for ACS/Unstable Angina/Non ST Elevation Myocardial Infarction.
Reversal Agent:

- Protamine sulfate can be used to reverse severe bleeding from heparin overdose 1mg/IV for every 100 units of Heparin, given over 1 to 3 minutes; infusion rates not to exceed 50 mg per 10 minutes
- Further therapy should be guided by monitoring PTT every 5 to 15 minutes

Enoxaparin Sodium (Lovenox)

Dosing:

- ACS, PCI, DVT treatment, Pulmonary embolus, acute myocardial infarction, atrial fibrillation, & prosthetic cardiac valve thrombosis prophylaxis – 1 mg/kg SQ every 12 hours
- Postoperative DVT prophylaxis – 30 mg SQ every 12 hours or 40 mg SQ daily

Note: For patients with creatinine clearance <30 ml/min, dose should be adjusted daily or discuss with pharmacist.
Enoxaparin Sodium (Lovenox) (continued)

Reversal Agent:

- Protamine sulfate can be used to reverse severe bleeding from an enoxaparin sodium/heparin overdose, 1 mg IV for every 1 mg of enoxaparin to be reversed, given over 1-3 minutes: infusion rate not to exceed 50 mg per 10 minutes

- Further therapy should be guided by monitoring PTT every 5-15 minutes

Fondaparinux (Arixtra)

Fondaparinux (Arixtra) is an antithrombotic drug that selectively binds to antithrombin III (ATIII); thus potentiating the neutralization of Factor Xa

Neutralization of Factor Xa disrupts the blood coagulation cascade, which inhibits thrombin formation and thrombus development
Common Uses:
- DVT Treatment
- Postoperative DVT prophylaxis
- Pulmonary embolism
- ACS
- Acute myocardial infarction
- PCT

Dosing:
- Treatment DVT, Pulmonary embolus
- Body weight < 50 kg – 5 mg SQ daily
- Body weight 50 kg-100 kg – 7.5 mg SQ daily
- Body weight > 100-10 mg SQ daily DVT prophylaxis – 2.5 mg SQ daily

Note: For patients with creatine clearance 30 – 80 ml/min or age > 75; consider empiric dosage reduction.
Note: Creatinine clearance < 30 ml/min drug is contraindicated.
Fondaparinux (Arixtra) (continued)

Reversal Agent:
- Under investigation. Currently no approved reversal agents.

Note: Protamine sulfate and fresh frozen plasma (FFP) is not effective in reversing the effects of Arixtra.

Warfarin (Coumadin)

Dosing:
- Dosing may be done by consulting pharmacy or by linking to the nationally accepted guidelines for the University of Washington which have been approved for use by the medical staff at Summit Health.
Warfarin (Coumadin)

Monitoring:
- PT, CBC, baseline INR
- Therapeutic INR should be 2-3 times baseline INR, 2.5-3.5 if the patient has a prosthetic heart valve
- For patients with tilting disk valves bileaflet mechanical valves in the mitral position, therapy with warfarin to a target INR of 3 (range, 2.5-3.5) is recommended.
- For patients with caged ball or caged disk valves, therapy with warfarin to target INR of 3 (range, 2.5-3.5) is recommended

Warfarin (Coumadin) (continued)

Reversal Agent:
- Vitamin K (phytonadione)
- If PT/INR are elevated, Vitamin K may be given
  - DOSE: 1 to 5 mg (child), 5 to 10 mg (adult)
  - Most patients will not need 10 mg. Giving excess Vitamin K will make future efforts at oral anticoagulation difficult.
- In the absence of vomiting, oral dosing is preferred
- In the case of a major bleed, PCC (Prothrombin Complex Concentrate) can be used. PCC is not indicated for routine reversal
Reversal Agent:
- Vitamin K can also be given subcutaneously
- The intramuscular route should be avoided, since patients are at risk for hematoma formation
- Because of the risk of severe allergic reactions, intravenous administration should be reserved for patients with severe toxicity, and for those who cannot be given vitamin K orally or SQ

Common Uses:
- Only current approval is to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation (NVAF)
- First oral direct thrombin inhibitor
Dabigatran (Pradaxa) (continued)

Dosing:
• Normal dose is 150 mg BID
• Dose reduction required in renal impairment. (< 30 ml/min)
• Dabigatran not recommended for patients on dialysis
• Hold 3-5 days before elective surgery

Dabigatran (Pradaxa) (continued)

Monitoring:
• Regular coagulation monitoring not required (similar to low molecular weight heparins)

Reversal Agent:
• Reversal agent in development, but nothing currently available
Rivaroxaban (XARELTO)

- Factor Xa inhibitor
- Indications:
  - Reduction of Risk of Stroke and Systemic Embolism in Nonvalvular Atrial Fibrillation
  - Treatment of Deep Vein Thrombosis
  - Treatment of Pulmonary Embolism
  - Reduction in the Risk of Recurrence of Deep Vein Thrombosis and of Pulmonary Embolism
  - Prophylaxis of Deep Vein Thrombosis Following Hip or Knee Replacement Surgery

Rivaroxaban (XARELTO)

Dosing Recommendations:

- Risk of Stroke in Nonvalvular Atrial Fibrillation
  - CrCl >50 mL/min: 20 mg once daily with the evening meal
  - CrCl 15 to 50 mL/min: 15 mg once daily with the evening meal

- Treatment of DVT or PE
  - 15 mg twice daily with food, for first 21 days
  - *after 21 days, transition to* 20 mg once daily with food, for remaining treatment

- Reduction in the Risk of and Recurrence of DVT and PE
  - 20 mg once daily with food

- Prophylaxis of DVT following Hip or Knee Replacement Surgery
  - Hip replacement: 10 mg once daily for 35 days
  - Knee replacement: 10 mg once daily for 12 days
Rivaroxaban (XARELTO)

- No Reversal Agent. Administer FFP. For a major bleeding episode, PCC may be considered, but it is NOT FDA approved.

Apixaban (ELIQUIS)

Xa inhibitor anticoagulant indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation

Dosing:
- The recommended dose is 5 mg orally twice daily
- In patients with at least 2 of the following characteristics:
  - age ≥80 years, body weight ≤60 kg, or serum creatinine ≥1.5 mg/dL, the recommended dose is 2.5 mg
- No Approved Reversal agent. Administer FFP. For a major bleeding episode, PCC may be considered.
**Conversions between Anticoagulants:**

<table>
<thead>
<tr>
<th>Conversion</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enoxaparin → heparin</td>
<td>d/c enoxaparin. Start heparin 6 hours after the last enoxaparin dose if transitioning from a prophylaxis dose. Start heparin 12 hours after the last enoxaparin dose if transitioning from a treatment dose.</td>
</tr>
<tr>
<td>Heparin → Enoxaparin</td>
<td>Stop heparin infusion. Start enoxaparin 60-90 minutes after discontinuation of heparin. Maximum of 2 hours after discontinuation of heparin. No overlap</td>
</tr>
<tr>
<td>Warfarin → XARELTO</td>
<td>Discontinue warfarin and start XARELTO as soon as international Normalized Ratio (INR) is below 3.0 to avoid periods of inadequate anticoagulation.</td>
</tr>
<tr>
<td>XARELTO → Warfarin</td>
<td>No clinical trial data are available to guide converting patients from XARELTO to warfarin. XARELTO affects INR, so INR measurements made during co-administration with warfarin may not be useful for determining the appropriate dose of warfarin. One approach is to discontinue XARELTO and begin both a parenteral anticoagulant and warfarin at the time the next dose of XARELTO would have been taken.</td>
</tr>
<tr>
<td>XARELTO → Anticoagulants other than Warfarin</td>
<td>Discontinue XARELTO and give the first dose of the other anticoagulant (oral or parenteral) at the time that the next XARELTO dose would have been taken [see Drug Interactions (7.3)]</td>
</tr>
<tr>
<td>Anticoagulants other than Warfarin → XARELTO</td>
<td>0 to 2 hours prior to the next scheduled evening administration of the drug (e.g., low molecular weight heparin or non-warfarin oral anticoagulant) and omit administration of the other anticoagulant. For unfractionated heparin being administered by continuous infusion, stop the infusion and start XARELTO at the same time.</td>
</tr>
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</table>
THE CHAMBERSBURG HOSPITAL

Subject: Hand Hygiene

Department: Hospital

Discipline: Epidemiology and Infection Prevention

Area: Hospital-wide

Classification: Clinical

Original Date: 6/03

Revision Date(s): 1/09, 6/03, 7/04, 9/05, 7/07, 11/07

Purpose: To provide guidelines to healthcare workers concerning proper hand hygiene.

Policy: It is the policy of the Epidemiology and Infection Prevention Department of the Chambersburg Hospital to promote proper and complete hand hygiene according to the Centers for Disease Control Hand Hygiene Guidelines. Hand hygiene is the single most important way to prevent the spread of infection.

Content:

Hand washing procedure
a. When hands are visibly soiled they are to be washed according to the following procedure:
   1) Wet hands and apply soap.
   2) Rub hands vigorously for 15 seconds. Pay close attention to fingernail areas, wedges between fingers, and area under rings so that hands are properly cleansed.
   3) Sweaters and other long-sleeved clothing should not be allowed to become wet as this could promote bacterial growth.
   4) Rinse hands pointing down letting the dirty water run into the sink.
   5) Dry hands. Then turn off the faucet with the paper towel.
   6) Dry hands well to help prevent chapping.
   7) Handwashing rather than hand sanitizer should be used at the following situations:
      a) Before eating
      b) After restroom use
      c) When hands are visibly soiled
      d) After caring for patients with C. difficile (or suspected C. difficile) or other spore-forming organism.

b. Waterless Hand Sanitizer use
   1) Waterless hand sanitizer can be used on the hands as long as the hands are not visibly soiled.
   2) Use enough hand sanitizer to cover hands thoroughly.

c. Indications for Hand hygiene:
   1) Before beginning work shift.
   2) Immediately before patient contact (Perform hand hygiene in the presence of the patient).
   3) Immediately after direct patient contact.
   4) After gloves are removed.
   5) After use of the restroom facilities.
   6) After any other personal care such as working with contacts, applying cosmetics, etc.
   7) After sneezing, coughing, blowing or wiping the nose or mouth.
   8) After touching any patient equipment.
   9) Upon completion of work shift.

d. Other practice relating to hand hygiene
   1) Some studies have shown that acrylic nails, overlays, tips, silk wraps, etc. may pose an infection control hazard; these are not to be worn by any direct patient care providers. This policy applies to all hospital...
e. Education on Hand Hygiene
   1) New Employee Orientation.
   2) Annual Competency (CBT)

THE WAYNESBORO HOSPITAL

<table>
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<tr>
<th>Subject:</th>
<th>Hand Hygiene</th>
<th>Original Date:</th>
<th>10/03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>Hospital</td>
<td>Revision Date(s):</td>
<td>6/04, 9/07, 01/11</td>
</tr>
<tr>
<td>Area:</td>
<td>Hospital-wide</td>
<td>Classification:</td>
<td>Clinical</td>
</tr>
<tr>
<td>Discipline:</td>
<td>Infection Control</td>
<td>Review Cycle:</td>
<td>3 years</td>
</tr>
</tbody>
</table>

CONTENT:

PURPOSE: To provide a guideline for healthcare workers as it relates to proper Hand Hygiene.

POLICY: It is the policy of the Infection Control Department of the Waynesboro Hospital to promote proper and complete hand hygiene according to the Centers for Disease Control Hand Hygiene Guidelines. Hand hygiene is the single most important way to prevent the spread of infection.

1. Hand washing procedure:

   A. Soap/Foam Product:

      When hands are visibly soiled they are to be washed according to the following procedure:

      (1) Wet hands And apply soap/foam
      (2) Rub hands vigorously for 15 seconds. Care should be given to assure that fingernail areas, wedges between fingers, and area under rings are properly cleansed.
      (3) Sweaters and other long-sleeved clothing should not be allowed to become wet as this could promote bacteria growth.
      (4) Rinse hands pointing down letting the dirty water run into the sink.
      (5) Dry hands. Then turn off the faucet with the paper towel. Discard.
      (6) Dry hands well to help prevent chapping.
      (7) Handwashing with soap and water rather than hand sanitizer should be used in the following situations:
         a. Before eating
         b. After restroom use
         c. When hands are visibly soiled
d. After caring for a patient with C diff or any other spore-forming organism

B. Alcohol based hand sanitizer use:
   1) Alcohol based hand sanitizer can be used on the hands as long as there is no visible soiling. **Do not use product with a known or suspect Clostridium Difficile patient.**
   2) Use sufficient sanitizer to cover hands thoroughly.

C. Hand hygiene indications:
   a. Before beginning the work assignment.
   b. Immediately before patient contact (Perform hand hygiene in the presence of the patient)
   c. Immediately after direct patient contact.
   d. Immediately after touching any patient equipment or any surface within the patient’s environment
   e. Immediately after gloves are removed.
   f. After use of the restroom facilities.
   g. After any other personal care such as working with contacts, applying cosmetics, etc.
   h. After sneezing, coughing, blowing or wiping the nose or mouth.
   i. After touching any patient equipment such as but not limited to; sputum containers, soiled urinals, specimen container, etc.
   j. Upon completion of the work assignment.

2. Other practices to consider relating to hand hygiene:
   1) A hospital approved hand lotion is to be used rather than any personal lotion.
   2) As some studies have shown that artificial nails, overlays, tips, silk wraps, etc. may pose an infection hazard, artificial nails are forbidden with any Waynesboro Hospital direct care provider.
   3) Personnel are to consider that the wearing of multiple rings can promote the colonization of bacteria underneath the rings.
   4)
   5) Direct care personnel should keep natural nails less than one quarter of an inch long.
   6) Allergic contact dermatitis due to alcohol hand rubs or the soap product is very uncommon. However, if symptoms should occur, staff will advise the Infection Prevention & Employee Health Nurse of the occurrence.

3. Education on Hand Hygiene will be:
   a. Done at new employee orientation.
   b. Done on an annual basis.
PURPOSE: To comply with the requirements of the privacy regulations issued under the Health Insurance Portability and Accountability Act that pertain to training members of the Hospital's workforce.

POLICY: The Chambersburg Hospital will ensure that members of its workforce are trained with respect to the Hospital's privacy policies and procedures that pertain to them.

CONTENT:

A. **Orientation:** Privacy training will be included in all new employee orientation programs through the usage of computer based training and competency. The computer-based training will provide necessary information to employees regarding the Hospital's privacy practices. In addition each new employee will be oriented to the Hospital's Notice of Privacy Practices, The Confidentiality and Privacy of Health Information Policy, and required to sign the Statement of Confidentiality and Privacy (See Privacy Orientation Tool on page 2 of this policy)

B. **Initial Training Pre April 14, 2003:** All members of the Hospital’s workforce were oriented to the Hospital’s Notice of Privacy Practices, The Confidentiality and Privacy of Health Information Policy, and required to sign and date the Statement of Confidentiality and Privacy. Members of the workforce were trained regarding applicable confidentiality and privacy policies. The training included, at a minimum, the following:

1. **Nursing Staff, Therapists and other direct care providers:** Training respecting all of the Hospital’s Privacy Compliance Policies and Procedures.

2. **Students/Contracted staff:** the educational institution with which the Hospital has an educational affiliation or the staffing agency, as the case may be, shall be required, pursuant to the applicable affiliation agreement or staffing agreement, to train all students or temporary staff who will be placed with the Hospital with respect to the Hospital’s privacy policies. An orientation will be provided upon presentation to the Hospital that will include privacy.

3. **Volunteers:** general training respecting the Hospital's privacy practices that informs volunteers that they may not discuss patients or disclose any information that they obtain while volunteering at the Hospital.

4. **Management/Administration:** training respecting all of the Hospital’s Privacy Compliance Policies and Procedures.

C. **Support Staff:** General training respecting the Hospital’s privacy practices, unless such staff report to an individual in category 1 or 4 above, in which case the staff will receive training respecting all of the Hospital’s Privacy Compliance Policies and Procedures.

D. **Annual In-service Training:** Privacy training and competency will be included in all annual employee in-service programs along with periodic training tips throughout the year.
E. Remedial Training: Remedial privacy training will be initiated by the Privacy Officer on an as needed basis contingent upon audits and findings of investigations. Remedial training will consist of one on one training of employees or training for entire departments on an as needed basis.

F. Responsibility. The Privacy Officer will be responsible for developing, implementing and updating the Hospital’s privacy training programs. The education department will maintain records on privacy training.

**HIPAA Privacy Orientation Training Tool**

<table>
<thead>
<tr>
<th>Group</th>
<th>Requirement</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Nurses, Traveling Nurses, Temporary staff, Contract Workers</td>
<td>1. Review HIPAA Privacy and Security Information Sheet and give a copy to candidate.</td>
<td>Department Manager</td>
</tr>
<tr>
<td></td>
<td>2. Review and refer to the online Confidentiality and Privacy Policy and Procedure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Review and give an explanation of the Notice of Privacy Practices.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Review, and have candidate sign Statement of Confidentiality. (Original signed copy to file, candidate should receive a copy to refer to)</td>
<td></td>
</tr>
<tr>
<td>Board of Directors</td>
<td>1. Supply board members with appropriate HIPAA training book and a HIPAA Privacy and Security Information sheet. (Privacy for beginners).</td>
<td>Vice President of Finance</td>
</tr>
<tr>
<td>Forensics Staff, Law Enforcement who accompanies a prisoner</td>
<td>If here more than 20 hours, they must:</td>
<td>Director Of Plant Operations</td>
</tr>
<tr>
<td></td>
<td>1. Review HIPAA Privacy and Information Security Sheet and give a copy to the candidate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Review and have candidate sign Statement of Confidentiality. (Original signed copy to file, candidate should receive a copy to refer to)</td>
<td></td>
</tr>
<tr>
<td>Medical Staff</td>
<td>1. Supply physician with the appropriate HIPAA for physician’s training book with a HIPAA Privacy and Information Security sheet.</td>
<td>Manager of Medical Staff Services</td>
</tr>
<tr>
<td></td>
<td>2. Supply physician with the Notice of Privacy Practices.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Have physician sign the Statement of Confidentiality. (Original signed copy to file, physician should receive a copy to refer to)</td>
<td></td>
</tr>
<tr>
<td>New Employees</td>
<td>1. Attend new employee orientation: Complete the Computer Based HIPAA Privacy and Security training.</td>
<td>Education Department</td>
</tr>
<tr>
<td></td>
<td>a. Review and give an explanation of the Notice of Privacy Practices.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Review and refer to the online Confidentiality and Privacy Policy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Review and have employee sign Statement of Confidentiality. (Original signed copy to file, employee should receive a copy)</td>
<td></td>
</tr>
<tr>
<td>Relief Security</td>
<td>1. Review HIPAA Privacy and Information Security Sheet and give a copy to candidate.</td>
<td>Director of Plant Operations</td>
</tr>
<tr>
<td></td>
<td>2. Review and have Relief Security sign Statement of Confidentiality. (Original signed copy to file,</td>
<td></td>
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<tr>
<td>Role</td>
<td>Tasks</td>
<td></td>
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<tr>
<td>------</td>
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<td></td>
</tr>
</tbody>
</table>
2. Have Privacy Competency completed to be graded, feedback given, and filed.  
3. Review and give an explanation of the Notice of Privacy Practices  
4. Review and refer to the online Confidentiality and Privacy Policy.  
5. Review and have Security staff sign Statement of Confidentiality. (Original signed copy to file, security staff should receive a copy) |
| Students | 1. Review and give an explanation of the Notice of Privacy Practices.  
2. Review and refer to online Confidentiality and Privacy Policy.  
3. Review and give a copy of the HIPAA Privacy and Information Security Sheet.  
4. Review and have student sign Statement of Confidentiality. (Original signed copy to file, employee should receive a copy) |
| Traveling and Agency Nurses on Behavioral Health Unit | 1. Supply candidate with the HIPAA for Behavioral Health book including the HIPAA Privacy and Information Security Sheet.  
2. Review and give an explanation of the Notice of Privacy Practices.  
3. Review and have Nurse sign Statement of Confidentiality. (Original signed copy to file, nurse should receive a copy) |
| TV Personnel | 1. Review HIPAA Privacy and Information Security Sheet and give a copy to candidate.  
2. Review and have TV staff sign Statement of Confidentiality. (Original signed copy to file, TV staff should receive a copy) |
2. Have Privacy Competency completed to be graded, feedback given, and filed.  
3. Review and give an explanation of the Notice of Privacy Practices.  
4. Review and refer to the online Confidentiality and Privacy Policy  
5. Review and have volunteer sign Statement of Confidentiality (Original signed copy to file, volunteer should receive a copy) |
Airborne Precautions are designed to reduce the risk of airborne transmission of infectious agents. Airborne transmission occurs by dissemination of either airborne droplet nuclei (small-particle residue [5 μm or smaller in size] of evaporated droplets that may remain suspended in the air for long periods of time) or dust particles containing the infectious agent. Microorganisms carried in this manner can be dispersed widely by air currents and may become inhaled by or deposited on a susceptible host within the same room or over a longer distance from the source patient, depending on environmental factors; therefore, special air handling and ventilation are required to prevent airborne transmission. Airborne Precautions apply to patients known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue [5 μm or smaller in size] of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance).

POLICY: It is the policy of The Chambersburg Hospital Epidemiology and Infection Prevention Department that airborne precautions shall be utilized to reduce the transmission of diseases that are airborne.

CONTENT:

A. Patient Placement

Place the patient in a private room that has 1) monitored negative air pressure in relation to the surrounding areas, 2) 6 to 12 air changes per hour, and 3) appropriate discharge of air outdoors or monitored high-efficiency filtration of room air before the air is circulated to other areas in the hospital. Keep the room door closed and the patient in the room. When a private room is not available, place the patient in a room with a patient who has active infection with the same microorganism, unless otherwise recommended, but with no other infection. An Airborne Precaution sign must be hung at the patient door. Upon patient discharge, the room must be empty with door closed for one hour prior to cleaning.

B. Respiratory Protection

Wear respiratory protection (N95 respirator) when entering the room of a patient with known or suspected infectious pulmonary tuberculosis or other airborne disease regardless of immune status of healthcare worker. Remove mask upon exiting room.

C. Patient Transport

Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize patient dispersal of droplet nuclei by placing a surgical mask on the patient, if possible. Wheelchair - use designated with green Infection Control Card.
D. Patient-Care Equipment
   When possible, dedicate the use of noncritical patient-care equipment to a single patient (or cohort of patients infected or colonized with the pathogen requiring precautions) to avoid sharing between patients. If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another patient.

E. Special Air Handling – Negative air pressure
F. Door to Patient Room – Must remain CLOSED
G. Signage
   1. Airborne Precautions sign must be hung at patient door.
   2. “STOP” sign must be hung at patient door.
   3. Place Airborne Precautions sticker on front of patient chart.

H. Isolation at the End of Life
   If the patient nears the end of life, the family may have concerns about following Isolation Precautions. If a family wishes to have the Isolation Precautions lifted when the patient is nearing death, nursing staff should contact Epidemiology and Infection Prevention or Infectious Disease so that a decision can be made based on the patient’s condition and infection risk. In the event it is determined that the precautions can be lifted for the family/close friends, all healthcare workers will maintain the appropriate isolation. Hand Hygiene is to be encouraged during this time.

The isolation policy guidelines apply to any staff member, physician, student, contract-worker or volunteer in ALL departments who enters a room where patient isolation is required. The isolation precautions noted in this policy are expected to be followed exactly as written. Any divergence from this policy may result in significant disease exposure and/or disease transmission risk. Therefore NO deviation will be tolerated. Any deviation, regardless of the extent will be followed up with disciplinary action.

PURPOSE: Contact Precautions are designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Direct-contact transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn patients, bathe patients, or perform other patient-care activities that require physical contact. Direct-contact transmission also can occur between two patients (e.g., by hand contact), with one serving as the source of infectious microorganisms and the other as a susceptible host. Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment. Contact Precautions apply to specified patients known or suspected to be infected or colonized (presence of microorganism in or on patient but without clinical signs and symptoms of infection) with epidemiologically important microorganisms than can be transmitted by direct or indirect contact.

POLICY: It is the policy of The Chambersburg Hospital Epidemiology and Infection Prevention Department that Contact Precautions shall be utilized to reduce the transmission of disease through direct or indirect contact.

CONTENT:

A. Patient Placement

Place the patient in a private room. When a private room is not available, place the patient in a room with a patient(s) who has active infection with the same micro-organism but with no other infection (cohorting). Consultation with Epidemiology and Infection Prevention professionals is advised before patient placement.

B. Gloves and Handwashing (Hand hygiene)

Wear gloves (clean, non-sterile gloves are adequate) when entering the room. During the course of providing care for a patient, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage). Remove gloves before leaving the patient's room and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. Soap and water must be used after caring for a C-difficile patient. 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 microorganisms to other patients or environments.

C. Gown
Wear a gown (a clean, non-sterile gown is adequate) when entering the room. Remove the gown before leaving the patient's environment. After gown removal, ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other patients or environments.

D. Patient Transport
   a) Limit the movement and transport of the patient from the room to essential purposes only. If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other patients and contamination of environmental surfaces or equipment.
   Wheelchair - use designated with green Epidemiology and Infection Prevention Card.
   b) Isolation Practices for Transcentral Staff When Transporting a Patient

While helping to prepare the isolation patient for transport, the transporter will follow the appropriate isolation requirements.

1. The transporter will use the hospital approved germicidal cloth to wipe off the handrails on the stretcher or the handlebars on the wheelchair (while still wearing gloves and gown).
2. Upon exiting the patient room the transporter will take off gloves, gowns, etc. according to protocol and perform hand hygiene.
3. The transporter will then put on a clean gown, gloves, etc. to transport the patient.
4. After delivery of the patient, the transporter will take off gown, gloves, etc. and perform hand hygiene.
5. When picking up patient from ancillary department, put on gloves, wipe off the handrails on the stretcher or the handlebars on the wheelchair and, dispose of gloves in trash.
6. The transporter will put on clean gown, gloves, etc. and transport patient back to room.
7. If entering the isolation room upon patients return to room, keep on the appropriate PPE per isolation precaution protocol.
8. The transporter will then use the hospital approved germicidal cloth to wipe off the handrails on the stretcher or the handlebars on the wheelchair (while still wearing gloves and gown).
9. Upon exiting the patient room the transporter will take off gloves, gowns, etc. according to protocol and perform hand hygiene.

E. Patient-Care Equipment

When possible, dedicate the use of noncritical patient-care equipment to a single patient (or cohort of patients infected or colonized with the pathogen requiring precautions) to avoid sharing between patients. If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another patient.

F. Special Air Handling – None
G. Patient Room Door – May remain open
H. Signage
   a) Contact Isolation sign to be hung at door
   b) “STOP” sign to be hung at door
   c) Hand hygiene sign “Soap and Water only” to be hung at door (C-difficile only)
   d) Hand hygiene sticker “Soap and Water only” to be placed over alcohol-based hand product holder (C-difficile only)
   e) Place Contact Precautions sticker on front of patient chart.

I. Isolation at the End of Life
If the patient nears the end of life, the family may have concerns about following Isolation Precautions. If a family wishes to have the Isolation Precautions lifted when the patient is nearing death, nursing staff should contact Epidemiology and Infection Prevention or Infectious Disease so that a decision can be made based on the patient’s condition and infection risk. In the event it is determined that the precautions can be lifted for the family/close friends, all healthcare workers will maintain the appropriate isolation. Hand Hygiene is to be encouraged during this time.

The isolation policy guidelines apply to any staff member, physician, student, contract-worker or volunteer in ALL departments who enters a room where patient isolation is required. The isolation precautions noted in this policy are expected to be followed exactly as written. Any divergence from this policy may result in significant disease exposure and/or disease transmission risk. Therefore NO deviation will be tolerated. Any deviation, regardless of the extent will be followed up with disciplinary action.

**CONTACT PRECAUTIONS**

**FAMILY AND VISITORS:**
Please Report to Nurse **Before** Entering.

**Gloves and Gown REQUIRED**

Use Dedicated Patient-Care Equipment
PURPOSE: Droplet Precautions are designed to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 μm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated from the source person primarily during coughing, sneezing, or talking and during the performance of certain procedures such as suctioning and bronchoscopy. Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances, usually 3 ft or less, through the air. Because droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission. Droplet Precautions apply to any patient known or suspected to be infected with epidemiologically important pathogens that can be transmitted by infectious droplets.

In addition to Standard Precautions, use Droplet Precautions, or the equivalent, for a patient known or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 μm in size] that can be generated by the patient during coughing, sneezing, talking, or the performance of procedures).

POLICY: It is the policy of the Epidemiology and Infection Prevention Department that Droplet Precautions shall be utilized to reduce the transmission of diseases that are spread through droplets generated by respiratory secretions.

CONTENT:

A. Patient Placement
   Place the patient in a private room. When a private room is not available, place the patient in a room with a patient(s) who has an active infection with the same micro-organism, but with no other infection (cohorting).
   When a private room is not available and cohorting is not achievable, maintain spatial separation of at least 3 ft between the infected patient and other patients and visitors. Special air handling and ventilation are not necessary, and the door may remain open.

B. Mask
   Wear a surgical mask when entering the patient room. Remove the surgical mask when exiting the room.

C. Patient Transport
   Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize patient dispersal of droplets by masking the patient, if possible.

D. Patient Care Equipment
   When possible, dedicate the use of noncritical patient-care equipment to a single patient (or cohort of patients infected or colonized with the pathogen requiring precautions) to avoid sharing between patients. If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another patient.
E. Special Air Handling – None
F. Door to Patient Room – may remain open
G. Signage
   1. Droplet Precaution sign to be hung at door.
   2. “STOP” sign to be hung at door.

H. Isolation at the End of Life
If the patient nears the end of life, the family may have concerns about following Isolation Precautions. If a family wishes to have the Isolation Precautions lifted when the patient is nearing death, nursing staff should contact Epidemiology and Infection Prevention or Infectious Disease physician so that a decision can be made based on the patient’s condition and infection risk. In the event it is determined that the precautions can be lifted for the family/close friends, all healthcare workers will maintain the appropriate isolation. Hand Hygiene is to be encouraged during this time.

I. Influenza
   a. During the influenza season employees who have refused the influenza vaccination and/or have contraindications to the influenza vaccination are encouraged to:
      i. Wear surgical masks during influenza season when taking care of patients in the hospital or clinic settings especially those who present with influenza like illness.
      ii. Use appropriate hand hygiene before and after seeing patients during influenza season.

The isolation policy guidelines apply to any staff member, physician, student, contract-worker or volunteer in ALL departments who enters a room where patient isolation is required. The isolation precautions noted in this policy are expected to be followed exactly as written. Any divergence from this policy may result in significant disease exposure and/or disease transmission risk. Therefore NO deviation will be tolerated. Any deviation, regardless of the extent will be followed up with disciplinary action.
### PURPOSE:
To aid in the prevention of hospital acquired infections.

### POLICY:
It is the policy of the Epidemiology and Infection Prevention Department to take measures to reduce the risk of infection transmission to immunocompromised patients.

### CONTENT:
The isolation terms: Reverse, Neutropenic and Immunosuppressed may be interchangeable. Regardless of the specific term used in the isolation order, the isolation precautions remain the same.

#### A. Definition:
- Neutropenia (neutrophil # < 1.5), Leukemia, Lymphoma, HIV with CD4 count <200, Splenectomy (at physician discretion), patients who are in their transplant hospital stay, patients who are on cytotoxic chemotherapy, high dose steroids, or other immunosuppressives daily for >2 weeks. (i.e. >40mg of Prednisone or its equivalent: >160mg hydrocortisone, >32 mg methyl prednisone, >6mg dexamethasone, >200mg cortisone).

#### B. Patient Placement
- Admit patient to a private room and post “Reverse Isolation Precautions” sign.

#### C. Personal Protective Equipment
- Anyone entering the room must wear a surgical mask, gloves, and isolation gown while in the room. When exiting the room the mask can be discarded into a trashcan placed just inside the room door and the gown into a linen hamper placed just inside the room door. (“Just inside the room door” refers to placement as close as is possible to the exit.)

#### D. Patient Transport
- Patient must wear a mask when out of the room.

#### E. Patient-Care Equipment
- When possible, dedicate the use of noncritical patient-care equipment to a single patient (or cohort of patients infected or colonized with the pathogen requiring precautions) to avoid sharing between patients. If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another patient.
F. Special Air Handling – None
G. Door to Patient Room – Must remain closed
H. Signage
   1. “Reverse Isolation Precautions” sign to be hung at door
   2. “STOP” sign to be hung at door

I. Other Guidelines
   1. The nurse may request a Neutropenic Diet from the Dietary Department.
   2. No fresh/raw produce or outside food permitted.
   3. No flowers permitted.
J. Isolation at the End of Life

If the patient nears the end of life, the family may have concerns about following Isolation Precautions. If a family wishes to have the Isolation Precautions lifted when the patient is nearing death, nursing staff should contact Infection Prevention staff or Infectious Disease so that a decision can be made based on the patient’s condition and infection risk. In the event it is determined that the precautions can be lifted for the family/close friends, all healthcare workers will maintain the appropriate isolation. Hand Hygiene is to be encouraged during this time.

The isolation policy guidelines apply to any staff member, physician, student, contract-worker or volunteer in ALL departments who enters a room where patient isolation is required. The isolation precautions noted in this policy are expected to be followed exactly as written. Any divergence from this policy may result in significant disease exposure and/or disease transmission risk. Therefore NO deviation will be tolerated. Any deviation, regardless of the extent will be followed up with disciplinary action.
THE CHAMBERSBURG HOSPITAL

Subject: Pain Management  Original Date: 11/05

Department: Hospital-wide  Revision Date(s): 12/08; 09/10; 12/11; 9/12

Area:  Discipline:

Classification: Administrative  Review Cycle: Annually

PURPOSE: Our health care provider’s pain promise to our patients is to meet or exceed all patients pain management expectations, i.e. pain will either be prevented, responded to expediently, relieved effectively or managed to a level of patient tolerance.

POLICY: It is the policy of Chambersburg Hospital to respect the patient’s right to pain management and that all associates (physicians, employees, volunteers, students, contracted affiliates etc.) pledge to respond to any patients expression of pain and communicate in an expedient manner to the most appropriate health care provider who can provide effective intervention(s).

CONTENT:

2. Supplies and Equipment:
   a. Clinical Record.
   b. Medication Administration Record
   c. Pain Rating Scales
   d. Intervention Supplies

3. Steps:
   a. All associates will report any patient who demonstrates or verbalizes pain to the most appropriate health care provider.
   b. A member of the health care team will adhere to the following steps for pain management:
      1) Assessment: A systematic method of data collection consisting of evaluation of the patient, family/significant other and legal guardian.
         a) Initial
            (1) A member of the health care team is responsible for educating the patient regarding pain management upon entry to the hospital.
            (2) The patient’s statement of pain will be accepted as valid.
            (3) A comprehensive pain assessment is conducted and documented as appropriate to the patient’s condition, scope of care, treatment and services provided.
            (4) All patients will receive a pain assessment within one (1) hour of admission. The patient’s self-report of pain will be obtained using the 0-10 pain rating scale (verbal analog scale = VAS). Other pain assessment methods utilize physiological and behavioral cues, either as a compliment to the standard pain scale or as a substitute when the pain scale cannot be used. The FLACC (Face, Legs, Activity, Crying and Consolability) or Wong-Baker scale will be utilized for the patient who cannot communicate verbally, gesture or unable to comprehend, and the NVPS- Non verbal Pain Scale will be used for the ventilated patient in CCU/ICU.
            (5) The patient will be assessed to reflect consideration of needs related to: physical, psychosocial, spiritual, cultural diversity and age-specific appropriateness, which may contribute to
perception/interpretation of pain and intensity.

b) Ongoing
   (1) All patients will have their pain assessed and documented at a minimum of every 8 hours, or per unit
   –specific criteria regarding timeliness of pain assessment.
   (2) In addition to the minimum requirement, pain will be assessed when pain changes, with each new
   report of pain, when there is unrelieved pain or when changing care settings.

c) Discharge:
   (1) Pain will be assessed and documented upon discharge.

2) **Analysis and Planning:** The process of interpreting the data/assessment obtained and engaging in the active
decision-making process which results in the development of the patient’s plan of care with emphasis on the physical,
psychosocial, developmental, emotional educational and spiritual needs of the patient.
   a) The patient’s pain assessment will be evaluated by a Registered Nurse to develop and document the patient’s
   plan of care.
   b) Through the ongoing analysis of the patient’s pain assessment, new goals will be added to the plan of care.

3) **Implementation:** The application of strategies, activities and observations to support the plan of care.
   a) Pain relief interventions will be initiated as needed, based on the patient need, pain etiology or
diagnosis/condition.
      (1) Pharmacologic: The patient will receive pharmacological therapies as ordered
          by the medical professional to maintain minimal pain scores.
      (2) Non-pharmacological comfort measures and various therapeutic measures, e.g.
          diversional therapy, positioning, heat and cold, massage, distraction, and relaxation, physical therapy etc.
          should be discussed with the patient/family/significant other.
   b) Each health team member is responsible for notifying the patient’s designated nurse for patients with
      escalating/unacceptable pain scores; decreasing levels of consciousness; and presentation of unpleasant side
      effects.
   c) Documentation of the implementation strategy will be recorded in the clinical record by the health care team
      member.

4) **Reassessment:** The measurement of the treatment effect on successful outcomes such as patient comfort, function
   and healing.
   a) When pain management intervention occurs the health care team member shall reassess the patient and their
   responses within one (1) hour, or per unit-specific criteria regarding timeliness of pain assessment.
   b) Upon reassessment, interventions will be discussed with the patient/family/significant other and health care team.
   c) Changes in pain management interventions should be adopted once mutually agreed upon by the health care
   team and patient/significant other/family.
   d) Sleeping patients will not be woken up for reassessment. If patient is sleeping this should be documented in the
   medical record.

5) **Patient Outcomes:**
   a) The outcome goal for any intervention will be to reach a pain level that is acceptable to the patient.
      (1) If an acceptable pain level is not achieved, the appropriate physician will be notified.
      (2) If the pain level is unacceptable at the time of discharge, the physician and health care team have
          planned for appropriate intervention.

6) **Patient Education:** The act of educating the patient and/or significant other/family on pain management.
   a) Patient education is provided to enhance understanding of the pain management plan and is documented
      in the clinical record.
   b) Education may include discussion of pain, risk for pain, the importance of effective pain management,
      and pain assessment process methods for pain management.

4. **Documentation:**
   a. Documentation of pain assessment, analysis and planning, implementation, reassessment, outcomes and
      education will be found in the clinical record.

5. **Notes:**
   a. Pain Services Consult/Referral available by physician order.
   b. Pain Standard of Care in PPOC (attached below)
PATIENT EDUCATION REQUIREMENT: Patients will be educated regarding their pain management plan.

AGE SPECIFIC REQUIREMENT: The appropriate pain scale will be utilized as per appropriateness, which is inclusive of age specific considerations (VAS, FLACC, Wong-Baker, NVPS).

THE CHAMBERSBURG HOSPITAL CHAMBERSBURG, PENNSYLVANIA

PAIN MANAGEMENT STANDARDS OF CARE

Patients will be recognized as holistic beings with unique and individual pain experiences. The assessment, analysis, outcome planning, implementation and reassessment of pain management are a collaborative process of the health care team, patient and significant other. Pain management can include pharmacological and/or alternative modalities as approved by use by appropriate governing bodies.

Education regarding pain management is introduced during the patient’s initial evaluation and is ongoing throughout their hospital stay.

The Chambersburg Hospital staff will respond to patient needs within their job description.

I. ASSESSMENT:
A systematic method of data collection which consists of evaluation of the patient, family/significant other and legal guardian.

A. All patients will receive a pain assessment within one (1) hour of admission. The patient’s self-report of pain will be obtained using the 0-10 pain rating scale (verbal analog scale = VAS). Other pain assessment methods like physiological and behavioral cues, either as a compliment to the standard pain scale or as a substitute when the pain scale cannot be used (inability to communicate verbally, through gestures, or unable to comprehend) will also be used. Chambersburg Hospital has several in-house Spanish interpreters and in addition Chambersburg Hospital subscribes to the Language Line, which is 24-hour language service.
B. The patient will receive a pain history within eight (8) hours of admission.
C. The patient’s statement of pain will be accepted as valid.
D. The patient will be assessed according to age specific needs, physical, psychological, social and spiritual needs.
E. The patient will be assessed for location and intensity of pain using the pain scale as appropriate. Record on the appropriate tool.
F. Post-op pain will be assessed according to department policy.
G. If the patient’s pain level is not acceptable or has not been relieved, the care provider will contact the physician.
H. Continue to educate patient/family on pain prevention, management during the patient’s admission and involve patient/family in pain relief goals and plan.

II. ANALYSIS
The process of interpreting the data/assessment obtain.

A. The patient’s pain assessment will be evaluated by the RN to develop the patient’s plan of care.
B. The patient’s pain history will be evaluated for incorporation into the development of the plan of care.

III. OUTCOME IDENTIFICATION
Identification of patient goals to be achieved.

A. Pain management goals will be incorporated into the patient’s plan of care. These goals will be mutually set in collaboration with the patient, significant other and health care team.
B. The patient’s plan of care will incorporate the patient’s pain assessment, pain history and bill of rights.

IV. PLANNING:
The active decision making process which results in development of the patient’s plan of care with emphasis on the physical, psychosocial, developmental, emotional, educational and spiritual needs of the patient.
A. A plan of care will be developed using pain assessment with emphasis on age specific criteria, physical, psychosocial, developmental, emotional, educational and spiritual needs of the patient.

V. **IMPLEMENTATION:**
The application of strategies, activities and observations to support the plan of care.

A. The patient will receive non-pharmacological therapy as appropriate.
B. The patient will receive pharmacological therapies to maintain minimal pain scores as ordered by the medical professional plan according to approved policies and procedures.
C. Each direct care provider is responsible for notifying the RN of escalating/unsatisfactory pain scores; decreasing levels of consciousness; and presentation of unpleasant side effects.

VI. **REASSESSMENT:**
The measurement of the treatment effect on successful outcomes such as patient comfort, function and healing.

A. The patient can expect reassessment of his/her pain level on a regular basis and following each relief strategy implementation.
B. Upon reassessment, interventions will be discussed with the patient/significant other and health care team. Changes should be adopted once mutually agreed upon by the team member and patient/significant other.
C. When pain management intervention occurs, the care provider shall reassess the patient and their responses and relief within one hour.

*Original Date: 9/93*
*Revised: 8/00; 07/03, 9/12*
PURPOSE: To ensure optimal patient comfort through a proactive pain control plan which is mutually determined by the patient, family members, and members of the health care team.

POLICY: It is the policy of Waynesboro Hospital that all associates (physicians, employees, volunteers, students, contracted affiliates etc.) are committed to providing a means of assessing and managing an individuals pain on an ongoing basis. Collaboration by team members will occur with the attending physician. We will strive to provide a level of pain control that produces an effective outcome for the patient. The effectiveness of pain management will be documented in the patient’s medical record. We will communicate in an expedient manner to the most appropriate health care provider who can provide effective intervention(s).

CONTENT:

6. Supplies and Equipment:
   a. Clinical Record.
   b. Medication Administration Record
   c. Pain Rating Scales
   d. Pain Pamphlet
   e. Intervention Supplies

7. Steps:
   a. All associates will report any patient who demonstrates or verbalizes pain to the most appropriate health care provider.
   b. A member of the health care team will adhere to the following steps for pain management:

      1) **Assessment:** A systematic method of data collection consisting of evaluation of the patient, family/significant other and legal guardian.
         a) Initial
            (6) A member of the health care team is responsible for educating the patient regarding pain management upon entry to the hospital.
            (7) A comprehensive pain assessment is conducted and documented as appropriate to the patient’s condition, scope of care, treatment and services provided.
            (8) All patients will receive a pain assessment within one (1) hour of admission. The patient’s self-report of pain will be obtained using the 0-10 pain rating scale (verbal analog scale = VAS). Other pain assessment methods utilize physiological and behavioral cues, either as a compliment to the standard pain scale or as a substitute when the pain scale cannot be used:

            ➤ **Verbal Analog Pain Rating Scale (VAS) Adult** (0 to 10) a subjective scale where the patient communicates the current level of pain. Zero equals no pain and 10 equals the most severe pain the patient can imagine. For the patient to use this scale they must be alert, oriented and
cognitively able to understand the rating scale.

- **FLACC Pain Rating Scale** = Face, Legs, Activity, Cry and Consolability (0 to 10). This scale is an objective measure that can be used for the patient who is unable to communicate. When using this scale it is important to obtain a complete history of the patient or patient’s care giver. In addition, a baseline of unusual behavior can be obtained from records of this or another facility. It is essential to differentiate behavioral expressions of pain from otherwise normal behavior for the patient in a similar situation.

- **Wong Baker FACES Pain Rating Scale** (0 to 10). This is a subjective scale where the patient communicated their level of pain by pointing to the picture that most accurately describes this current level of pain. Happy face means no pain and sad face with tears is the most severe pain the patient can imagine. To use this scale the patient must be alert and oriented.

- **NVPS Non Verbal Pain Scale** – for patients undergoing moderate sedation or anesthesia, pain assessment and interventions should begin when the patient shows behavioral expressions or verbal expressions of pain.

- **PCA Pain Scale Assessment** - Policy for Procedure for the Management of PCA Patient Controlled Analgesia  
  [hyperlink](http://winnebago/summitppdocs/WH_PANDP/NURSING/patient_controlled_analgesia_(pca)_infuser,_procedure_for_the.doc)

- **Epidural Analgesia Policy Protocol** for the Management of Patient with Epidural Analgesia  
  [hyperlink](http://winnebago/summitppdocs/WH_PANDP/NURSING/epidural_analgesia,_protocol_for_mana
gement_of_patient_with.doc)

(9) The patient will be assessed to reflect consideration of needs related to: physical, psychosocial, spiritual, cultural diversity, age-specific appropriateness, and ability to understand, which may contribute to perception/interpretation of pain and intensity.

b) Ongoing
   
   (3) All patients will have their pain assessed and documented at a minimum of every 8 hours, or per unit –specific criteria regarding timeliness of pain assessment.
   
   (4) In addition to the minimum requirement, pain will be assessed when pain changes, with each new report of pain, when there is unrelieved pain or when changing care settings.

   c) Discharge:
      
      (1) Pain will be assessed and documented upon discharge.

2) **Analysis and Planning**: The process of interpreting the data/assessment obtained and engaging in the active decision-making process which results in the development of the patient’s plan of care with emphasis on the physical, psychosocial, developmental, emotional educational and spiritual needs of the patient.

   a) The patient’s pain assessment will be evaluated by a Registered Nurse to develop and document the patient’s plan of care.

   b) Through the ongoing analysis of the patient’s pain assessment, new goals will be added to the plan of care.
3) **Implementation:** The application of strategies, activities and observations to support the plan of care.
   a) Pain relief interventions will be initiated as needed, based on the patient need, pain etiology or diagnosis/condition.
      (2) Pharmacologic: The patient will receive pharmacological therapies as ordered by the medical professional to maintain minimal pain scores.
      (2) Non-pharmacological comfort measures and various therapeutic measures, e.g. diversional therapy, positioning, heat and cold, massage, distraction, and relaxation, physical therapy etc. should be discussed with the patient/family/significant other.
   b) Each health team member is responsible for notifying the patient’s designated nurse for patients with escalating/unacceptable pain scores; decreasing levels of consciousness; and presentation of unpleasant side effects.
   c) Documentation of the implementation strategy will be recorded in the clinical record by the health care team member.

4) **Reassessment:** The measurement of the treatment effect on successful outcomes such as patient comfort, function and healing.
   a) When pain management intervention occurs the health care team member shall reassess the patient and document their responses within one (1) hour, or per unit-specific criteria regarding timeliness of pain assessment.
   b) Upon reassessment, interventions will be discussed with the patient/family/significant other and health care team.
   c) Changes in pain management interventions should be adopted once mutually agreed upon by the health care team and patient/significant other/family.

5) **Patient Outcomes:**
   a) The outcome goal for any intervention will be to reach a pain level that is acceptable to the patient.
      (3) If an acceptable pain level is not achieved, the appropriate physician will be notified.
      (4) If the pain level is unacceptable at the time of discharge, the physician and health care team have planned for appropriate intervention.

6) **Patient Education:** The act of educating the patient and/or significant other/family on pain management.
   a) Patient education is provided to enhance understanding of the pain management plan and is documented in the clinical record.

8. **Documentation:**
   a. Documentation of pain assessment, analysis and planning, implementation, reassessment, outcomes and education will be found in the clinical record.

9. **Notes:**
   a. The Pain Pamphlet will be distributed at time of admission
   b. Pain Services Consult/Referral available by physician order.
   c. Family Birthing Services will follow their specific Pain Management Policy for Laboring Patients
TO: Medical Staff and Allied Health Professionals

FROM: SUMMIT HEALTH CREDENTIALS VERIFICATION ORGANIZATION

PAIN MANAGEMENT SELF EXAM

*** Circle one answer for each of the five questions below. ***

1. Who is responsible for responding to a patient’s expression of pain?
   a. Physicians
   b. Nurses
   c. Students
   d. Volunteers
   e. Non-clinical staff
   f. All of the above

2. To assess a patient’s pain, from whom should you obtain information?
   a. The patient
   b. The patient’s significant other
   c. The patient’s family
   d. The patient’s legal guardian
   e. All of the above

3. How do you determine if a patient’s statement of pain is valid?
   a. Do a mental status exam
   b. Ask the patient’s family
   c. Review the medical record
   d. The patient’s statement of pain is accepted as valid

4. How is the patient’s level of pain assessed?
   a. Physical exam
   b. Tone of voice
   c. Personal experience
   d. A pain rating scale such as the 0 – 10 verbal analog scale

5. What is the goal for pain intervention?
   a. The patient stops complaining
   b. The family is happy
   c. The patient is discharged patient
   d. A pain level that is acceptable to the patient

Answers:
1. F – All the above
2. E – All of the above
3. D – The patient’s statement of pain is accepted as valid
4. D – A pain rating scale such as the 0 – 10 verbal analog scale
5. D – A pain level that is acceptable to the patient
What is ACT 13?

- Medical Professional Liability Reform
- CAT Fund Phase-out and coverage changes
- Patient Safety provisions
- Medical Records compliance that deals with alterations &/or destruction
- Professional Licensure Requirements.

Reporting by Physicians

- As of May 19, 2002, physicians must report to their state licensing board any time they receive notice of a medical malpractice complaint.
- Report must include the docket number of the case, where the case was filed, and a description of the allegations.
- Report must be made within 60 days of notice of Complaint.
Reporting is Mandatory

Applies to:
- physician
- health care workers and
- facilities in which they work

Covered Facilities

- Hospitals
- Birth centers
- Ambulatory surgical facilities
- Physicians' offices not covered unless a birth center or ambulatory surgical center
Creates a Patient Safety Authority

- Receives reports of events from facilities
- Analyzes reports and recommend safety improvements
- Investigates anonymous reports received

Internal Reporting

- The hospital encourages reporting of all events or situations that may have harmed or have harmed patients.
Internal Reporting

- All members of the medical staff and employees are required to report suspected and/or identified events, occurrences, or situations involving the clinical care of a patient which could have caused or did cause injury and any event or situation that would be considered an Adverse Event.

Reporting and Notification Requirements

- Health care workers who reasonably believe that a serious event or incident has occurred must report the event or incident as prescribed by the medical facility’s patient safety plan. The report must be made immediately or as soon as possible after the discovery of the event or incident, but no later than 24 hours after occurrence of discovery of the event or incident.
Internal Reporting

- The hospital will not retaliate against an employee or member of the medical staff for the good faith submission of a report required or permitted by this policy, nor will it tolerate any such retaliatory actions by any person within its control.

Self Check

Before continuing to the next slide, please respond to the following item by clicking True or False:

All members of the medical staff and employees are required to report suspected and/or identified events, occurrences, or situations involving the clinical care of a patient which could have caused or did cause injury and any event or situation that would be considered an Adverse Event.

Correct!  Click Next to continue or Back to review the previous topic.

ANSWER IS TRUE
Failure to Report

- Facilities must report licensed professionals who fail to report to his/her respective state professional licensure board.
- Facilities subject to disciplinary actions and fines of $1000 per day for failing to report.
- The Hospital may institute disciplinary corrective action, as applicable.

Self Check

Before continuing to the next slide, please respond to the following item by clicking True or False:

Facilities must report licensed professionals who fail to report to his/her respective state professional licensure board.

Correct! Click Next to continue or Back to review the previous topic.

ANSWER IS TRUE
Patient Safety Hotline ext 6677

• Report within 24 hours of the occurrence or discovery
• Accessible at all times
• Phone system instructs call to leave a message containing
  ▪ Patient name
  ▪ Medical record or account number
  ▪ Room number
  ▪ Description of the event/incident

The Patient Safety Officer

• Serves on Patient Safety Committee
• Ensures investigation of all reports of serious events and incidents
• Takes action as immediately necessary to ensure safety
• Reports to committee any action taken resulting from investigation
Notification of Patients

- Affected patient or legal representative must be notified in writing of serious event within 7 days of occurrence or discovery
- Notification cannot be considered admission of liability
- Documentation in medical record is not protected.

Answer is True

Act 13 requires hospitals to report:

- Serious Events
- Incidents
- Infrastructure Failure
Serious Event

- An event, occurrence, or situation involving the clinical care of a patient in the medical facility (hospital, ambulatory surgery facility, or birthing center) that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health services to the patient.

- Reportable to Patient Safety Authority and Department of Health (DOH) under Act 13

Incident

- An event, occurrence, or situation involving the clinical care of a patient in the medical facility (hospital, ambulatory surgery facility, or birthing center) which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient.

- Reportable to the Patient Safety Authority under Act 13.
Infrastructure Failure

- An undesirable or unintended event, occurrence, or situation involving the infrastructure of a medical facility (hospital, ambulatory surgery facility, or birthing center) or the discontinuation or significant disruption of a service, which could seriously compromise patient safety.

- Reportable to the Pennsylvania Department of Health under Act 13

The role of a “Safety Culture” in our hospital requires a cultural change for all employees and physicians.
Cultural Change

FROM
- All’s fine!
- Errors rare
- Tell as little as you can
- Keep Board out
- MD’s don’t participate
- Error rate is average
- Not reporting your error is accepted norm

TO
- Endless opportunities
- Errors everywhere
- Tell whatever you can
- Actively involve Board
- Doc’s actively involved
- No threshold for errors
- Not reporting your own error is unprofessional and against the law

Self Check

Before continuing to the next slide, please respond to the following item by clicking True or False:

As of May 19, 2002, physicians must report within sixty days to their state licensing board any time they receive notice of a medical malpractice complaint.

True    False

ANSWER IS TRUE
Before continuing to the next slide, please respond to the following item by clicking the most correct answer:

**Act 13**

- a. Addresses the medical malpractice in Pennsylvania.
- b. Mandates creation of a patient safety committee and development of a patient safety plan.
- c. Requires reporting of incidents, serious events, and infrastructure failure.
- d. All of the above

Correct! Click Next to continue or Back to review the previous topic.

**Answer is D – All of the Above**

**Contacts**

If you have questions, contact the Quality Management Dept:

- Chambersburg Hospital, 717-267-7757
- Waynesboro Hospital, 717-765-4000 ext. 5317
- Roy Himelfarb Surgery Center, 717-217-6725
Rationale for Restraints Training

Required by Medicare’s Conditions of Participation “Physicians authorized to Order Restraints or Seclusion must have a working knowledge of hospital policy regarding restraint and seclusion.”

Accreditation agencies will validate this when they are onsite for survey by reviewing CME records.

Current Trends In Restraints

Nursing homes are restraint-free.

Scrutinized by accreditation agencies because of low volume high risk.

Expectation is reduction in use of restraints.

Of reported restraint related sentinel events the root causes of error are attributed primarily to miscommunication and patient assessment.

Physicians and nursing alike must be educated on alternatives to restraint to decrease the numbers of restraints used.
Self Check

Before continuing to the next slide, please respond to the following item by clicking True or False:

We expect to reduce the use of restraints.

Correct! Click Next to continue or Back to review the previous topic.

CORRECT ANSWER IS TRUE

Identifying Restraints

What is considered a restraint?

- Any physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body or head freely.

- Any medication that is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is NOT a standard treatment or dosage for the patient’s condition.
Identifying Restraints (continued)

NOT considered a restraint:

- Orthopedically prescribed devices, dressings or bandages
- Protective helmets
- Methods used to hold a patient during procedures
- Devices used to prevent patient from falling out of bed
  - i.e., 2 side rails
- Sedation through medications such as Diprivan are for the patient’s comfort and not considered an additional restraint

Self Check

Before continuing to the next slide, please respond to the following item by clicking True or False:

Medication used as a restriction to manage the patient’s behavior when prescribed as standard treatment or dosage for the patient’s condition is considered a restraint.

Correct! Click Next to continue or Back to review the previous topic.

CORRECT ANSWER IS FALSE
Appropriate Use of Restraints

Restraints may NOT be used:

• To prevent falling
  • Risk of fall not adequate

• To prevent wandering
  • i.e., Sundowners

• For convenience

Appropriate Use of Restraints (continued)

Restraints should be used as a last resort when:

• All other alternatives have been exhausted
  • i.e., distraction, family to sit with patient, 1:1 sitter, etc.

• Documentation supports that all other alternatives have been used
  • This is supported in the order sheet

Note: It may not always be prudent to attempt an alternative first (i.e., violent behavior) but the alternatives should at least be considered.
It is appropriate to use restraints:

- a. To prevent the patient from wandering
- b. For convenience when short staffed
- c. Before asking visiting family members to sit with the patient
- d. When no alternative has been tried but the patient is violent

Correct! Click Next to continue or Back to review the previous topic.

Seclusion is:

- Confining the patient involuntarily in a room or area where he/she is physically prevented from leaving.

- Restricting the patient to a room where staff intervene to prevent him/her from leaving or give the impression that physical intervention will occur if he/she attempts to leave.

Seclusion is not utilized at Summit Health.
Self Check

Before continuing to the next slide, please respond to the following item by clicking True or False:

Seclusion is utilized at Summit Health when the family requests it.

[Radio buttons: True, False]

**Correct!** Click Next to continue or Back to review the previous topic.

Brightness: 101x419 to 511x725

CORRECT ANSWER IS FALSE

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Violent Versus Non-Violent Restraints

**Violent:**
- Emergent situation with imminent danger of physical harm to patient or others

**Non-Violent:**
- Actual disruption of therapy (pulled out lines, ETT etc.)
- To prevent life threatening disruption of therapy (pulling at lines, ETT etc.)
Self Check

Before continuing to the next slide, please respond to the following item by clicking True or False:

A basic difference between violent restraints and non-violent restraints is the factor of Medical Necessity.

Correct! Click Next to continue or Back to review the previous topic.

Orders for Non-Violent Restraints

- Physician order must be obtained within 24 hours of initiation of new restraint.
- Physician must reorder non-violent restraint daily (or sooner if a new episode).
- Order must be signed, dated and timed.
- No PRN orders are permitted.
Orders for Violent Restraints

Orders are time limited and must be obtained within 1 hour of initiation.

Must be re-ordered:
- Every 4 hours for patient >18 years old
- More frequently for younger patient as outlined in hospital policy

Order must be signed, dated and timed.

If you order violent restraints, there are special rules on face to face evaluation, etc. clearly defined in policy.
Before continuing to the next slide, please respond to the following item by clicking True or False:

Orders for violent restraints must be re-ordered every 4 hours for patient >18 years old.

**Correct!** Click Next to continue or Back to review the previous topic.

CORRECT ANSWER IS TRUE

Ending Restraints

All restraints must end at earliest possible time based on assessment.
Physician’s Role

Write an order (re-order as necessary).

Assure that alternatives have been tried and failed (or consiered in certain situations).

Review hospital policy.

Differentiate the use of violent and non-violent restraints.

Comply with educational requirements regarding hospital policy.

Self Check

Before continuing to the next slide, please respond to the following item by clicking True or False:

The physician is not responsible for assuring that alternatives have been tried and failed or that alternatives have at least been considered.

Correct! Click Next to continue or Back to review the previous topic.

CORRECT ANSWER IS FALSE
COPING WITH AN ACTIVE SHOOTER SITUATION

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

PROFILE OF AN ACTIVE SHOOTER

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

CHARACTERISTICS OF AN ACTIVE SHOOTER SITUATION

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

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

CALL 911 WHEN IT IS SAFE TO DO SO
<table>
<thead>
<tr>
<th>HOW TO RESPOND</th>
<th>WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Run</strong></td>
<td>• Have an escape route and plan in mind</td>
</tr>
<tr>
<td></td>
<td>• Leave your belongings behind</td>
</tr>
<tr>
<td></td>
<td>• Keep your hands visible</td>
</tr>
<tr>
<td><strong>2. Hide</strong></td>
<td>• Hide in an area out of the shooter’s view</td>
</tr>
<tr>
<td></td>
<td>• Block entry to your hiding place and lock the doors</td>
</tr>
<tr>
<td></td>
<td>• Silence your cell phone and/or pager</td>
</tr>
<tr>
<td><strong>3. Fight</strong></td>
<td>• As a last resort and only when your life is in imminent danger</td>
</tr>
<tr>
<td></td>
<td>• Attempt to incapacitate the shooter</td>
</tr>
<tr>
<td></td>
<td>• Act with physical aggression and throw items at the active shooter</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW TO RESPOND</th>
<th>WHEN LAW ENFORCEMENT ARRIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Remain calm and follow instructions</td>
</tr>
<tr>
<td></td>
<td>• Put down any items in your hands (i.e., bags, jacket(s))</td>
</tr>
<tr>
<td></td>
<td>• Raise hands and spread fingers</td>
</tr>
<tr>
<td></td>
<td>• Keep hands visible at all times</td>
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<tr>
<td></td>
<td>• Avoid quick movements toward officers such as holding on to them for safety</td>
</tr>
<tr>
<td></td>
<td>• Avoid pointing, screaming or yelling</td>
</tr>
<tr>
<td></td>
<td>• Do not stop to ask officers for help or direction when evacuating</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INFORMATION</th>
<th>YOU SHOULD PROVIDE TO LAW ENFORCEMENT OR 911 OPERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Location of the active shooter</td>
</tr>
<tr>
<td></td>
<td>• Number of shooters</td>
</tr>
<tr>
<td></td>
<td>• Physical description of shooters</td>
</tr>
<tr>
<td></td>
<td>• Number and type of weapons held by shooters</td>
</tr>
<tr>
<td></td>
<td>• Number of potential victims at the location</td>
</tr>
</tbody>
</table>

**CALL 911 WHEN IT IS SAFE TO DO SO**
I have received and read the material presented. I acknowledge understanding of the material and its importance. I will incorporate this information and knowledge into my role as a member of the medical staff.

The material included:

- Mission, Vision, Values – Chambersburg Hospital
- Respect for People
- Emergency Management/Security – Chambersburg Hospital
- Emergency Management/Security – Waynesboro Hospital
- Anticoagulant Training
- Hand Hygiene
- HIPAA Privacy and Information Security
- Isolation Precautions
- Pain Management
- Patient Safety Act13
- Restraints
- Active Shooter

_________________________________________     _________________________
Printed name        Date

_________________________________________
Signature