We want your experience at Saddleback to be an excellent one! Everyone is here to help and answer questions, guide you along the way, and develop your pride in choosing an esteemed profession in healthcare.

MemorialCare® and SMMC are committed to providing a safe environment and quality care to all our patients.

This guide provides information about the hospital and clinical policies that will help you in preparing for your clinical rotation. Additional information and resources available to you when you are on campus are found on the SMMC intranet site including Policy & Procedures, For Clinicians, Micromedex, Care Notes, and Mosby Nursing Skills.

Contents:
- SMMC Mission, Vision, Values
- Parking, ID Badges, Hospital Maps
- Nursing Student Guidelines
- Communication
- MEWS, Rapid Response Team, Code Blue
- Patient Identification
- Medication Administration
- Fall Prevention, Clinical Alarms, Suicide Risk
- Cultural Diversity
- Newborn Abandonment Policy
- Abuse Reporting
- Infection Prevention
- Linen, Medical Waste, Chemical Spills, Medical Equipment
- Emergency Procedures
Saddleback Memorial Medical Center
and MemorialCare®

Mission:
To enhance the health and well being of individuals, families and our community.

Vision:
Extraordinary People. Extraordinary Care. Every Time.

Core Values: the ABC’s

Accountability:
Being responsible for meeting the commitments we have made, including ethical and professional integrity, meeting budget and strategic targets and compliance with legal and regulatory requirements.

Best Practices:
Requires us to make choices to maximize excellence and to learn from internal and external resources about documented ways to increase effectiveness and/or efficiency.

Compassion:
Serving others through empathy, kindness, caring, and respect.

Synergy:
Combining our efforts so that together we are more than the sum of our parts.

Parking
Laguna Hills:
Please park toward the back of the visitor parking lot, on the Paseo de Valencia (street) side of the green belt dividing the lot. This will leave the parking spaces closest to the hospital for our patients and visitors. Parking in the mall puts you at risk for having your car towed.

San Clemente:
Please park along the back wall of the west side parking lot (near Ralphs supermarket).

Security ID Badges
Please wear your school name badge at all times while on campus.

SMMC LH - by floor

Basement: Conference Rooms 1 - 8; Professional Development, Medical Library, Café, Laboratory/Blood Bank, In-Patient Pharmacy.

First Floor: OR, PACU, Outpatient Unit (OU), Radiology, Cardiac Catheterization Lab, Women’s Surgical Unit (WSU), Admitting, and Emergency (ED).

Second floor: ICU, 2E, 2W, 2S.

Third Floor: 3E and 3W (medical/surgical units)

Off-site: Human Resources - located at 23961 Calle de la Magdalena, Suite 307 (next door to the hospital).
General Guidelines for Nursing Students

After selecting your patients, list them in the student or school notebook on the unit. A copy of the student assignment is also at the nurses’ station.

Introduce yourself to the RN and any other caregivers assigned to your selected patient(s). Let them know what care you will be providing (e.g. AM care, medications, procedures) and how long you will be on the unit that day. Please keep them updated throughout the shift as appropriate.

The hospital has the ultimate responsibility for the patient. Staff nurses attempt to provide learning experiences for students, but must ensure the ultimate safety and care of our patients. Immediately report any change in patient status to the RN responsible for the patient. Report off to the patient’s RN when leaving on breaks and at the end of the day.

Direct supervision by your instructor or a staff RN is required when:
- Performing any procedure for the first time.
- Performing any invasive procedures. You may start IVs with immediate supervision if you have completed a course in IV therapy.
- Hanging IV infusions, injecting medications into an IV solution or administering add-A-line medications
- Transfusing blood or blood products
- Administering medications
  - An RN or instructor must confirm the procedure and dosage of any medications requiring reconstitution or computation of dosage

Resources and references are available on the SMMC Intranet including SMMC Policies, Mosby Skills for clinical procedures, Epic Clinical Documentation Guidelines, IV Medication Guidelines.

Security and Confidentiality

Treat all information as if it were about you or your family. Access only the information you need to care for your patients.
- Refrain from discussing patient information in public places.
- Use only your own ID and password to access Epic (the electronic medical record).
- Please limit printing from Epic and do not leave printouts lying around.
- Dispose of printouts or any papers with patient information in recycle bins, not in regular trash.
- **Do not remove documents containing patient information from the hospital** (lab reports, notes, etc.)

Documentation

Epic training is completed via a Web Based Training Module/exam. The HIPAA and Epic exam should be completed within 2 business days prior to the start of your rotation to ensure activation of your Epic Access code.

When logging on to Epic, your “N” number (provided by your instructor) is your user ID. The initial password is “password1$”. You will then be prompted to create your own password.

If you need to have your password reset, ask one of the staff members to call the Helpdesk.

In addition to staff, the SMMC Epic Clinical Documentation Guidelines site on the SMMC Intranet is an online resource on what and where to document care provided to the patient. Please make every attempt to document the care you provide in a timely manner so that the information is available to other team members.
Communication

Effective communication is an essential element of working together for the common goal of patient safety and quality of care. Listed below are several tools adopted at SMMC to enhance communication.

To optimize and standardize nursing communication during patient hand-offs (shift to shift, new admissions from the ED, transfers between units), we use the Professional Exchange Report and ED to Floor Handoff Report in Epic. There are separate versions of the Professional Exchange Report for Adult, OB, and Newborn/NICU. The reports contain information and links to reports/chart activity organized in a manner to facilitate telling the patient's story. Links to both hand-off reports are available on the Nursing Index Report in the patient's Epic chart.

When a patient is transported to a diagnostic area and not accompanied by nursing, the Transportation and Safety Checklist is used to communicate significant patient safety information. Nursing prints the report, fills in additional information (such as RN contact numbers), reviews the report with the person transporting the patient and sends the report with the patient.

In high risk situations, we use SBAR to as a tool to facilitate clear and accurate communication.

- **S**: Situation
- **B**: Background
- **A**: Assessment
- **R**: Recommendation

The way we communicate with patients and families is also an essential element of quality care. AIDET<sup>SM</sup> is a proven framework for structuring patient interactions in ways that decreases patient anxiety, increases compliance and demonstrates that we care about a high level of service excellence.

<table>
<thead>
<tr>
<th>A</th>
<th>Acknowledge</th>
<th>Be polite and respectful. Use a greeting, smile, make eye contact. Acknowledging a person sends a message that they are important to you.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Introduce</td>
<td>Introduce yourself using your name, with your title if appropriate.</td>
</tr>
<tr>
<td>D</td>
<td>Duration</td>
<td>Explain how long evaluation and diagnostic work-up will take, use key words for keeping the patient informed. Providing this information helps to manage patient expectations about time.</td>
</tr>
<tr>
<td>E</td>
<td>Explain</td>
<td>The plan of care, what tests and treatments are to be accomplished, and what you feel is going on.</td>
</tr>
<tr>
<td>T</td>
<td>Thank you</td>
<td>No matter if you are speaking to a patient or colleague or if on the phone or in person, at the end of the conversation add a “thank you”. You can personalize it to a thank you that fits the situation. ( “Thank you for your suggestion”. “Thank you for your patience”. “Thank you for choosing Saddleback”.)</td>
</tr>
</tbody>
</table>

**Teach Back** is an evidence-based method for confirming understanding and improving retention when providing patient education. Provide content in small, manageable chunks using common, everyday language. Ask the patient to repeat in their own words what they understand or to demonstrate what they will do. Don’t assume that being able to verbalize steps equates to correct performance.
**MEWS**

Modified Early Warning Signs (MEWS) score is a tool to promote early identification of clinical changes in the patient and to prevent cardiac arrest. The clinical scores are documented with every vital sign taken in Med/Surg/Telemetry. The ICU, ED and PACU performs MEWS score at the time of transfer out of the unit.

<table>
<thead>
<tr>
<th>Score</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Temperature</strong></td>
<td>X</td>
<td>Less than 95.0 F / 35.0 C</td>
<td>95.1-96.7 F / 35.05-36 C</td>
<td>96.8-100.4 F / 36.05-38 C</td>
<td>100.5-101.3 F / 38.05-38.5 C</td>
<td>More than 101.4 F / 38.55 C</td>
<td>X</td>
</tr>
<tr>
<td><strong>Heart Rate per minute</strong></td>
<td>X</td>
<td>Less than 40</td>
<td>40-50</td>
<td>51-100</td>
<td>101-110</td>
<td>111-130</td>
<td>More than 130</td>
</tr>
<tr>
<td><strong>Respiratory rate per minute</strong></td>
<td>X</td>
<td>Less than 8</td>
<td>8</td>
<td>9-14</td>
<td>15-20</td>
<td>21-30</td>
<td>More than 30</td>
</tr>
<tr>
<td><strong>Systolic Blood Pressure</strong></td>
<td>Less than 70</td>
<td>70.80</td>
<td>81.100</td>
<td>101.150</td>
<td>160.199</td>
<td>200.220</td>
<td>More than 220</td>
</tr>
<tr>
<td><strong>Conscious level Change From Baseline</strong></td>
<td>Unresponsive</td>
<td>Responds to pain</td>
<td>Responds to voice</td>
<td>Alert</td>
<td>Agitation / Confusion</td>
<td>New onset of agitation / confusion</td>
<td>X</td>
</tr>
<tr>
<td><strong>Urine output ml/hour</strong></td>
<td>0-9 ml/hour</td>
<td>10-29 ml/hour</td>
<td>30 ml/hour</td>
<td>ESRD/anuric</td>
<td>31-199 ml/hour</td>
<td>X</td>
<td>&gt;200 ml in absence of diuretic</td>
</tr>
<tr>
<td><strong>Urine totals 2 hours</strong></td>
<td>0-19 ml/2 hour</td>
<td>20-59 ml/2 hour</td>
<td>60 ml/2 hr</td>
<td>61-300 ml/2 hour</td>
<td>X</td>
<td>&gt;400 ml in absence of diuretic</td>
<td>X</td>
</tr>
<tr>
<td><strong>Urine totals 4 hours</strong></td>
<td>0-39 ml/4 hour</td>
<td>40-119 ml/4 hour</td>
<td>120 ml/4 hr</td>
<td>121-799 ml/4 hour</td>
<td>X</td>
<td>&gt;800 ml in absence of diuretic</td>
<td>X</td>
</tr>
<tr>
<td><strong>Urine totals 8 hours</strong></td>
<td>0-79 ml/8 hour</td>
<td>80-230 ml/8 hour</td>
<td>240 ml/6 hr</td>
<td>241-1599 ml/8 hour</td>
<td>X</td>
<td>&gt;1600 ml in absence of diuretic</td>
<td>X</td>
</tr>
</tbody>
</table>

Green = 0 score
- Continue monitoring patient and document vital signs

Yellow = 1-3 score
- PCT/PCA/Student informs primary RN immediately. Patient is reassess every 1-2 hours

Orange = 4-5 score
- PCT/PCA/Student informs primary RN immediately. RN calls *Rapid Response Team*, stays with the patient and continues to assess.

Red = >6 score
- PCT/PCA/Student informs primary RN immediately. RN calls *Rapid Response Team* or *Code Blue* as appropriate, stays with the patient and continues to assess.

**Rapid Response Team and Code Blue**

A Rapid Response Team may be called by staff or family members by dialing 21111.

To initiate Code Blue, use the Code button on the wall panel or dial 21111. Be prepared to provide the team with a report of events leading to the calling of the code. For a cardiac arrest of a pregnant woman, ask the operator to page “OB Code Blue” and the OB/NICU staff will also respond. (Depending on the reason for admission, a pregnant woman may be admitted to any unit in the hospital). You may stay to participate in or observe the code blue response. However, if space is an issue, you may be asked to leave the room.
Patient Identification

Use at least 2 patient identifiers when providing care, treatment, and services. The primary patient identifiers are the patient’s full name and date of birth. The patient’s room or bed number is never used to identify any patient.

To prevent patient identification errors related to diagnostic testing, all specimens must be labeled immediately after collection and in the presence of the patient. All specimen labels need to include: the patient’s full name, medical record number, time & date of collection, initials of the person collecting the specimen and the source (if other than blood).

Universal Protocol  (Applies to all surgical and non-surgical invasive procedures.)

Pre-Procedural Verification Process
Prior to any surgical or non-surgical procedure, we are responsible to verify:
♦ Correct procedure for the correct patient at the correct site.
♦ All required documentation is available including: H&P, signed procedure consent form, nursing assessment and pre-anesthesia assessment, medications; diagnostic and radiology test results; any blood products, implants, devices, and/or special equipment.

For procedures performed in the OR and other procedural areas, nursing completes a checklist (in Epic) prior to sending the patient from the unit. For bedside procedures, the verification process must be completed, but completion of the checklist is not required.

Time-out
A time-out must be conducted immediately before starting the invasive procedure or making the incision. All the team members must agree, at a minimum to the correct:
  • Patient identity,
  • Site/Site, and
  • Procedure to be done.

Medication Administration
♦ Medications must be administered under the supervision of a nursing instructor or staff RN.
♦ In preparation for the implementation of bar code medication administration, patient identification is verified and all meds are administered by bringing a computer to the bedside and not by using a computer printout of the Medication Administration Record (MAR).
♦ All IV drug administration is to be done in accordance with the guidelines and requirements described in the SMMC’s on-line IV Medication Guidelines (a link to the guidelines is on the intranet For Clinician’s page).
♦ Meds requiring an independent double check by 2 RNs: Insulin (SQ and IV), PCA settings and continuous opiate infusions, Heparin IV, 3% Saline, Chemotherapy, Argatroban/lepirudin/bivalirudin, Epidural/Intrathecal/Intraspinal Opiates, Magnesium Sulfate concentrate / high dose (4 GM & 25 GM IV bags), Oxytocin, and Alteplase (tPA).
♦ Unit dose packages are to be opened at the bedside.
♦ Standard start times for new medications:
  STAT: within 30 minutes
  ASAP: within 1 hour
  All other one time doses: within 2 hours
  Time-critical scheduled meds*: within 1 hour
  All other scheduled meds: within 2 hours
♦ Allowable medication administration time variances for scheduled medications:
  Time-critical meds*: 30 minutes before or after scheduled time
  Non-time critical meds: 1 hour before or after scheduled time

*Time critical meds include such meds as those given every 4 hours or more frequently, scheduled opioid for chronic/palliative care, immunosuppressive agents, meds with a critical relationship to meals such as insulin and oral hypoglycemic agents
Fall Prevention

All hospitalized patients have the potential to fall and should have appropriate fall prevention measures in place (such as raised side-rails, bed in low position with wheels locked, non-skid slippers, etc.). Patients who are identified as at moderate risk for falls, have a yellow arm band and a “Fall Alert” sign on the outside door of their room. If the patient is at high fall risk with a risk of harm, a yellow “Falling Star” sign is used. Additional safety measures, (bed alarms, frequent toileting, observational rounds) are put in place based on individual patient need.

Clinical Alarms

The use of alarms is an important patient safety practice. Check all alarm settings for your patients when rounding. It is everyone’s responsibility to respond to alarms.

**Stryker bed alarms:** All patients should have bed alarm set at Zone 1. The patient does have the right to refuse the bed alarm. Patient refusal of bed alarms must be documented. The alarm is set at Zone 2 if the patient has had a fall during the current admission or within 6 months prior to admission.

When the patient is a fall risk, a chair alarm should be used when out of bed.

Pulse oximeter alarms are to be responded to in person. The oximeter should be plugged in to the call light system to facilitate prompt response.

Suicide Risk

If a patient exhibits behaviors indicating a risk for suicide, an initial assessment is completed by an RN or MD within 24 hours of admission or by the completion of the ED visit. The assessment will help to determine the degree of lethality. A safety attendant will be assigned to the patient.

Sitters and Safety Attendants

For patients who are assessed to be at risk for harm, the hospital may decide it is appropriate to provide sitter or safety attendant:

A **Sitter** is a staff or registry PCT/PCA, a family member or other individual who stays with a confused or otherwise disabled patient.

A **Patient Safety Attendant** is a staff member who has been trained on maintaining a safe environment to prevent injury to the patient or others. In addition to providing individualized care, the safety attendant:

- Works with the primary nurse to clear the room of any sharp or dangerous items
- Remains with the patient at all times to ensure continuous observation (including bathroom visits, transfers to radiology or other departments, change of shift, etc.). The safety attendant is not to read, study, socialize, sleep or attend to anything but the patient, even when the patient is sleeping.
- Asks visitors if they have checked in at the nurse’s station prior to entering the room
- If visitors leave items, ask to inspect them to be sure no sharp or dangerous objects are present. If present, remove the items and notify the nurse.

**Restraints**

Our goal is to reduce, prevent or eliminate the use of restraints. They are only implemented as a last resort.
Cultural Diversity and Sensitivity

It is essential to the mission, vision and core values of SMMC that all employees, volunteers and physicians deliver care that is compassionate and respectful to the needs of patients and families of all ages, cultures, religious beliefs and lifestyles. It is also essential that we respect fellow employees, volunteers and physicians in the same way.

Language Interpreters are available and should be used when there is a language barrier present. AT&T Language Line interpreters can be used via a language line phone that is available on each patient care unit.

American Sign Language interpreters can be accessed via the Dayle MacIntosh Center (800) 422-7444.

Social Services and Chaplains are available for assistance in dealing with culturally sensitive issues (after hours, the hospital operator will provide access to a social worker or chaplain).

Newborn Abandonment Policy

California law does not hold parents and/or legal custodians criminally liable for abuse and neglect when they voluntarily surrender newborns 72 hours old or younger to any public or private hospital or fire station.

Based on the California law, SMMC authorizes the emergency department (ED) registered nurses to accept custody of these newborns and implement other mandatory responsibilities.

In the event an attempt is made by an individual to surrender a newborn to anyone other than an emergency department RN, that employee, volunteer or contracted services employee will escort the individual to the ED to assume physical custody of the child.

Abuse Recognition and Reporting

SMMC requires any health practitioner or volunteer in the facility, who has knowledge of, or observes a patient whom he/she suspects has suffered an injury as a result of an abusive relationship to report this to the local law enforcement agency. Assistance with reporting can be obtained from the social service or chaplaincy departments.
Infection Prevention
MemorialCare® has a goal for reducing hospital-acquired infections to the “Zero Zone” (rare to none) and increasing hand hygiene compliance to 100%.

Hand Hygiene
Hand hygiene is the single most important thing you can do to prevent the spread of infection. All staff and students are expected to perform hand hygiene before direct (ungloved) patient contact, before preparing or administering medications, and after patient contact or any situation during which microbial contamination of hands is likely.

Alcohol-based hand cleanser dispensers are located throughout the hospital. Soap and water is recommended when hands are visibly soiled or when providing care for patients with diarrhea.

Artificial nails and nail tips have been implicated in hospital acquired infections and are prohibited for all direct patient care providers.

Personal Protective Equipment (PPE) is clothing or equipment that puts a barrier between you and a patient’s blood or body fluids. When required, don PPE before entering the room. Remove & discard before exiting the room except for masks when in an airborne isolation room.

Isolation Precautions

Standard Precautions are used for all patients regardless of diagnosis.

Transmission Based Precautions are used for patients known or suspected to be infected or colonized with epidemiologically important pathogens that can be transmitted through the air or by direct contact. They are used in addition to, not instead of, Standard Precautions. Patients may be on more than one type of transmission based precautions for disease with multiple routes of transmissions.

All linen is handled as potentially infectious regardless of the patient source. Regardless of isolation status, there is no need to red bag linen unless it is dripping with blood. Disposable trays, dishes and utensils are used for patients in isolation.

<table>
<thead>
<tr>
<th>Precaution</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| **Airborne Precautions**          | ◊ Negative pressure rooms  
| For microorganisms that remain suspended in the air for long periods | ◊ Both rooms doors remain closed  
|                                   | ◊ An N95 mask is required when entering room  
|                                   | ◊ A surgical mask is placed on patient for transport                        |
| **Droplet Precautions**           | ◊ Private room (negative pressure not required). If a private room is not available, the patient will be cohorted with a patient infected with the same organism  
| For microorganisms transmitted via droplets are dispersed in the air when an infected person coughs, sneezes or talks | ◊ Wear a surgical mask upon entering the room  
|                                   | ◊ Surgical mask on the patient for transport                                 |
| **Contact Precautions**           | ◊ Wear gloves upon entering the room  
| To prevent transmission of infection from direct person to person spread. | ◊ Use a gown if there’s a potential for contamination of your clothing  
|                                   | ◊ Wear a mask if the patient has MRSA in the respiratory tract  
|                                   | ◊ Reusable equipment is cleaned prior to being taken out of the room         |
Linens
- Use linens judiciously, only bringing to the patient room the necessary amount of linen.
- Use Standard Precautions with all soiled linen. Fold or roll soiled portion into center of bundle and keep away from uniform.
- Bag soiled linen in the area where generated.
- Do not fill linen bag beyond 2/3 of its capacity.
- Double bag linen if the outside of the bag is visibly soiled.

Medical Waste
Medical waste includes:
- Blood Products
- Any item soiled with blood to the extent that the blood separates from the item (drips)
- Body fluid filled containers
- All sharps/needles
- Pathological specimens, lab specimens
- Transfusion bags and tubing

Medical waste is disposed of in the red biohazardous waste bags/containers or in red sharps containers (needles and sharps).

Chemical Spills
Building Services provides a team of trained employees to assist with pick up of chemical spills.

For large spills:
- Confine the spill area
- Call Building Services/Housekeeping Supervisor
- Refer to MSDS for hazards/precautions

Material Safety Data Sheets (MSDS) give detailed information about hazardous materials including chemical/generic name, ingredients, health hazards & first aid, fire hazards and transportation & handling instructions. The MS Online link on the SMMC intranet home page provide access to the MSDS for hazardous materials used at the hospital.

Medical Equipment Malfunctions
If you encounter a piece of equipment that isn’t working properly notify the RN so that the equipment can be isolated and tagged for service.
# Emergency Procedures

In the event of an emergency, please follow the directions of SMMC staff.

To report an emergency, call 21111 from any in-house phone.

<table>
<thead>
<tr>
<th>Overhead Page</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code Red</strong></td>
<td>If you are at the point of origin, follow the steps for <strong>RACE</strong>:  &lt;br&gt; Rescue anyone in danger  &lt;br&gt; Activate the alarm  &lt;br&gt; Confine the fire (close doors)  &lt;br&gt; Extinguish  &lt;br&gt; Fire Alarm Pull Stations are located at every fire exit, building separation and escape corridor.  &lt;br&gt; If you need to use a fire extinguisher, follow the steps for <strong>PASS</strong>:  &lt;br&gt; Pull the pin  &lt;br&gt; Aim at the base of the fire  &lt;br&gt; Squeeze the handle  &lt;br&gt; Sweep side to side  &lt;br&gt; In all areas, fire extinguishers are located 150 feet apart and in the direction of departure.  &lt;br&gt; If you are away from the fire’s point of origin: close all doors and windows and clear the hallways. Check for signs of smoke or fire. Prepare fire extinguishers, identify exits. Listen to the overhead page for instructions. Reassure patients and visitors that they are your first priority.</td>
</tr>
<tr>
<td><strong>Fire</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Code Pink</strong></td>
<td>◊ Available staff report to nearest hospital exit and monitor for any suspicious persons; if exits are guarded, patrol hallways &amp; stair wells  &lt;br&gt; ◊ Ask those leaving to remain until the emergency is over and attempt to obtain the ID of those who do leave.  &lt;br&gt; ◊ Ask politely to check contents of parcels and bags.  &lt;br&gt; ◊ Remain on guard until relieved by security or “Code Pink all clear” is paged.</td>
</tr>
<tr>
<td><strong>Infant abduction</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Code Gray</strong></td>
<td>Security and other able-bodied personnel respond</td>
</tr>
<tr>
<td><strong>Threat of violence</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Code Silver</strong></td>
<td>◊ Security staff will respond and law enforcement will be summoned.  &lt;br&gt; ◊ Exit or stay away from area involved. Close all doors to rooms, exits, etc.  &lt;br&gt; ◊ Remain calm and assist law enforcement as necessary</td>
</tr>
<tr>
<td><strong>Weapon or hostage situation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Code Yellow</strong></td>
<td>If you receive a bomb threat over the phone:  &lt;br&gt; ◊ Keep the person on the line and obtain as much information as possible (location, detonation time, etc.)  &lt;br&gt; ◊ Listen for any background noises, accent, unusual phrases, etc. that could help identify the caller.  &lt;br&gt; ◊ Notify the hospital operator immediately; use a second person if necessary.</td>
</tr>
<tr>
<td><strong>Bomb threat</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Code Triage</strong></td>
<td>“Code Triage Internal” is page for damage to the medical center  &lt;br&gt; “Code Triage External” indicates an external disaster with potential for multiple casualties  &lt;br&gt; Follow the directions of your instructor and hospital staff.</td>
</tr>
<tr>
<td><strong>Disaster</strong></td>
<td></td>
</tr>
</tbody>
</table>
Professional Courtesy Behaviors

Social conversations should be held to break times in an area where staff and patients cannot hear the conversation.

Students should not cluster together on the floors. No more than “two at a time” works best.

Be observant as to whether any staff or physicians need a computer. Limit computer time to less than 20 minutes per sitting.

Please be considerate of staff use the break rooms for breaks or meals. Ask your instructor for appropriate areas for you to use for breaks or other school related activities.

Thank you for your attention to these professional courtesy behaviors.