MISSION, VISION, VALUES
Our mission is to help keep people well in body, mind and spirit by providing safe, quality healthcare in a compassionate environment. Our vision: We are an integral partner in elevating our communities’ health. CVHP values: respect, excellence, stewardship, compassion, and integrity.

SERVICE EXCELLENCE/CUSTOMER RELATIONS/SATISFACTION
CVHP strives to provide quality patient care in a customer friendly manner. The essence of good customer service is to treat others, as you would like to be treated. The following service standards have been adopted and are expected.

- Wear your name badge where patients and visitors can easily see it.
- When entering a patient’s room introduce yourself.
- Always ask if there is anything else you can do for them before leaving their room and pull their cubicle curtain for privacy.
- Offer directions to someone who looks lost. Take them where they need to go. Do not point.
- Answer call lights requests timely.
- When answering the phone state your department name and say, “How may I help you?”
- Pay attention to the 3 p’s (pain, positioning and potty)
- Complete hourly rounding during the day shift and minimally every 2 hours at night.

DRESS CODE
Professional in appearance
Neat, clean and well groomed
Male/Female—may wear colored uniforms white shoes only
ID badge—Your agency photo ID badge must be worn at all times in the upper third of your body.
Artificial nails will not be worn in any patient care area. Natural nail tips are to be less than 1/8” long

VISITING HOURS
Please follow campus specific policy.

PATIENT-CENTERED COMMUNICATION
These standards focus on effective communication, cultural competence as well as patient and family centered care. We must meet patient communication needs and effective communication that is necessary for patient safety. To help us ensure that there is effective, patient-centered communication we will do the following:

1. Inform the patient of his/her patient rights. (separate handout)
2. Provide information tailored to the patient’s age, language and ability to understand.
3. Provide an interpreter or translation service as necessary. See below.
4. Communicate with the patient in a manner that meets the needs of the patient who may have visual, hearing or cognitive impairments. Staff must identify the patients oral and written communication needs, including the patient’s preferred language. Examples include personal devices such as hearing aids, glasses, interpreters, communication boards and translated materials.
5. Allow a family member, friend or other individual to be present to provide emotional support and comfort.

INTERPRETERS/INTERPRETALK/VRI MOBILE CART/TDD AND VOICE CARRY OVER TELEPHONES
CVHP will make interpreters available for customers with limited English proficiency (LEP) at no cost. INTERPRETALK phones are available to use to speak to an interpreter. Please ask the charge nurse for assistance. When using an interpreter, please record the interpreter name, clinician’s name, date of service and brief description of interpreter service. Human Resources and the nursing supervisor keep a master list of interpreters. A Video Remote Interpreting (VRI) mobile cart is available to obtain sign language interpreter on the computer within minutes. A Telephone Device for the Deaf (TDD) and a Voice Carry Over (VCO) are available from the nursing supervisor.
HIPAA

Regulations contained in the Health Insurance Portability and Accountability Act (HIPAA) place significant emphasis on the release of Protected Health Information are responsible in sharing data with others and to know the procedures for release of information in the facility in which you are working. Patient information that is considered protected health information under the HIPPA Privacy Standards includes the following:

- Anything that can be used to identify the patient including the patient’s name, address, social security number, and medical record number.
- Anything about the patient’s past, present, or future medical conditions.
- Anything about the patient’s past, present, or future medical treatment.

Do not share patient information in the cafeteria, elevators or halls where others may overhear you.
Do not share information with your friend or neighbor.
Follow hospital procedures when releasing copies of records.
Do not leave the patient chart open and visible.
Do not leave patient information on computer screens visible to public view.

Patients have the following rights regarding medical information we maintain:

- Inspect and copy
- Amend the record
- Request restrictions
- Request confidentiality

If you receive such a request, refer to the medical records department. The nurse is not permitted to give the record to the patient even if the physician writes an order. Choosing not to comply with the Hospital’s privacy policies and procedures may result in disciplinary action such as a verbal or written warning, suspension of duties or termination (do not return status) and the risk of individual civil and/or criminal penalties including fines and imprisonment.

PATIENT RIGHTS

Care must be provided without regard to race, culture, economic, educational, or religious background, sexual orientation or ability to pay. A patient has the right to: (see separate leaflet for full rights and responsibilities)

- Considerate and respectful care including spiritual and cultural preferences
- Names of caregivers and have a family member or representative be notified of admission
- Information about treatment plan and outcomes of care and the right to make decisions about their care
- Confidentiality
- Assessment and management of pain
- Consent to, request or refuse treatment
- Freedom from the inappropriate use of all restraints and seclusion when used as a means of coercion, discipline, convenience for staff or retaliation
- Designate visitors of their choice
- Formulate advance directives
- Personal privacy respected
- Review hospital bill
- File a grievance

ADVANCE DIRECTIVES

CVHP recognizes the patient’s right to make an Advance Directive (AD) and outline their wishes. If an AD is initiated, it is noted on the Daily Plan of Care and Administrative Data Screen in the electronic medical record. If a patient has an advance directive but it is not on file or is not present ask the family member or significant other to bring copy ASAP. An interim advance directive can be initiated if so desired. Ask the charge nurse for directions. If the patient would like to make an advance directive ask for the social worker who will assist the patient.

ETHICAL ASPECTS OF CARE TREATMENT SERVICES PROCESS for ADDRESSING ISSUES

The Ethics Committee is available to assist and advise the patient, patient family or significant others and the healthcare team when patient situations present complex medical/ethical issues that warrant further discussion or clarification.

Request for a meeting of the Ethics Committee can be made during normal business hours by notifying the Medical Staff Office. During off hours and weekends, contact the Nursing Supervisor. You may also notify Risk Management if you feel there are issues not being addressed.

END OF LIFE CARE

CVHP is committed to caring for our patients during any time in their lives. Part of this care includes culturally competent end-of-life care. In order to meet the needs of the dying, not only physically, but also spiritually and emotionally, during the last years of their lives; not just the last days. Pain and symptom management is a patient’s right, along with education about
their disease process. In addition to the nursing services we provide i.e., social services and chaplains, patients often require additional support in their last years and months of life and in order to meet this need, we have a Palliative Care program in the hospital for patients needing treatment and Hospice (at home and in our hospice unit). We also provide grief support for adults and children.

**ORGAN/TISSUE DONATION**

It is important to identify the patient’s wishes regarding organ/tissue donation at the time of admission, if possible. The patient’s wishes are to be considered in making donor decisions. The main role of the healthcare provider in this area is simple: provide patients and families with a link to organ/tissue donation information via One Legacy. CVHP contracts with One Legacy, an organ procurement organization (OPO) which has trained personnel who will talk to the family members about consent to donation. Regulations prohibit anyone (nurse or physician) who has not received special training and certification from approaching the patient or family regarding organ donation. If a family member approaches you assure them that a representative will be coming in or available via telephone to discuss this.

We contact the OPO when a death is imminent so that they may ascertain suitability for donation. All deaths must be called to the tissue donation hotline within 1 hour of the patient being pronounced. Ask your charge nurse/ supervisor for assistance.

**CODE BLUE STATUS**

A lavender armband should be placed on the patient when it is noted the patient is a Do Not Resuscitate patient (DNR). The codes status of the patient is located on the Status Board. DNR orders should be reviewed by a physician if there is a change in condition, level of care and before and after a surgical procedure.

**RAPID RESPONSE TEAM (RRT)**

A Rapid Response Team (RRT) has been designated to respond to changes in a patient’s condition. The Rapid Response Team consists of a RN, Respiratory Therapist and others as defined by hospital policy. A patient, visitor, employee may call the team by dialing 6 and notifying the hospital operator to page an RRT.

**CONFIDENTIALITY**

In the course of your duties you may have access to information, which is to be held in the strictest of confidence. This includes patient, employee, business and medical information. Never discuss Hospital, patient, or patient family information in or outside the hospital, where it could be inappropriately overheard. Written authorization is required before any confidential information may be released. Violation of confidentiality is subject to disciplinary action, which can include termination. More seriously, the loss of trust by the patient, family or coworker, which impacts us all.

**REPORTING CONCERNS**

Staff are encouraged to report any safety or quality of care concerns to the charge nurse, nursing supervisor or director. In addition anyone may report a concern to the California Department of Public Health or the Joint Commission. There will be no disciplinary action taken to any outside agency/contract/student because of reporting safety or quality of care concerns you may have.

**CHAIN OF COMMAND**

CVHP supports quality of patient care and concerns must be addressed in a timely manner. If a patient care issue arises that must be handled immediately, you may activate the Chain of Command.

**EMTALA**

It is a federal law intended to prevent hospital from refusing to treat patients or transferring them because of inability to pay. Individuals must receive a medical screening examination to determine if an emergency medical condition exists. A patient in active labor must be admitted and treated until delivery is completed, unless a transfer is appropriate. Signage must be posted in ED entrance, waiting room, admitting and treatment areas. Hospitals with specialized capabilities and capacity to treat may not refuse a transfer that requires specialized capabilities.

**NATIONAL PATIENT SAFETY GOALS:**

Identify patients correctly

NPSG 01.01.01 Use 2 forms of Identification. These are the patient first and last name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment. For confused patients, check desktop e-MAR against the ID bracelet. This must be done EVERYTIME before medication administration, blood draws, administering blood products, hanging IV’s, labeling specimens and prior to any invasive procedure.
NPSG 01.03.01 Make sure that the correct patient gets the correct blood when they get a blood transfusion. Before administering a blood transfusion match the blood component to the order; match the patient to the blood or blood component; verify you have the correct patient and use the two person verification process. Follow the TAR (Transfusion Administration Record) procedure when administering blood products.

Improve staff communication
NPSG .02.03.01 Get important test results to the right staff person on time. Report critical results of tests and diagnostic procedures to the MD within 30 minutes of receiving the results. If the physician does not call back within 30 minutes, notify your charge nurse or supervisor as we have a total of 60 minutes to close the loop. Follow the “Chain of Command” policy if unable to contact the physician or the physician does not respond to the call. When contacting the physician’s exchange make sure that you mention you have a critical result. Document notification of the physician using the “Notify Physician of” process intervention or enter as a nursing note.

Use medications safely
NPSG .03.04.01 Before a procedure, label medications that are not labeled. Labels must contain the name of the drug, strength, quantity, diluents and volume (if not apparent from the container), preparation date, expiration date when not used within 24 hours and expiration time. Labeling meds is required if medications are drawn up prior to the case/procedure and not immediately used or if someone else is administering the medication or if there is a gradual administration of the medication.

NPSG .03.05.01 Take extra care with patients who take medications to thin their blood. This goal requires that hospitals have a defined anticoagulant management program in place. Each campus has established approved protocols for the use of anticoagulants. Any IV infusion of an anticoagulant (HEPARIN) requires the use of an IV Pump and it is considered a high risk medication with the requirement of having 2 nurses check all orders, programming prior to administration with both nursing documenting in the electronic medication record. If you have a patient receiving anticoagulant therapy please check with the charge nurse for any protocols in place. An educational handout should be given to the patient regarding the specific anticoagulant the patient is receiving. Patient teaching should include the importance of follow-up monitoring; compliance; drug/food interactions and any potential adverse drug reactions. Document patient teaching on Patient Teaching Record.

NPSG.03.06.01 Reconciling Patient Medication by recording and pass along correct information about a patient’s medicines. Find out what medications the patient is taking. Compare those medications to new medications given to the patient. Make sure the patient knows which medications to take when they are at home. Tell the patient it is important to bring their up-to-date list of medications every time they visit a doctor.

Use alarms safely
NPSG 06.01.01. Make improvements to ensure that alarms on medical equipment are heard and responded to on time. You are expected to respond to any patient alarm. Do not pass the patient room. Go and attend the patient.

Prevent Infections
NPSG .07.01.01. Use hand hygiene, No artificial nails. Use hand washing and hand sanitizers to prevent the spread of infection before/after patient care. Equipment must be cleaned between use or as indicated in policy. Please check with the charge nurse on your unit to find out who is responsible for cleaning the equipment and how it should be cleaned.

NPSG .07.03.01. Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01 Preventing Central Line Associated Blood Stream Infections by use of proven guidelines to prevent infection of the blood from central lines. Comply with central line insertion guidelines. CLIP binders are on each nursing unit to assist you. Provide educational handouts to the patient and document patient education.

NPSG.07.05.01 Preventing Surgical Site Infections by use proven guidelines to prevent infection after surgery.

NPSG.07.06.01 Preventing Catheter Associated Urinary-Tract Infections by use of proven guidelines to prevent infections of the urinary tract that are caused by catheters. Check to see if the catheter is to removed in 24 hours.

Identify patient safety risks
NPSG.15.01.01 Find out which patients are most likely to commit suicide. A suicide risk assessment is to be performed. The risk assessment is part of the Admission History/Assessment. Please ask your charge nurse for help to determine if the patient is at risk, require additional monitoring or physician intervention as identified by the
risk assessment. Contact Social Services for a consultation. Upon discharge or transfer provide the patient or family with a crisis hotline phone number.

Prevent mistakes in surgery.

UP.01.01.01 (Pre-op verification procedure, Time Out & Marking Operative site)
Make sure the correct surgery is done on the correct patient and at the correct place on the patient’s body.
Mark the correct place on the patient’s body where the surgery is to be done.

UP.01.02.01
Pause before the surgery to make sure that a mistake is not being made.

UP.01.03.01

UNAPPROVED ABBREVIATIONS
- U, u, IU: Use “units”, international unit
- ug: Use micrograms or mcg
- qd, QD, Q.D q.d: Use daily, every day, every morning
- qod, q.o.d, QOD, Q.O.D: Every other day
- MS, MSO4: Use Morphine Sulfate
- MgSO4: Use Magnesium Sulfate
- Leading/trailing decimal: Use 0.X or x. Do not lead with a decimal. A trailing zero may not be used in medication orders or other medication related documentation. A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes.

MEDICATION RECONCILIATION
A list of medications the patient is currently taking is obtained upon admission. (Meditech Reconcile RX) Upon discharge the physician will update Med Rec in the Discharge Routine. The nurse will “Print Packet which is given to the patient. The “Patient Visit Report” is printed and placed in Medical Records bin and the “Patient Health Summary” is printed and placed in the ZEMBO box for the physician who will be caring for the patient upon discharge. (Please review the RN/LVN Students and Registry staff charting handout)

MEDICATION MANAGEMENT
- Always check with CVHP staff for administration policies.
- No medications may be left at the bedside.
- When using the Desktop Electronic Medication Record (eMAR), the computer is to be taken.
- Follow Bedside Medication Verification (BMV) process. Refer to BMV procedure.
- All medications administered should be dated, signed, and initialed by licensed personnel (when using a paper form).
- Verify patient understanding of all medications. If this is a first time medication, you may print the Drug Monograph from the computer and review the signs and symptoms with the patient. Monitor the patient for response and document any adverse outcomes or patient’s perceptions.
- **FPH Policy:** All IV Heparin, Insulin, Chemotherapy, Magnesium Sulfate, Pitocin, Epidurals, and PCA require double-checking by 2 RN’s.
- **CVMC Policy:** All Narcotic Infusions, Dopamine, Heparin, Insulin, Chemotherapy, TPN for neonates, Magnesium Sulfate Infusions/Piggybacks, Aminophylline, Platelets Inhibitors, Neuromuscular Blockers, Epidural/Intrathecal Medications, Lidocaine, Amlodipine, Promethazine, Sterile Water require double-checking by 2 health care providers.
- All telephone or verbal orders must be written down, read back and receive confirmation of accuracy of information provided.
- Contact Pharmacy to pick up all discharged medications.
- Verbal orders are only accepted in Emergency Situations.
- Be aware of Look Alike, Sound Alike (LSA) drugs and take precautions to avoid storing them together. Think HIPPOS: H (Heparin) I (Insulin) P (Potassium) P (phosphates) O (Opiates) and S (concentrated saline). Most have been standardized and a list is usually posted in your medication preparation areas.

NARCOTICS
- 2 nurses perform narcotic counts at each change of shift. All staff must stay until the count is complete and correct.
- Registry staffs are not permitted to take narcotics between units.
- Wastage of partially infused doses must be visually witnessed and co-signed by another nurse on the narcotic record.
- Wastage from PCA syringes, narcotic solutions, epidural syringes and Fentanyl (Duragesic) patches must be discarded in the white and blue Pharmacy waste containers. Fentanyl (Duragesic) patches must be cut up.
SELF-ADMINISTRATION OF MEDICATIONS
Persons who administer medications but are not staff members (i.e., patient or family) must receive training and information about the nature of the medication to be administered, how to administer the medication (frequency, route, and dose); the expected actions and side effects of the medication; and how to monitor the effects of the medication. Prior to teaching the patient or family member how to self-administer the medication (this applies to PCA and insulin and any other self-administered drug) the staff nurse must determine if the patient or family member is competent at medication administration. The information must be reviewed with the person and decision made whether the person is competent to perform the duty. Please ask the charge nurse regarding the policy for PCA etc.

MEDICATION ERRORS/ADVERSE DRUG REACTIONS
Medications are to be administered within 30 minutes before or after they are due. Medication errors, adverse drug reactions, and medication incompatibilities are immediately to be reported to the attending physician.

HOW TO PREVENT MEDICATION ERRORS?
Work together. Focus on systems and processes. Help patients understand their medications, follow their treatment plans and take an active role. Use benchmarks to compare. Weigh patients in kilograms instead of pounds. Report errors voluntarily so that a root cause analysis can be performed and education shared.

IV ADMINISTRATION
IV solutions should be administered using the Alaris IV pump and Use of guardrails. Basic infusion is NOT be selected. You must receive education on the use of the pump before use. Whenever you start an IV on any patient always do the following:
✓ Always check your orders.
✓ Follow the policy for use of 2 patient identifiers at all times.
✓ Discard IV bags in the pharmaceutical waste container after all patient identification has been removed.
✓ Follow hospital policy regarding narcotic infusion wastage protocols.
✓ Assure all drugs are compatible. Check for incompatibility. Some signs of visual incompatibility are precipitation, gas formation and color changes. To prevent incompatibilities be alert to commonly used drugs that are known to be incompatible with other drugs like Potassium and multivitamins which alter the ph; Lasix, Dilantin, Heparin, Versed and Valium.
✓ Always follow the 7 Rights of medication administration (right patient, right drug, right route, right dose, right time, medication appearance and expiration date, right patient teaching).

TUBING MISCONNECTIONS
Tubing and Catheter misconnection errors may lead to deadly consequences. The types of tubes and catheters involved include CVP catheters, IV catheters, epidural catheters, NG tubes, percutaneous feeding tubes, automatic BP cuffs, tracheotomy cuff inflation systems and peritoneal dialysis catheters. Many of the misconnections have involved luer connectors. To help prevent misconnections please do the following:
- Trace a tube or catheter from the patient to the point of origin before connecting a device or infusion
- Recheck connections upon arrival to a new setting or when assuming the care of a patient
- Inform non-clinical staff, patients and their families that they must get help from the nursing staff when there is a real need to connect or disconnect any devices or infusions.

BLOOD TRANSFUSIONS
Obtain patient consent for blood administration. Establish IV access using a 20G or larger bore IV catheter. Administer all pre-transfusion medications that have been ordered. Only licensed staff may obtain blood products. All blood products MUST be administered with a blood filter or transfusion set. Before administering a blood transfusion match the blood component to the order; match the patient to the blood or blood component; verify you have the correct patient (Name and DOB) and use the two person verification process. Two licensed personnel will check the blood products at the patient bedside. Follow Transfusion Administration procedure/record (TAR). Indicate route of administration on the TAR. Document the vital signs pre-transfusion, first 15 minutes during transfusion and post transfusion. Stay with the patient the first 15 minutes to observe for any severe reactions which are more likely to occur during this time. If a reaction does occur, STOP infusion immediately! Call physician and blood bank. Blood products should not hang longer than 4 hours. Blood tubing and filter set will be changed after 2 units. Only 0.9% normal saline is approved by the FDA to be administered with blood transfusions. Return blood products to Blood Bank within 30 minutes if they cannot be used immediately. Remember, the most common cause of fatal transfusion reaction is a patient receiving incompatible blood due to a clerical error in patient identification.
EXPIRATION DATES: Multidose vials and solutions kept in warming cabinets
All multidose vials expire in 28 days, unless otherwise indicated by the manufacturer. They are to be dated when opened and with the expiration date. A preprinted label is to be used.

All irrigation solutions placed in a warming cabinet that has been approved for that solution are to be discarded in 14 days. If they are taken out for any reason they cannot be placed back into the warmer. They must be used within 24 hours.

SAFETY OFFICER
Charlene Janz RN is our Safety Officer. She can be reached by calling extension 24921.

REPORTING OF AN UNSAFE CONDITION
Everyone is expected to participate in maintaining a safe environment for patients, visitors, physicians and their coworkers. This means taking an ACTIVE role in reporting any UNSAFE CONDITION.

To report safety issues or concerns contact the SAFETY HOTLINE x 12303. Calls remain anonymous. You may also notify the charge nurse, department director or nursing supervisor.

PERSONAL SAFETY/ASSAULTIVE BEHAVIOR
We can prevent most injury, abusive treatment and involvement in compromised situations by preventive action. Learn to assess the situation, if a person or situation makes you uncomfortable, look for clues. What is going on? What are you communicating by your presence? What can you do to prevent problems?
Although assaultive behavior can happen anywhere and at anytime the following areas are considered high risk for violence: Emergency Department, Registration Department and Cashier’s areas.

To protect yourself and others:
- Report suspicious persons or activities to the charge nurse or security
- Do not compromise door locks and other security devices (i.e.-alarms)
- Wear your name badge at all times
- Know how to get help
- Dial 6.

STAFF INJURY/PERSOAL SAFETY
On the job injuries must be reported to the nursing supervisor. Except in emergency situations, authorization for treatment must be given by the Registry, which might require treatment at another facility.

FALL PREVENTION
On admission and every shift, document Morse fall risk score in patient chart. If the patient is identified as a high risk for fall, initiate the fall protocol. A yellow armband is to be placed on the patient and a magnetized sign is placed on the doorframe at the entrance to the patient’s room. In some cases there is no door frame in which case the sign is placed above the patient bed. Check the environment to increase safety, offer frequent toileting etc. Educate the patient and the patient’s family on any fall reduction strategies that are in place. Use yellow slippers.

RADIATION SAFETY
The best way to protect yourself is to follow these 3 basic rules
- Time- do not spend unnecessary long time in area.
- Distance- a distance of 6 feet will remove you from danger
- Shielding- lead aprons are always available for your protection.

Questions regarding radiation safety can be directed to the radiation safety officer.

BODY MECHANICS
To eliminate unnecessary strain, these guidelines should be observed
- Maintain alignment and balance. Keep your feet pointed in the direction you are moving.
- Work at a comfortable height.
- Keep the work close to your body. Hold and carry objects close to you at about waist level.
- Use smooth coordinated movements.
- When lifting objects, stand close to the object to be lifted with feet apart and one foot slightly in front of the other. bend at your knees; lift using your leg muscles and carry the object close to your waist.
- Always use a footstool to reach objects.
SECURITY MANAGEMENT

The hospital employs security officers who are on duty all shifts to safeguard employees, patients, the hospital and its physical assets. The officers are authorized to check all packages or boxes brought into or taken from the hospital and to enforce parking regulations.

Identification badges

When you are in the hospital, it is required that you wear your identification badge that was issued by your school/employer. The badge is to be worn above the waist and the picture must be visible. If you lose your badge, notify security who will issue a temporary badge.

Parking

You will be expected to park in the areas listed as employee parking. If you have questions ask security where to park.

HAZARDOUS MATERIALS

SDS (Safety Data Sheets)

♦ Safety Data Sheets are kept in in each department. The master manuals are located in engineering, materials management and emergency departments. At CVMC pharmacy also has a master manual.
♦ SDS describes safe use/precautions/action if exposure occurs.
♦ SDS identifies hazards, physical or chemical, for products used in that area. Please familiarize yourself with the SDS manual located in your department.
♦ A 24-hr hot line number is available. Contact 3E Company: 1.800.451.8346

LIFE SAFETY/FIRE

Hospital Response to Fire: CODE RED is paged over the intercom system to indicate a fire within the Hospital.

Important locations you need to know

♦ Fire extinguisher in your department
♦ Closest fire-alarm pull
♦ Evacuation route
♦ Fire doors and walls
♦ Next safe fire zone (smoke compartment)

Important facility conditions to maintain

♦ Keep emergency exits, fire-fighting equipment and fire alarm pull stations clear at all times.
♦ Never put door wedges that prevent doors from closing under doors.
♦ Keep doors closed unless they are controlled by an electromagnetic system.
♦ Keep all corridors and exits clear of all unnecessary traffic and/or obstruction.
♦ Keep telephone lines clear for fire control.

Your role at a fire’s point of origin and away from a fire’s point of origin

♦ At fire’s point of origin: follow the fire safety procedure
♦ Away from the point of origin: close all doors, free hallways from clutter, calm patients, and await specific instruction.

Smoke compartments:

Your department’s evacuation plan, posted near to every fire pull, outlines the floor plan of your department, including the location of your department’s automatic fire doors, which define smoke compartments. These are important to locate, since patients will need to be moved beyond them if you are instructed to move them due to a fire. Remember that smoke compartments prevent smoke or fire from spreading for up to 2 hours.

Discovering a Fire: Keep Calm

When an individual discovers smoke or fire the action that is taken in the first few minutes can be the difference between life and death or severe injury to you and/or the fire victim. Always remember:

R = Rescue. Remove all patients from the fire room. Close all doors.

A = Activate the Closest Alarm. Call the Hospital Emergency Operator. Dial 600 @ FPH or 6 @ CVMC.

C = Confine the fire. Close all doors. Clear the hull of all equipment.
E = Extinguish or Evacuate/Relocate
Extinguish with a fire extinguisher. Evacuate if fire cannot be safely extinguished. Evacuate in this order:
1. Fire Room
2. Room across from the fire door
3. Rooms adjacent to the fire
4. All remaining rooms.

PASS
OPERATION OF FIRE
EXTINGUISHERS

P Pull out the safety pin

A Aim the nozzle at the BASE of the fire (stand about 10 feet away from the fire).

S Squeeze the handle

S Sweep the nozzle from Side to side.

SMOKING POLICY
Smoking is prohibited within the hospital and on hospital grounds. Smoking outside the hospital is permitted in designated areas only which is on public property or in your car.

OXYGEN SAFETY
Verify portable oxygen cylinders are stored in appropriate holder and location. Oxygen cylinders should be kept upright at all times in the appropriate holder. No more than 12 cylinders in one oxygen storage area.

MEDICAL EQUIPMENT MANAGEMENT
The objective of the Medical Equipment Management Program is to:
♦ Ensure that medical equipment is safe and effective for use by patients and staff;
♦ You must be sure that equipment has been safety inspected prior to use;
♦ Be certain you know how to operate a piece of equipment properly before using and if you do not, ask a staff member to help you.

Check equipment prior to use with a visual inspection of:
♦ Cords and plugs have no exposed wires and are not frayed
♦ Expiration Tags are current
♦ Functional checks, where applicable.

Report, label and remove from service equipment that has been dropped, had liquid spilled on it, gives a shock, overheats, or has frayed cords, bent or loose plugs/cables.

Equipment training is required when:
♦ You are new to a work area or assignment;
♦ There is any new equipment introduced to an area;
♦ A change or update occurs with equipment.

Defibrillator: The defibrillator is checked daily with the crash cart. It is battery operated and must be unplugged from the wall charger before testing or moving the cart.

IV Pumps
Nursing units use the Alaris system using Guardrails. It is imperative that the pumps be set correctly.
♦ Turn the “brain” on, attach either a pump, syringe or PCA module
♦ Select the appropriate “Channel select”.
♦ Insert the tubing
♦ Follow directions.
Check to see that fluid is dripping into the drip chamber before leaving the patient.
Use your guardrails at all times. Basic infusion should NOT be used.
Emergency Equipment.
Assure life support equipment is plugged into an emergency power outlet (red plug) at all times. (FPH & QVC). If you have any questions or concerns about the operation of the equipment, contact your charge nurse/supervisor.

SAFETY MEDICAL DEVICE ACT (SMDA)
Purpose: Enacted to ensure reporting of an illness or serious injury or death that resulted from a medical device. Action: Any person who knows of a medical device that may have caused illness or injury shall immediately:
- Attend to the patient’s needs;
- Report the incident to your supervisor;
- Remove the device from service and the patient’s room;
- Label the device;
- Complete an electronic Incident Report.

EMERGENCY PREPAREDNESS
The hospital disaster plan is designed to direct how our business of patient care can be carried out during a disaster. Be prepared to respond to the following.

Code Triage Standby
A disaster appears imminent. Managers will begin preparation for an impending event. If you are off of your assigned area, report back to that area immediately.

Code Triage
The disaster has been confirmed. There are TWO types of disasters:

TRIAGE INTERNAL - Internal Disaster: an incident that happens on campus and results in damage to our property or injury to our employees.

TRIAGE EXTERNAL - External Disaster: an incident that happens outside of the hospital. A response to a disaster is department specific.

WHAT IS MY ROLE IN A DISASTER?
The Fire/Disaster Manual contains the full Disaster Plan that describes each department’s responsibility. It is your responsibility to familiarize yourself with the specific responsibilities of your department. The “T” packet is in all areas and is your immediate “GO TO” packet to use in case of an emergency. The Emergency Reference and Response Guide is also available on all units which is a quick reference guide for staff response.

If you are ON-DUTY when a disaster strikes, you have certain duties to perform:
Contact your Charge Nurse/Supervisor to find out where to report, or if you should continue your work assignment. Use pay phones if personal calls are necessary.
- Wear your photo identification badge at all times.
- Physicians: report to the physician labor pool located in the physician lounge.

Communication
Use regular telephones when available. Walkie-talkies are in all patient-care areas. Use of runners and cell phones are alternatives.

Supplies and Equipment
Backup supplies and equipment are available for disasters. Disaster supplies are located on most units or in designated locations.

UTILITY SYSTEM MANAGEMENT/UTILITY FAILURE
Utility systems are designed to keep our environment comfortable for employees, visitors, contract staff, and patients. However, these systems may experience problems. When a disruption in a utility occurs, you must be familiar with procedures for maintaining a safe environment. In the event of utility failure, immediately notify your supervisor or PBX operator.

Utility systems include:
- Nurse call Systems
- Telephone
- Paging System
- Bocor System
- Medical Gas System
- Vacuum System
- Domestic Water
- Steam
- Electricity with/without Emergency Power
- Natural Gas
- Elevators
- Air Conditioning
- Heating and Ventilation System
- Pneumatic Tube System

**MEDICAL GAS SHUT-OFF**

In the event of a failure of the medical gas equipment, designated individuals have been authorized to shut off the equipment.

**EMERGENCY POWER**

**Generators**

- In the event of a loss of electricity, emergency generators become operational in 10 seconds or less.
- Essential patient-care equipment should be plugged into RED receptacles for access to emergency power. (QVC and FPH only).

**PREVENTION AND CONTROL OF INFECTIONS**

Infections are most frequently spread by hand. Hand Hygiene incorporates both hand washing with soap and water and the use of a waterless, alcohol-based solution. Soap and water should be used when hands are visibly soiled or you have come into contact with body fluids. Waterless alcohol gel can be used when additional hand sanitizing is needed (before and after medication administration), after touching patient equipment, and after removing of gloves. *Please make sure to take at least 15 seconds to wash your hands. USE HAND HYGIENE!!!*

**Wash your hands**

- Before starting work
- When hands are soiled
- After handling body fluids
- Between patients
- Before and after eating
- Before and after toileting

**Remember!**

_The single most important thing you can do to prevent the spread of infection in the hospital is hand hygiene._

**Standard Precautions:**

All body substances are potentially infectious. If you anticipate contact with body fluids, take precautions. Personal Protective equipment supplies include: gowns, gloves, goggles and masks.

**Transmission Based Precautions**

**Contact Precautions:**

Staff must wear gowns and gloves when entering any Contact Isolation room. The door may remain open.

Examples of patients in Contact Precautions include:

Scabies, MDRO, MRSA, VRE, Lice

**Droplet**

Staff will wear procedure/surgical mask within 3 feet of the patient. The door may remain open.

Examples of patients in Droplet Precautions include:

Meningitis, Influenza
Airborne Precautions
Staff will wear fit tested N95 respirator mask when in the room. Patient's in a negative air flow room should have the door closed.
Examples of patients in Airborne Precautions include:
TB, Chickenpox, SARS, Measles

Neutropenic Precautions
Staff will keep the door closed and prohibit fresh fruits, vegetables, or flowers from being taken into the room. Serve only cooked food. Avoid unprepared fresh fruits, raw vegetables, garnishes, herbal tea and pepper. Do not place the patient in a negative air flow room.

PERSONAL PROTECTIVE EQUIPMENT (PPE)
PPE is available for your protection and safety. Please contact your supervisor for a detailed description of appropriate PPE available in your work area.

RESPIRATORY HYGIENE/COUGH ETIQUETTE
Always cover your cough. If you don’t have a tissue, sneeze or cough into your sleeve, not your hands. After sneezing or coughing, always wash your hands with soap and water or an alcohol-based hand cleaner. Place soiled use in nearest waste receptacle.

HIGH LEVEL DISINFECTION
High level disinfection will be done using Metricide OPA Plus solution or the Trophon High Level Disinfection Unit per manufacturer’s instructions. This is done in the Perioperative Service, SPD and Ultrasound. Examples of equipment that use high level disinfection are: GI endoscopes, vaginal probes, transrectal transducers.

CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTIONS (CLABS)
The central line bundle is a group of interventions that are used to improve the outcomes for our patients with central lines.
Please do the following:
✓ Daily bathing with CHG.
✓ Hand Hygiene before and after inserting, replacing, accessing, application of dressings and removal of a central line
✓ Full barrier precautions are used during a central line insertion. DO NOT PROCEED unless all components are performed.
✓ Chlorhexidine skin prep is used for at least 30 seconds before accessing site
✓ Flush each lumen with 10ml normal saline every 12 hours when not in use.
✓ Daily review of line necessity.

Documentation is done in the electronic medical record (EMR) in Process Interventions by adding an intervention and typing in /CLIP for insertion, dressing change, flush and PI for all inpatients. ER documentation is done in Triage.Doc, highlight “Treatment”, click on the document and type in “CLIP” for insertion.

Dressing changes are done every 7 days along with the Chlorhexidine bath.

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)
Urinary tract infection is the most common hospital-acquired infection. To help prevent urinary catheter infection do the following:
✓ Insert catheter using sterile technique utilizing appropriate hand hygiene
✓ Maintain a closed sterile drainage system
✓ Nurse must assess the need for continued use every 24 hours and refer to guidelines for removal. SCIP core measures for post surgical patients require removal of the catheter within 48 hours unless reason is documented by the physician
✓ Document insertion of catheter, removal of catheter

SHARPS INJURIES
* Always use safety needles when available
* Do not bend, shear, or break contaminated needles
* Discard all needles in leak proof, puncture resistant containers
* Close sharps containers when ¾ full
If you sustain a needle stick, wash the area with soap and water and notify the house supervisor immediately.

Additional Self-Protective Controls
• Use only hospital approved soaps and hand creams
- Do not eat at the nurse station where specimens have been placed
- Never mouth pipette or suction blood or other potentially infectious materials
- If you are exposed to blood or body fluids, wash with soap and water and rinse mouth with ½ strength peroxide.
- Do not apply makeup, or handle contact lenses where you may have had contact with blood or potentially infectious materials.

_Students must notify their instructor immediately for any body substance exposures. Registry staff is to notify the house supervisor and contact their registry for any body substance exposures._

**PATIENT EDUCATION REGARDING VACCINATIONS:**

Whenever any vaccination is to be administered to a patient the patient or family must receive a Vaccine Information Statement (VIS) from the Centers for Disease Control and Prevention (CDC). These can be downloaded directly from the Status Board by clicking on References which takes you directly to the CDC web page. Print the vaccination the patient is to receive and review the information with the patient prior to administration. When documenting the vaccination in eMAR (electronic medication record) you must enter the date the vaccination form was given to the patient and the VIS date located in the bottom right or left corner of the form.

**PATIENT CARE PLAN**

Each patient must have an individualized care plan with reflective charting included in the patient care notes. Updating care plans is the responsibility of all health team members. The RN is to assess the patient and develop a plan of care to meet the identified needs. The planning process must include collaboration with other disciplines needed to support the patient recovery process such as the physician, physical therapist, respiratory therapist, dietician, case manager, and social worker. Portions of patient care may be delegated to an LVN, nurse aide, or other discipline. When this occurs the RN is responsible to monitor the care and modify the plan if desired outcome is not achieved.

The RN is to review the Plan of Care daily and assure it is accurate and updated. This is a RN responsibility and cannot be delegated. Please review your charting instructions on how to initiate a care plan and to update a plan of care.

**IMPAIRED PHYSICIAN AND LIP**

If a physician or a licensed independent practitioner (LIP) appears to be impaired as evidenced by inappropriate behavior, language, orders, unsteady gait, slurred speech or inability to comprehend information they should be reported immediately using the Chain of Command. Activate the Chain of Command by contacting the charge nurse or nursing supervisor. The same process should be utilized if you suspect that an employee may be impaired.

**PATIENT INVOLVEMENT IN THEIR CARE**

The patient safety pamphlet, “Take Your Health into Your Own Hands” is given to each patient on admission. Included in our patient admission brochure is information related to our “ASK ME” program. Encourage the patients to ask you about how they can be involved in making sure they are safe. Examples are: Make sure that 2 patient identifiers are used, ask questions about their medications, and it is ok to ask if you have washed your hands.

Patients are encouraged to be involved in their care and to report safety concerns to the charge nurse, the nursing supervisor or the safety officer hotline x 12503.

Patients may also report any issues to the Joint Commission or to the California Department of Public Health. The phone numbers are listed in their Patient Brochure and on the Patient Rights posters posted in all Registration areas.

**CULTURAL DIVERSITY**

Cultures may define/affect how a patient perceives health; who is supposed to make the healthcare decisions and/or visitor expectations. However, these may not be clearly evident to the healthcare provider. Assess your personal beliefs and accept and respect others values as possible and safe. Plan care based on the communicated needs and cultural background. Always communicate in a non-threatening manner. Work with the patient and family to meet cultural and hospital needs when differences or conflicts occur. Use interpreters as appropriate to assure accurate communication.

If there are any questions on how to interact with a person with a different cultural value please speak to the charge nurse who can refer you to other resources available to you.

**TEAM BUILDING**

A team is a group of interdependent individuals organized and committed to working toward a common goal. Members of a team have a purpose, which gives them identity. Each team member has a unique function or position that must be combined with that of the other team members. Elements of effective teamwork are: commitment, common purpose, organization and interdependence. Examples of Multidisciplinary teams include: Medication Error Reduction Committee or the Medication
Safety Committee- a multidisciplinary team which examines actual or potential events/risks to the patient associated with medications.
Patient Safety Committee- a multidisciplinary team whose goal is to improve patient safety by reducing risks to patients.
Environment of Care Rounds- each department is visited throughout the year by a team that observes for correct safety compliance in each area.
Code Blue or Crash C-Section drills- random drills conducted on a regular basis to practice responses to emergency situations.

**HAND OFF COMMUNICATION (SBAR Communication: Situation, Background, Assessment and Recommendation)**

Hand-off communication is communication about the patients care, treatment and services, current condition and any recent or anticipating changes between practitioners. Complete the “Interdepartmental Hand Off Communication” form when sending patients off the unit. Exception: OR and GI lab. The pre-op checklist is used as part of the hand-off procedure.

Do a warm handoff whenever there is a change in caregivers and change of shift.

Miscommunication is frequently a cause of sentinel events and near-miss events in healthcare. A communication tool we use that is helpful in improving this process is the SBAR tool.

S- situation: what is going on, chief complaint, and acute changes?
B- background: what factors led up to this event, vital signs, and pertinent history?
A- assessment: What do you see, what do you think is going on?
R-recommendation: What action do you propose? What do you think should be done?

Remember to call the physician as soon as you sense a problem. Remember, as the patient advocate you are responsible for making sure their healthcare needs are communicated.

**AGE SPECIFIC CARE**

Our patient population includes many age groups. Patient care must be modified to address their special needs.

**Neonates: (0-30 days)**
- Transport in bassinet only. Support head at all times.

**Infants: (31 days to 1 year)**
- Crib rails up at all times. No small items in crib or within reach.

**Pediatric: (1-13 years)**
- Give age specific foods. Need a high level of supervision.

**Adolescent: (14-17 years)**
- Ensure privacy/modesty. Excuse others when interviewing.

**Adult: (18-64 years)**
- Allow participation in care decisions.

**Geriatric: (65+ years)**
- Keep covered as they lose body heat faster. Speak slowly, and in a tone to be heard, be patient, allow time to move. Keep needed items within reach. Offer frequent bathroom visits.

Please review with staff any age specific related equipment, safety or communication needs of your pt.

**ABUSE REPORTING**

All professional healthcare providers are mandated to report suspected abuse and neglect. Signs and symptoms include:

**Child:** unexplained bruises or injuries, withdrawn, fearful

**Elder:** physical abuse, lack of food, care, hygiene, isolation, misuse of funds, unsafe home, and inappropriate administration of medication, dependent person not given the opportunity to speak for self or to see others without the suspected abuser present.

**Domestic:** suspicious injuries, fear, delay in seeking care etc.

**Exploitation:** misuse of housing, clothing, money, and failure to allow access to health care

**ERROR REPORTING**

Quantros Event Reporting System is used for reporting potential, actual errors or safety concerns. Please record your concern clearly including objective and concise information. You may also speak directly to Risk Management or utilize the chain of command for issues related to unanticipated adverse events. Please let us know of any potential errors or actual errors so we may review and fix any system errors to prevent patient harm or injury. Remember: We embrace a Just Culture!

**PAIN MANAGEMENT**

On admission, assess and document the patient’s level of pain using the pain scale. The standard pain scale for most patients uses a 0-10 scale with 0 being pain free and 10 being the worst pain experienced. Descriptions and facial expressions associated with the numbers help rate the level of pain when the patient is non-verbal. Pain rulers are available on all units.

- **ADULT**- uses numbers and faces 0-10 scale
- **FLACC**- Use when child cannot understand the faces, usually under age 2-3 or when the patient cannot communicate needs (CVMC)
- **NPASS**- Use with neonates/infants
- **COGNITIVE**- (FPH) use when the patient is unable to be assessed using above scales.

Educate the patient on the pain scale rating system, the times when pain will be reassessed and the plan for controlling his/her pain and document.

Pain is considered the 5th vital sign. Each time routine vital signs are taken, the patient’s pain level also needs to be determined. A pain level greater than 4 or greater than the patient’s accepted pain level requires intervention such as repositioning, diversion activities, or medication.

Reassessment within 1 hour following intervention to determine the effectiveness of the intervention is required and must be documented. This includes using a pain scale to measure improvement. If the patient’s pain is not relieved, notify the charge nurse so the physician can be notified.

**RESTRAINTS POLICY/PROCEDURE**

Restraints are only to be used to protect the immediate physical safety of the patient, staff or others. Restraint is any manual, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body or head freely. If the patient cannot easily remove the device it will be considered a restraint. See list of exceptions located within the Restraint Policy.

Restraints require a physician order and face-to-face visit (Except in Emergency). Restraints may only be imposed to ensure the immediate physical safety of the patient, by a staff member or other trained personnel and must be discontinued at the earliest possible time. Restraints will not be imposed as a means of coercion, discipline, convenience or retaliation. Staff will assure that any use of restraint will protect and preserve the patient and his or her rights, dignity and well being.

Use alternatives prior to restraints such as: moving closer to nurses station, orient patient frequently, offer frequent restroom visits, camouflage IV or other sites, try diversion activities, provide pain relief, ask family to sit with the patient. The RN will use the least restrictive restraint and provide assessment, monitoring, and assurance that patient needs are met.

Do not use more than 3 side rails at any time. Using 4 side rails constitutes a restraint device and all monitoring and documentation requirements must be met. If you restrain a patient open the Restraint Nursing Care Plan and choose the appropriate interventions for your patient.

The physician’s order must specify time limits. **Orders may not exceed 24 hours.** If the need for restraints extends beyond 24 hours, the physician must review and renew the order based on the examination of the patient for clinical justification. "PRNs" are not permitted.

Restraints are ordered on the "Restraint Order Sheet" form and will be entered as an order using the electronic medical record. The nurse documents in the electronic medical record on the Restraint Flow Sheet form. At a minimum, a patient in restraint(s) is monitored every 15 minutes. Monitoring is accomplished by observation, interaction with the patient or related direct examination of the patient by qualified staff. Documentation is done every 2 hours. EXCEPTION: Restraints for violent, self-destructive patient in which the patient must be continually monitored and documentation recorded every 15 minutes.

With each monitoring the patient is reassessed to determine that continuation of the restraint is necessary and nutrition, fluid and elimination needs are addressed. Reduction or removal of the restraint will be considered when the patient demonstrates a change in the behavior that was the reason for the initial application.

**WAIVE TESTING**

You are not allowed to do any waive tests unless you have received education and have fully complied with all competency requirements related to the waive test. A signed competency form must be on file. This would include bedside blood glucose testing, urine dip, urine pregnancy testing. Occult blood for stools is NOT allowed by nursing personnel.

**HYPOGLYCEMIA**

Patients with diabetes who exhibit signs and symptoms of hypoglycemia and have a blood glucose meter reading of 60-70 with symptoms or less than 60 with or without symptoms are treated using the Hypoglycemia protocol (a standardized procedure). Please check with the charge nurse to determine the appropriate treatment and monitoring plan.
THE SWEET HOUR
The Sweet hour is defined as the maximum time from taking the patient’s pre-meal blood sugar, giving the diabetes medication, and the patient eating the meal. Diabetes medication should be scheduled for 8, 12 or 5pm for those patients eating.

TRANSFER
Key points to remember when transferring a patient to another hospital:
A physician must accept the care of the patient
The facility must accept the care of the patient
The physician must talk directly to the receiving physician
The nurse must give report to the receiving nurse
Copies of the appropriate medical record forms must be sent with the patient
The patient must consent to the transfer and must be made aware of the risks and benefits
Transfer forms must be completed and signed by the patient, physician and nurse
Documentation of the reassessment within 30 minutes of the transfer on the transfer summary form.

COMPUTERIZED CHARTING
All nursing units use computerized charting. On admission the RN is responsible to complete the following forms
- RN Admission History/Assessment
- Plan of Care
- Pain assessment/PCA screen
- Patient Teaching Record
- Reconcile Rx (Medication Reconciliation)
- Allergies
- Vital Sign Record
- Diabetes Knowledge Assessment (if patient is diabetic)

Other forms to be completed on admission include: vital signs, and bedside care record.

ONGOING DOCUMENTATION
Ongoing documentation includes; shift assessment forms; bedside care record, I & O; vital signs; pain assessment/reassessment; patient teaching record; updating patient care plan, patient care notes and any other forms as needed.

OTHER CHART FORMS NOT COMPUTERIZED
There are a few forms that are not computerized. When using a paper form, all members of the health team must use black ink only. Notations must be legible, clear in meaning, factual and concise. All entries must be dated, timed, and signed, including your professional status. Utilize the nursing process for documentation.

DISCHARGE PLANNING
Expected components of discharge planning include
- Patient or family is to repeat back the instructions
- MD telephone number is to be given to patient upon discharge for follow-up care
- Supplemental discharge instructions of signs and symptoms to report to MD are to be included
- Review of new medication side effects to be discussed
- The patient is to receive a copy of the Home Medication List, discharge instructions, prescriptions and any other education handouts or printed information.

COLOR CODED WRISTBANDS
Standardized color coded wristbands will be used to reduce confusion and to communicate patient safety risk factors to all health care workers.
- Yellow- patient is high risk for falls
- Red- allergy
- Purple- DNR status
- White patient wristband- patient identification
**LAW ENFORCEMENT EDUCATION**

The hospital is required to educate all law enforcement and security personnel when they have a patient in custody. Security Department is responsible for educating law enforcement personnel.

**MODERATE/DEEP SEDATION**

Please notify the charge nurse if the physician is planning on use of moderate or deep sedation. Review the Moderate and/or Deep Sedation policy to verify all pre-during-and post monitoring requirements are met.

Kt: registry folder :registry tip sheet
<table>
<thead>
<tr>
<th>CODES</th>
<th>DESCRIPTION</th>
<th>INITIAL RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>Fire, smoke or smell of something burning</td>
<td>☐ Safety of Life - Remove people/close doors</td>
</tr>
<tr>
<td>CODE RED</td>
<td></td>
<td>☐ Activate Alarm/Dial 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Fight the Fire if safe to do so</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Evacuate and Relocate</td>
</tr>
<tr>
<td>Adult Medical Emergency</td>
<td>Medical Emergency such as respiratory and/or cardiac arrest.</td>
<td>☐ Dial 6.</td>
</tr>
<tr>
<td>CODE BLUE</td>
<td></td>
<td>☐ Give location and description of call</td>
</tr>
<tr>
<td>Infant Medical Emergency</td>
<td>Infant Medical Emergency such as respiratory and/or cardiac arrest.</td>
<td>☐ Dial 6</td>
</tr>
<tr>
<td>CODE WHITE</td>
<td></td>
<td>☐ Give location and description of call</td>
</tr>
<tr>
<td>Person with Weapon/Hostage</td>
<td>Anyone encountering a person showing a weapon or a person who has taken</td>
<td>☐ Dial 6</td>
</tr>
<tr>
<td>Situation</td>
<td>hostages in the medical facility.</td>
<td>☐ Keep clear of the area; close/lock your doors, evacuate if you can. Do not go to the area</td>
</tr>
<tr>
<td>CODE SILVER/Active Shooter</td>
<td></td>
<td>☐ Clear the area of non-essential personnel</td>
</tr>
<tr>
<td>Infant Abduction</td>
<td>Removal/kidnapping of an infant from the medical facility by an unauthorized</td>
<td>☐ Dial 6</td>
</tr>
<tr>
<td>CODE PINK</td>
<td>person.</td>
<td>☐ Go to the nearest exit and prevent all visitors/staff with from leaving. Search all visitors/staff that are carrying packages/bags or wearing clothing that might conceal a baby</td>
</tr>
<tr>
<td>Child Abduction</td>
<td>Removal/kidnapping of a child from the medical facility by an unauthorized</td>
<td>☐ Dial 6</td>
</tr>
<tr>
<td>CODE PURPLE</td>
<td>person.</td>
<td>☐ Go to the nearest exit and prevent all visitors/staff with an infant/child from leaving. Search all visitors/staff that are carrying packages/bags or wearing clothing that might conceal a small child</td>
</tr>
<tr>
<td>Bomb Threat</td>
<td>Notification of a bomb on campus, usually by an outside caller.</td>
<td>☐ Obtain as much information as possible (Where is the bomb, when will it go off, what does it look like, why was it placed, etc.)</td>
</tr>
<tr>
<td>CODE YELLOW</td>
<td></td>
<td>☐ Dial 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Have staff and visitors to turn off all 2-way radios, cell phones, pagers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Evacuate Area/Bldg. As directed</td>
</tr>
<tr>
<td>Hazardous Material Spill</td>
<td>A major spill that may present a hazard to people or the environment, or one</td>
<td>☐ Isolate the area</td>
</tr>
<tr>
<td>CODE ORANGE</td>
<td>that may have effects that is unknown.</td>
<td>☐ Deny entry to others</td>
</tr>
<tr>
<td>Disaster Internal</td>
<td>Internal Disaster</td>
<td>☐ Dial 6</td>
</tr>
<tr>
<td>TRIAGE INTERNAL</td>
<td></td>
<td>☐ Contact Nursing Supervisor/Safety Officer/your Supervisor</td>
</tr>
<tr>
<td>Disaster External</td>
<td>External Disaster</td>
<td>☐ Report to your department for further instructions.</td>
</tr>
<tr>
<td>TRIAGE EXTERNAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security Requested Emergency</td>
<td>Used to obtain one security officer for an urgent call.</td>
<td>☐ Dial 6</td>
</tr>
<tr>
<td>CODE NORA</td>
<td></td>
<td>☐ Request 1 security officer for assistance</td>
</tr>
<tr>
<td>Medical Emergency after cardiac arrest</td>
<td>Induction of therapeutic hypothermia after cardiac arrest</td>
<td></td>
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<tr>
<td>--------------------------------------</td>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>CODE POLAR</strong></td>
<td>□ Dial 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Designated staff respond</td>
<td></td>
</tr>
<tr>
<td>Malignant Hyperthermia</td>
<td>MH is a sudden and life-threatening syndrome, which</td>
<td></td>
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<tr>
<td><strong>CODE MH</strong></td>
<td>occurs when a person with MH susceptibility is exposed to</td>
<td></td>
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<tr>
<td></td>
<td>triggering factors</td>
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<td></td>
<td>□ Dial 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Designated staffs respond to event and bring MH cart to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>scene</td>
<td></td>
</tr>
<tr>
<td>CODE SEPSIS</td>
<td>Suspected or actual sepsis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Dial 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Designated department responds</td>
<td></td>
</tr>
<tr>
<td>CODE STROKE</td>
<td>Medical Emergency for a patient with Stroke symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to activate the Stroke Team at OVH</td>
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<tr>
<td></td>
<td>□ Dial 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Designated stroke team members respond to site.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Initiate Code Stroke procedures</td>
<td></td>
</tr>
<tr>
<td>STROKE ALERT</td>
<td>Medical Emergency for a patient with stroke symptoms at</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ICH or FPH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Dial 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Designated procedures initiated with possible transfer of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>patient to QVH Stroke Center</td>
<td></td>
</tr>
<tr>
<td>CODE TRAUMA</td>
<td>Medical Emergency for a patient with major trauma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Dial 6</td>
<td></td>
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<tr>
<td></td>
<td>□ Give location and description of call</td>
<td></td>
</tr>
<tr>
<td>EMERGENCY ALERT LEVEL 2 OR 3</td>
<td>Emergency Department Overcrowding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Dial 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Give location and description of call</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Designated staff respond</td>
<td></td>
</tr>
</tbody>
</table>