The Joint Commission Continuous Compliance Pocket Guide

Naval Medical Readiness and Training Command Yokosuka (NMRTCY)
Japan
Here to **SERVE** with **CARE**

Image **QR code** for the most up to date digital PDF version

Updated: 28May2023

Table of Contents

NMRTC Yokosuka Commander's Guidance

MISSION

USNMRTC Yokosuka is strategically placed to generate readiness, drive operational performance, maximize health, and project medical power in the INDOPACOM AOR through a determined military posture built upon a solid foundation of dominant Naval Forces and strong alliances.

VISION

Warfighter Support. Always Ready.

COMMAND PHILOSOPHY

You are leaders: As Ambassadors for the Navy and NMRTC Yokosuka, our success depends on you. We shall carry ourselves with the utmost integrity, earning trust through timely and compassionate care for our service members and their families who place their lives in our hands.

As leaders: I Trust that you will constantly hone your competency and character. While this occurs mainly on the job, it must include character development and your commitment to our core values and your shipmates.

Self-awareness: You need to be willing to reflect on how you lead and accept responsibility to lead by example. Our strength lies in our ability to reassess and adapt to change; self-awareness affords us that ability.

One team, one Navy! You will be amazed by what we can do together! Treat all with dignity and respect. A mentor, a Chief, or a Department Head can serve to guide you along the way. Grow through these relationships. Seek them out!

TJC Survey Overview

Every three years, The Joint Commission (TJC) surveys NMRTC Yokosuka. During these surveys, a multidisciplinary team consisting of physicians, nurses, ambulatory, behavioral health, and life safety surveyors is on-site for three to five days. During this time, they review policies and procedures; conduct individual, system, and program-specific tracers to discern our compliance with TJC standards; and, if compliant, grant the Yokosuka enterprise a renewed accreditation and certification.

NMRTC Yokosuka has two accreditations: Hospital and Behavioral Health, and two certifications: Patient-Centered Medical Home (PCMH) and Laboratory. There are 20 applicable TJC chapters consisting of over 300 standards and more than 2,000 Elements of Performance (EP) in which to sustain compliance. We trace our compliance via the EOC/TJC Rounds program and score ourselves in the *Tracers with AMP®* system. Successful surveys earn the gold seal of approval.

Tracer Methodologies

Individual tracers: These tracers are designed to "trace" the care experiences that a patient had while receiving services from the organization. It is a way to analyze the organization's system of providing care, treatment, or services using actual patients as the framework for assessing standards compliance. Patients selected for these tracers will likely be those in high-risk areas or whose diagnosis, age, or type of services received may enable the best in-depth evaluation of the organization's processes and practices.

System tracers: While individual tracers follow a patient through their course of care, the system tracer evaluates the system or process, including the integration of related functions and the coordination and communication among disciplines and departments in those processes. The three assessed topics by system tracers are data management, infection control, and medication management.

Program-specific tracers: These tracers aim to identify risk points and safety concerns within different levels and types of care, treatment, or services. Program-specific tracers focus on critical issues relevant to the organization — such as clinical services offered and high-risk, high-volume patient populations.

Your Participation in the Survey

- Know the standards!
- Keep the conversation professional
- Ask questions if you don't understand.
- NEVER argue with the surveyors. They know what they're talking about. Be professional and use appropriate language and behavior.
- If you don't know an answer, say so, and tell the surveyor where or whom you would go to for the answer. Remember you may use any available resources, such as the intranet, policies, badge information, department resources, or supervisor.

- Keep your answers brief, focused, and specific.
- If you are present when someone else is being interviewed, please add any relevant information without being intrusive.
- Respond to questions with confidence—you know the answers better than anyone. Speak freely about all the great things we do—and there are many!

- Success is dependent on teamwork. Excellent patient care is no different. Your communication and interaction with other staff members of the healthcare team are critical to providing excellent care for the patient!

DO's

- Greet the surveyor and honestly answer the question(s) you are asked.
- Use phrases like, "Our policy/procedure/process is…"
- If you don't know the answer to a question, it's OK. Be honest and state, "I am not sure; let me find my supervisor for clarification."
- Emphasize that we are always looking for ways to improve our programs. We work as a team!
- Know where to find all required manuals and documents for your department/unit. If online, know how to navigate and access them.

This shows how staff are aware and know how to go about finding information. This may include referencing a policy manual, contacting a supervisor, or calling another department

DON'T's

- Attempt to hide, ignore, avoid, or run from the surveyors unless you are involved in a patient's care that would prohibit you from responding!
- Panic. Relax and take a deep breath. It's ok!
- Volunteer unrelated information.
- Use phrases that will demonstrate inconsistencies, such as, "It should be…," "Usually we…," or "Most of the time…".
- Let the surveyor make you feel defensive.
- Attempt to answer a question by assuming what the documentation was intended to mean; let the record speak for itself.

These phrases will lead the surveyors to ask more questions

The SAFER® Matrix

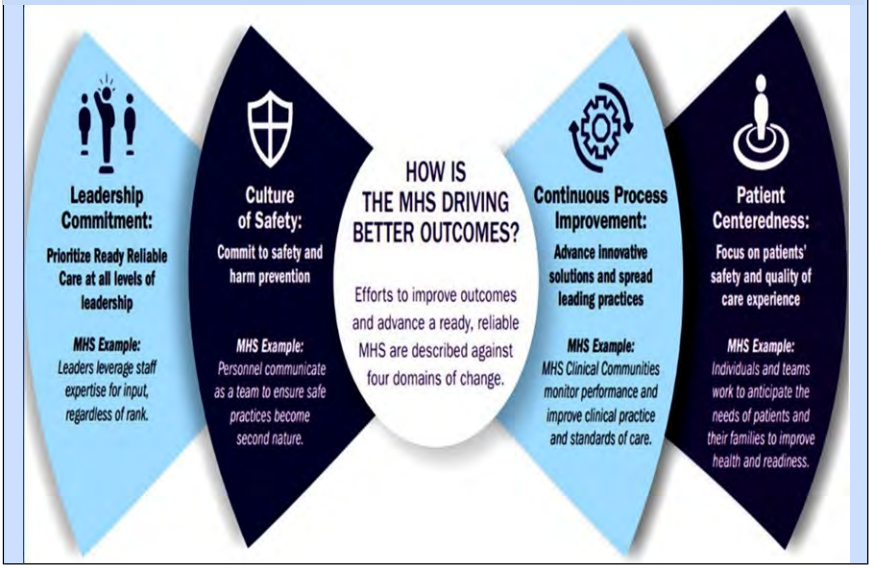
"SAFER® is the *Survey Analysis for Evaluating Risk®* process, a scoring approach used for surveys and reviews of health care organizations. The performance expectations for determining if a standard is in compliance are included in its elements of performance (EPs). If an EP is determined to be out of compliance, it will be cited as a Requirement for Improvement (RFI). Each RFI is placed in the SAFER Matrix according to how likely it is that the RFI will harm a patient(s), staff, or visitor (low, moderate, high) and the scope, or prevalence, at which the RFI was cited (limited, pattern, widespread). As the risk level of a finding or an observation increases, the placement of the standard and EP moves from the bottom left corner (lowest risk level) to the upper right corner (highest risk level)." (TJC)

Ready Reliable Care

READY RELIABLE CARE ANYTIME, ANYWHERE

MHS COMMITMENT TO HIGH RELIABILITY

Ready Reliable Care is the DHA-led effort to advance high reliability across the MHS. Our nation's fighting forces rely on us to provide high-quality care and trust us with their lives and the lives of their loved ones. Through a personal commitment to high reliability, we can deliver on our promise of great outcomes, a ready medical force, satisfied beneficiaries, and fulfilled staff.



Ready Reliable Care

ALL Leadership, staff, and patients contribute to the MHS' high reliability and improvements by applying the Seven *Principles* in their daily work within the four *Domains of Change*.

Patient Safety Program

The MISSION of Patient Safety is to promote a culture of safety to eliminate preventable patient harm by engaging, educating, and equipping patient-care teams to institutionalize evidence-based safe practices

Patient Safety's VISION is to support the military mission by building organizational commitment and capacity to implement and sustain a culture of safety to protect the health of the patients entrusted to our care.

NMRTCY Executive Leadership and staff are strong supporters of patient safety. The GOAL of the Patient Safety Program is to prevent avoidable patient harm. No patient harm is accomplished by:

- Identifying and reporting adverse events (including Sentinel Events) and near misses
- Reviewing adverse events in a fair and just way. We strive to understand how systems and processes may have contributed to the adverse event instead of just looking at the individual involved in the event
- Disseminating patient safety alerts and lessons learned
- Conducting proactive risk assessments – focusing on prevention!
- Partnering with patients and their families, which includes disclosing errors

If we do not provide resolution to adequately prevent or correct problems that can have or have had a serious adverse impact on patients, you may contact The Joint Commission regarding your concerns without fear of disciplinary or punitive action. Further information is available at www.jointcommission.org

Quality & Patient Safety Resources

Patient Safety Learning Center (PSLC)
https://info.health.mil/hco/clinicsup/patientsafety/PSLCHome/SitePages/PSAC.aspx

DHA Patient Safety Program
https://info.health.mil/hco/clinicsup/patientsafety/Pages/Home.aspx

National Patient Safety Goals
https://www.jointcommission.org/standards/national-patient-safety-goals/

TJC Patient Safety Fact Sheet
https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-patient-safety/

Joint Patient Safety Reporting System (JPSR)
https://patientsafety.csd.disa.mil/

Patient Safety Reporting (PSR)

Event reporting is done through the JPSR, linked on your desktop, indicated by this icon. Choose DHA > CAC Login > "Report Event" on the top left. The PSM is notified upon reporting, at which point an investigation is initiated. You have a choice of anonymous reporting or not.

Patient Safety/Risk Management
315-243-8638/9194

What Types of Incidents Should You Report?

Errors	Near Misses
An unintended act, either by omission or commission, or an action that does not achieve its intended outcomes.	A process variation that did not reach the patient but for which a recurrence carries a significant chance of a severe adverse outcome.
Hazardous Conditions	**Sentinel Events**
Any set of circumstances (unrelated to the patient's condition) which significantly increases the likelihood of a serious adverse outcome.	An unexpected occurrence that results in death or serious injury or outcome unrelated to the patient's course of illness. More details on the next page.

Note: Report needle sticks on a Bloodborne Pathogen Exposure Report form available on the intranet under "Reference Materials". Report staff injuries/illnesses online using a Supervisor's Report of Injury/Illness form through ESAMS under "My Tools".

Sentinel Events

- Death
- Permanent disability
- Severe temporary disability

A Sentinel Event can also be one of the following:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department
- Unanticipated death of a full-term infant
- Abduction of any patient receiving care, treatment, and services
- Discharge of an infant to the wrong family
- Any elopement (that is, unauthorized departure) of a patient from an around-the-clock care setting or within 72 hours of discharge, including from the ED, leading to death, permanent harm, or severe patient harm.
- Rape. Assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on-site at the hospital
- Wrong site surgery
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on-site at the hospital
- Hemolytic transfusion reaction involving the administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Unidentified retained foreign object
- Severe neonatal hyperbilirubinemia (bilirubin >30mg/dl)
- Prolonged fluoroscopy with cumulative does >1500 rids to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- Any intrapartum (related to the birth process) maternal death or severe maternal morbidity
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care

Employee Responsibilities in a Sentinel Event

- Immediately notify the Patient Safety/RiskManagement Office and your supervisor of a possible Sentinel Event.
- Secure all evidence and documentation about the event (equipment, syringes, IV bags, medication, vials, etc.).
- DO NOT change any settings on the equipment.
- Participate in the investigation of the root cause analysis if requested.
- Participate in changes to systems/processes to reduce the risk of reoccurrence.

What Happens to a PSR After You Submit It?

- The Patient Safety Office reviews the event, collects any additional information needed, and assigns a severity score that determines other review requirements, such as a Human Factors Analysis and Classification System (HFACS) or reporting to The Joint Commission.
- Data from event reports are analyzed, collated, and shared with leadership and appropriate committees to improve patient safety.

Please read NAVHOSPYOKO Instruction 6010.23 for more.

Good Catch Awards!

A GOOD CATCH is a problem or error that almost got to the patient but didn't because you caught it first and corrected it. Think of it as, "*Wow, that was a close...*"

Any employee may submit a Good Catch award here: https://esportal.med.navy.mil/sites/yoko/Apps/Pages/Good%20Catch%20Culture%20of%20Safety.aspx

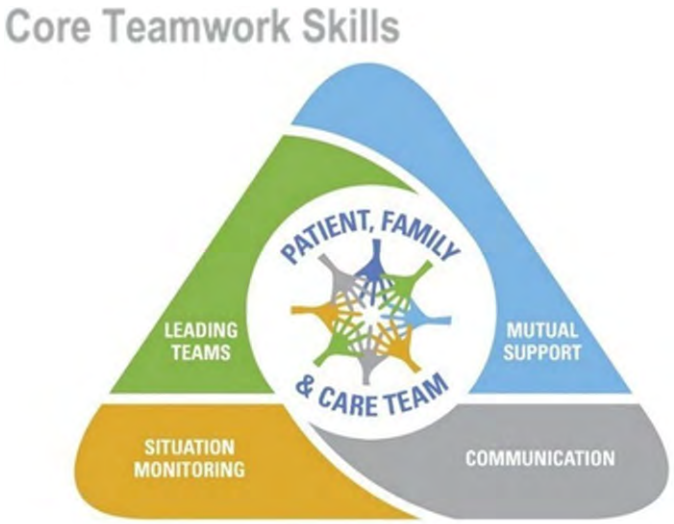
Award submissions are reviewed by the Patient Safety Manager and Quality Council members to determine applicability. Awards will be presented in the weeks to follow.

What are examples of a Good Catch?

- Incorrect medication orders
- Wrong labeling or patient identification on specimens
- Missed information
- Insufficient follow-up
- Patient consent inconsistencies
- A medication error that did not reach the patient
- Recognizing trip hazards or other unsafe conditions
- Identifying a patient's pre-procedural information was not updated or was not accurate before performing a procedure

TeamSTEPPS®

Team Strategies and Tools to Enhance Performance and Patient Safety

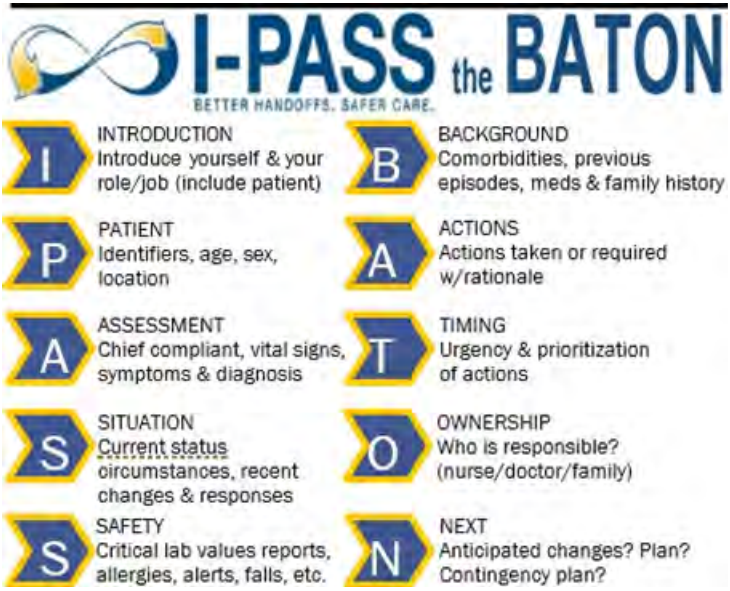


An evidence-based framework to optimize team performance across the healthcare delivery system. The core of the **TeamSTEPPS®** framework comprises **Four Skills**: Leadership Teams, Situation Monitoring, Mutual Support, and Communication. TeamSTEPPS® provides higher quality, safer patient care by producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients; increasing team awareness and clarifying team roles and responsibilities; resolving conflicts and improving information sharing; eliminating barriers to quality and safety.

TeamSTEPPS® is the structure of communication used at NMRTCY.

TeamSTEPPS Tools: SBAR & I-PASS

S	**Situation:** patient's / client's details - identify reason for this communication, describe your concern
B	**Background:** relating to the patient / client, significant history - this may include medications, investigations, treatments
A	**Assessment:** your assessment of the patient / client or situation - this can include clinical impression, concerns, vital signs, early warning score
R	**Recommendations:** be specific - explain what you need, make suggestions, clarify expectations, confirm actions to be taken



You are the Patient Experience

We provide personalized and compassionate care in a healing and welcoming environment for every patient.

H.E.A.R.T.

Hear what the person is saying
Empathize with the person's concern
Acknowledge the patient's concern
Review the details
Take responsibility for follow-through

C.L.E.A.R.

Connect with the person ASAP
Listen to what the person is saying
Explain things in understandable terms
Ask key questions at key times
Re-connect when the interaction is over

Patients are key members of our healthcare team.

Remind patients of these key points:

- Speak up if you have questions or concerns and ask again if you don't understand
- Pay attention to the care you are receiving. Make sure it matches what your health care team planned
- Educate yourself about your diagnosis, tests, and treatment
- Ask a trusted family member or friend to be your advocate
- Know what medications you take and why
- Use a credible health care facility
- Participate in all decisions about your treatment

National Patient Safety Goals

1. Identify patients correctly – Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to ensure that each patient gets the correct medicine and treatment.
2. Improve staff communication – Get important test results to the right staff person on time
3. Use medications safety:
   a. Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups, and basins. Do this in the area where medicines and supplies are set up.
   b. Take extra care with patients who take medicines to thin their blood.
   c. Record and pass along correct information about a patient's medicines. Find out what medications the patient is taking. Compare those medicines to new medications given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
4. Use alarms safely – Make improvements to ensure that alarms on medical equipment are heard and responded to on time
5. Prevent infection – Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
6. Identify patient safety risks – Reduce the risk for suicide
7. Prevent mistakes in surgery:
   a. Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
   b. Mark the correct place on the patient's body where the surgery is to be done.
   c. Pause before the surgery to make sure that a mistake is not being made

Useful links:

TJC Universal Protocol Poster
Official "Do Not Use" List of Abbreviations
TJC National Patient Safety Goals Poster
NMRTCY Instructions
Look Alike Sound Alike Drug List

National Patient Safety Goals

UNIVERSAL PROTOCOL
PREVENT MISTAKES IN SURGERY

*Follow the Universal Protocol Safety Checks – EVERY TIME
The 3 phases of UP applies to all inpatient and outpatient procedures that expose patients to more than minimal risk.

3 phases of Universal Protocol:

1. Pre-Procedure Verification
2. Mark the Procedure Site
3. Time Out Procedure by the Entire Team

YOU MUST DOCUMENT TIME OUT PROCEDURES

DHA UP Protocol Checklist Procedural Area DHA Form 229

DHA UP Checklist Operating Room: DHA Form 228

ESSENTRIS OR GENESIS:
--MultiD Universal Protocol
-Universal Protocol

Dental Universal Protocol: DHA Form 205, Dental UP Checklist

DHA Procedure Instruction 6025.44
DHA Procedure Instruction 6410.02

National Patient Safety Goals

UNIVERSAL PROTOCOL

The Universal Protocol applies to all surgical and nonsurgical invasive procedures, and is based on the following principles:

- Wrong person, wrong-site and wrong-procedure surgery can and must be prevented
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success
- To the extent possible, the patient and, as needed, the family are involved in the process
- Consistent implementation of a standardized protocol is most effective in achieving safety

The Universal Protocol also applies for invasive and other procedures performed outside the operating room and procedural areas, such as at the **bedside** and in the **clinics**!

You MUST document one of these forms for the procedure:

DHA Form 228 (OR) **Required for OR procedures**
DHA Form 229 (Clinic) **Required for All Clinical Procedures**
DHA Form 205 (Dental) **Required for All Dental Procedures**

National Patient Safety Goals

UNIVERSAL PROTOCOL

SpeakUP™

The Universal Protocol

for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

Guidance for health care professionals

This document has been adapted from the Universal Protocol. For specific requirements of the Universal Protocol, see The Joint Commission standards.

Conduct a pre-procedure verification process

Address missing information or discrepancies before starting the procedure.

- Verify the correct procedure, for the correct patient, at the correct site.
- When possible, involve the patient in the verification process.
- Identify the items that must be available for the procedure.
- Use a standardized list to verify the availability of items for the procedure. (It is not necessary to document that the list was used for each patient.) At a minimum, these items include:
  - ❑ relevant documentation
    Examples: history and physical, signed consent form, preanesthesia assessment
  - ❑ labeled diagnostic and radiology test results that are properly displayed
    Examples: radiology images and scans, pathology reports, biopsy reports
  - ❑ any required blood products, implants, devices, special equipment
- Match the items that are to be available in the procedure area to the patient.

Mark the procedure site

At a minimum, mark the site when there is more than one possible location for the procedure and when performing the procedure in a different location could harm the patient.

- For spinal procedures: Mark the general spinal region on the skin. Special intraoperative imaging techniques may be used to locate and mark the exact vertebral level.
- Mark the site before the procedure is performed.
- If possible, involve the patient in the site marking process.
- The site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed.
- In limited circumstances, site marking may be delegated to some medical residents, physician assistants (P.A.), or advanced practice registered nurses (A.P.R.N.).
- Ultimately, the licensed independent practitioner is accountable for the procedure – even when delegating site marking.
- The mark is unambiguous and is used consistently throughout the organization.
- The mark is made at or near the procedure site.
- The mark is sufficiently permanent to be visible after skin preparation and draping.
- Adhesive markers are not the sole means of marking the site.
- For patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (see examples below): Use your organization's written, alternative process to ensure that the correct site is operated on. Examples of situations that involve alternative processes:
  - ❑ mucosal surfaces or perineum
  - ❑ minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
  - ❑ teeth
  - ❑ premature infants, for whom the mark may cause a permanent tattoo

Perform a time-out

The procedure is not started until all questions or concerns are resolved.

- Conduct a time-out immediately before starting the invasive procedure or making the incision.
- A designated member of the team starts the time-out.
- The time-out is standardized.
- The time-out involves the immediate members of the procedure team: the individual performing the procedure, anesthesia providers, circulating nurse, operating room technician, and other active participants who will be participating in the procedure from the beginning.
- All relevant members of the procedure team actively communicate during the time-out.
- During the time-out, the team members agree, at a minimum, on the following:
  - ❑ correct patient identity
  - ❑ correct site
  - ❑ procedure to be done
- When the same patient has two or more procedures: If the person performing the procedure changes, another time-out needs to be performed before starting each procedure.
- Document the completion of the time-out. The organization determines the amount and type of documentation.

National Patient Safety Goals

UNIVERSAL PROTOCOL

Verify the correct patient, correct procedure, and correct site...

- at the time of scheduling
- at the time of admission
- anytime responsibility for care is transferred
- with the patient awake and involved
- before leaving the preprocedural area or entering procedural area

Use a checklist to assure you have...

- relevant documentation, including signed procedure consent form
- labeled diagnostic and radiology test results
- any required blood products, implants, devices, and/or special equipment needed

UP.01.01.01

Conduct a pre-procedure verification process

- Mark at or near the site
- Unambiguous mark
- Mark visible after prep and draping
- Performed by person performing the procedure
- Involves the patient – awake and aware
- There is an alternative process for patients who refuse site marking or for when it is technically or anatomically impossible or impractical to mark the site.

UP.01.02.01

Mark the procedure site

Performance Improvement

NMRTCY is committed to delivering safe quality health care with zero preventable patient harm and demonstrating the tenets of high-reliability organizations (HROs). As a military institution, our command's critical mission priorities are warfighter readiness, medical force generation, and high-quality healthcare. NMRTCY is dedicated to achieving the three high-reliability objectives: leadership commitment to zero preventable patient harm, safety culture practiced throughout the organization, and the widespread use of robust process improvement initiatives. NMRTCY supports an annual CPI Fair to showcase CPI projects completed by staff.

- What CPI projects are YOU working on in YOUR workspace?
- How does YOUR project align with DHA priorities?
- If YOU have an idea for an improvement, who would you ask for help?

NMRTC Master Black Belt

315-243-8511

Continuous Process Improvement (CPI)

BASIC

ADVANCED

Methodologies: Depending on the project's complexity, various methodologies may be utilized to make improvements at NMRTC.
Sort, Straighten, Shine, Standardize, Sustain (5S) • Workplace organizing • May be performed by any staff member
Just Do It (JDI) • The apparent solution is known and takes little effort to implement • Minimal resources needed to complete • It may be done solo or as a team with a leader • Teams consist of staff members working on the process being improved
Plan-Do-Study-Act (PDSA) • Examines a process utilizing the four steps to continuously improve each cycle • Utilizes a team that any staff member may lead • Teams consist of subject matter experts (SME)
Rapid Improvement Event (RIE/Lean) • Root cause known/solution unknown • Reduce steps/eliminate waste • It may be led by a Green Belt (GB) or Black Belt (BB)
Define, Measure, Analyze, Improve, Control (DMAIC) • Six Sigma methodology to reduce variation • Metric needs improvement but the root cause/solution is unknown • May be led by a Black Belt (BB) or Green Belt (GB) with a BB mentor
8-step A3 Practical Problem-Solving Model • A methodical and data-driven process that logically dissects and resolves a measurable problem • Incorporates many Lean Six Sigma tools and techniques • Scalable in size from Department to Enterprise problems • Requires a multidisciplinary team of stakeholders • May be led by a Black Belt (BB) or Green Belt (GB) with a BB mentor

Fall Prevention & Post-Fall Management

In Inpatient and ED Setting

- Assess all patients within 4 hours of admission or transfer to the unit, every shift after that, or when a significant change in status occurs.
- Inpatient patients aged 5 and older are assessed using the Morse Fall Scale
- ED patients aged 5 and older are assessed using Kinder Fall Assessment
- Pediatric patients under 4 years of age are considered a high fall risk
- A YELLOW wristband is applied to patients with high and moderate fall risk that are 5 years and older.

In Outpatient Setting

- All clinical areas will develop clinic standard operating procedures (SOP) for preventing falls based on risk assessment of the patient population seen in the clinic.
- Examples of high-risk patients:
  - Pediatric age 4 and under
  - Elderly patients
  - Patients having outpatient procedures or receiving medication that may temporarily increase fall risk

Post-Fall Assessment and Evaluation

- Un-witnessed inpatient falls require prompt patient evaluation
- Un-witnessed outpatient falls require ED evaluation
- Document assessment in Essentris / (MHS Genesis - Oct 2023)
- Consider imaging for patients at high risk for intracranial bleeding, like patients on anticoagulants, patients with altered mental status before the fall, or un-witnessed falls
- Complete Electronic Event Report (PSR) to Patient Safety

Infection Prevention & Control
Hand Hygiene

WHEN DO YOU WASH YOUR HANDS WITH SOAP AND WATER?

- When hands are visibly dirty or contaminated with blood or other body fluids
- When working with patients with known or suspected infections from spore-forming bacteria (e.g., Clostridium difficile) hands should be washed to physically remove spores from the surface of contaminated hands

WHEN TO USE ALCOHOL BASED HAND RUB AS HAND ANTI-SEPSIS?

- When hands are not visibly soiled and to reduce bacterial counts on hands

Hand Hygiene

Important HAND HYGIENE Points

√ Jewelry should be removed prior to hand cleaning.
√ Artificial nails **may not** be worn by employees who provide direct patient care or who handle or prepare food or medications.
√ Natural nails should not exceed 1/4 inch from the fingertip. Polish may be worn when well manicured and not chipped.
√ When Gloving:

- Perform hand hygiene **prior** to putting on gloves
- Wear gloves when in contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur.
- Change gloves during patient care if moving from a contaminated body site to a clean body site.
- Do not use the same gloves for the care of more than one patient.

How do we communicate Infection Control practices throughout NMRTCY?

The Infection Prevention and Control Manual, which acts as both a guide and reference is accessible on the NMRTCY intranet.

Our Infection Prevention Control Division conducts surveillance, education, and consultation. If you have any questions or concerns, documents and information are available on the Infection Control SharePoint page.

Questions regarding
Infection Prevention & Control CALL

315-243-5893

Bloodborne Pathogens

- Do you handle contaminated items or surfaces?
- Do you come in DIRECT CONTACT with blood, mucus membranes, non-intact skin?
- Do you perform vascular access procedures?

If yes, then you are at risk for exposure to **Bloodborne Pathogens.**

BLOODBORNE PATHOGEN EXPOSURE PROTOCOL

FAST

FLUSH	F– Flush the site/FIRST AID
ALERT	A– Alert supervisor or charge nurse of exposed individual Note: Supervisor initiates reporting requirements
STRAIGHT	S– Report Straight to Emergency Department Triage Area Note: Staff assigned to Naval Health Branch Clinics and outlying clinics may initially report to a physician, nurse practitioner, or physician's assistant to avoid delays in treatment
TIMELY	T– Timely Treatment Goal

In 1996, the CDC recommended the adoption of an infection control system, ***standard precautions,*** that effectively merged the most beneficial aspects of the **universal precautions** and **body substance isolation approaches.**

Source: Garner JS: Guideline for isolation precautions in hospitals.

Standard Precautions

An approach to infection control that treats all body fluids and substances as if they were infectious for Bloodborne Pathogens. The use of standard precautions is determined by the nature of the patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure. In other words,…" *treat all blood and body fluids as potentially infectious materials with appropriate precautions*".

Core Elements of Standard Precautions

- Use personal protective equipment (PPE): gloves, gown, mask, and face shield.
- Aseptic technique, including appropriate use of skin disinfectants.
- Personal hygiene practices, particularly handwashing and hand hygiene, and cough etiquette.
- Appropriate handling and disposal of sharps and clinical waste.
- Appropriate reprocessing of reusable equipment and instruments, including proper use of disinfectants.
- Environmental controls, including design and maintenance of premises, cleaning, and spills management

Infection Control Improvement Opportunities

- Are the hand antiseptic dispensers in your area working and filled?
- Do you have approved disinfectant wipes available?
- Do you know the contact time (the time the surface must remain wet) for the disinfectant you are using?
- Answer: At NMRTCY, we use a 3-minute contact (wet) time for all surfaces.

Infection Control Manual Link

Sterility & Peel Packs

STERILITY

Per MIFU—Considered sterile until use *unless*:

♦Moisture ♦Dust ♦Package Integrity

PEEL PACK CONSIDERATIONS

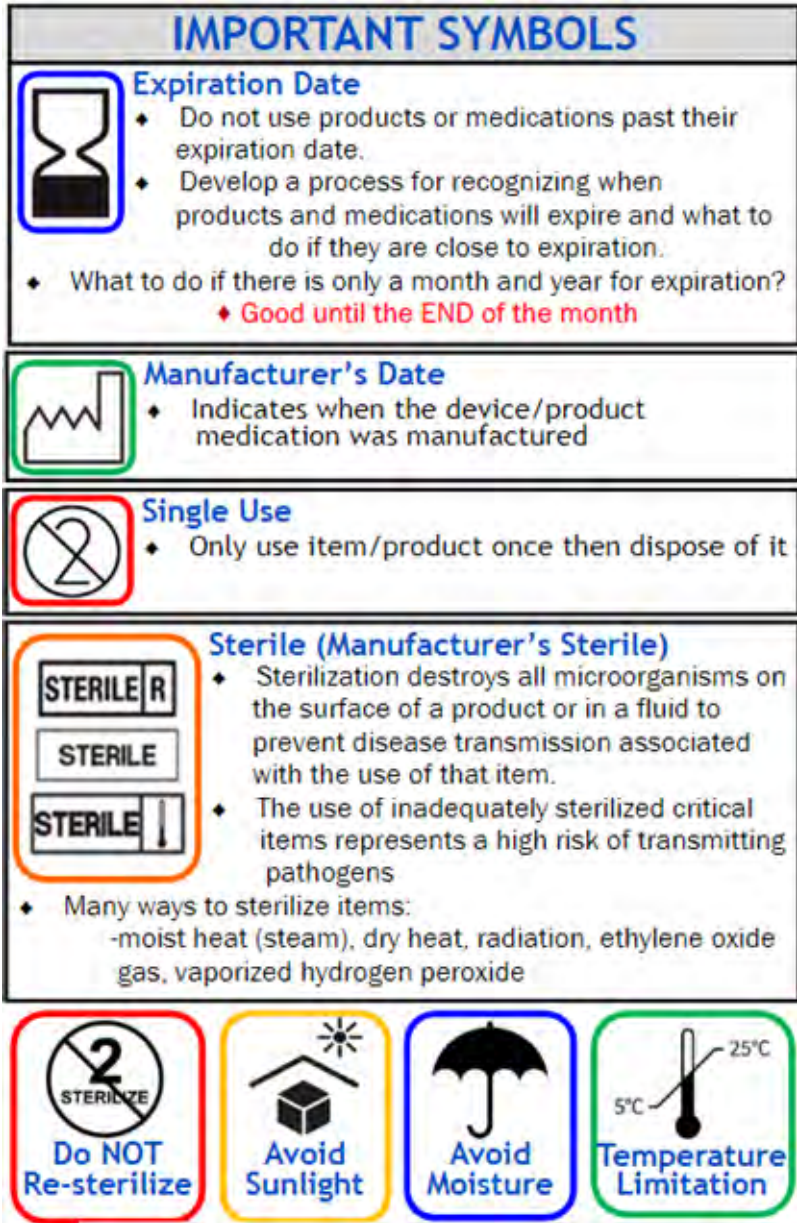
- Expiration date of supplies BEFORE sterilization
- Utilize tip protectors
- Chemical Indicator in EVERY peel pack
- Stored appropriately
  - -Not under sink or crowded
    Into storage bin
  - - Environmentally controlled conditions
  - - Minimize handling
- Adhere to FIFO (First In – First Out) inventory management

** Policy is reprocess at 365 days**

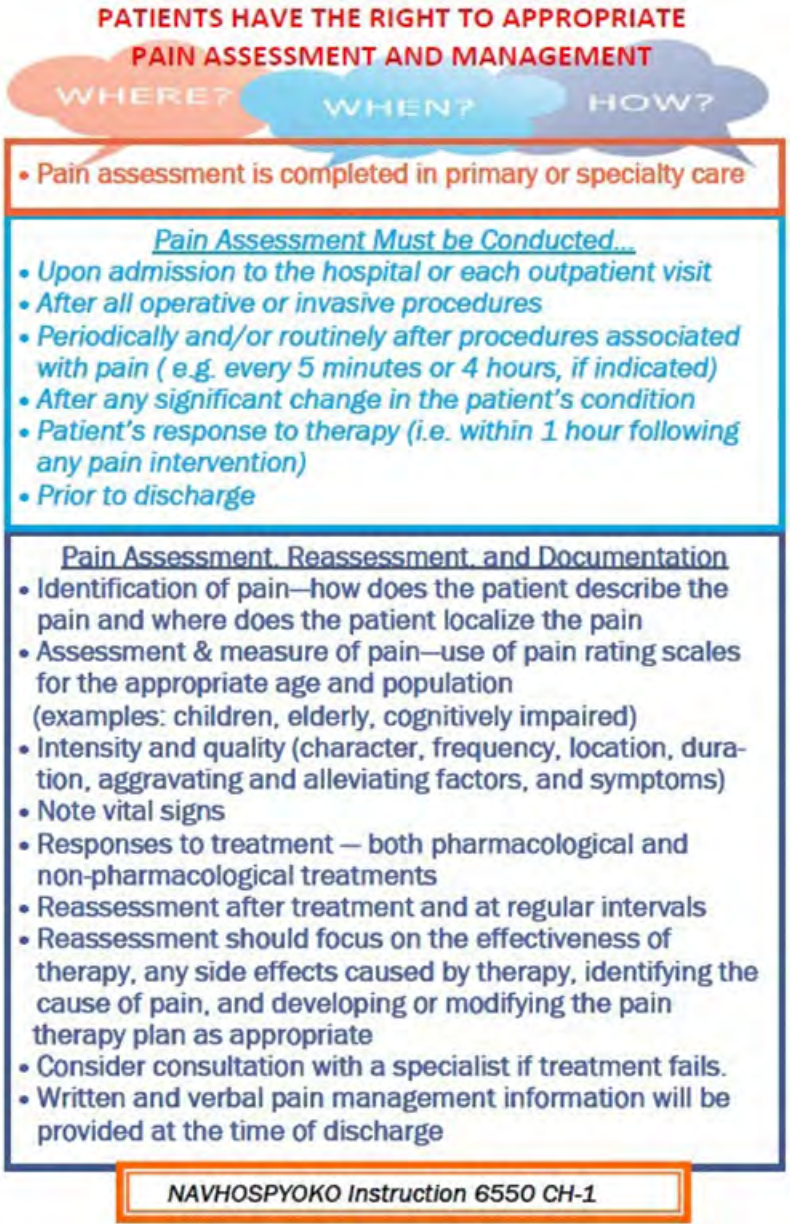
CHECKLIST BEFORE USE

- ☐ Package integrity: No dust, evidence to moisture, package still sealed/not punctured.
- ☐ Type 5 chemical integrator in each peel pack that has changed to indicate successful steam exposure.
- ☐ Load sticker on each peel pack.
- ☐ If any of the above items are missing/compromised, or the peel pack was exposed to an Aerosol Generating Procedure (even if not opened):
  DO NOT USE and return to SPD for reprocessing.

Important Symbols



Pain Management



Medication Management

⚠ Potential High Risk Findings on Survey

1. Not following policy regarding medication orders (Titration and Range Orders)
2. Emergency medication accessibility
3. Storage of medications
4. Clean separate area for medication preparation (Medication Compounding)
5. Medication Security

TITRATION ORDERS

Order that provides guidance for administration and dose adjustments.

REQUIRED ORDER COMPONENTS

- Medication name/route of administration
- Starting dose
- Frequency of titration
- Assessment parameters and final endpoint
- Incremental dose change; either increase/decrease the infusion rate
- Max dose and/or when to call LIP

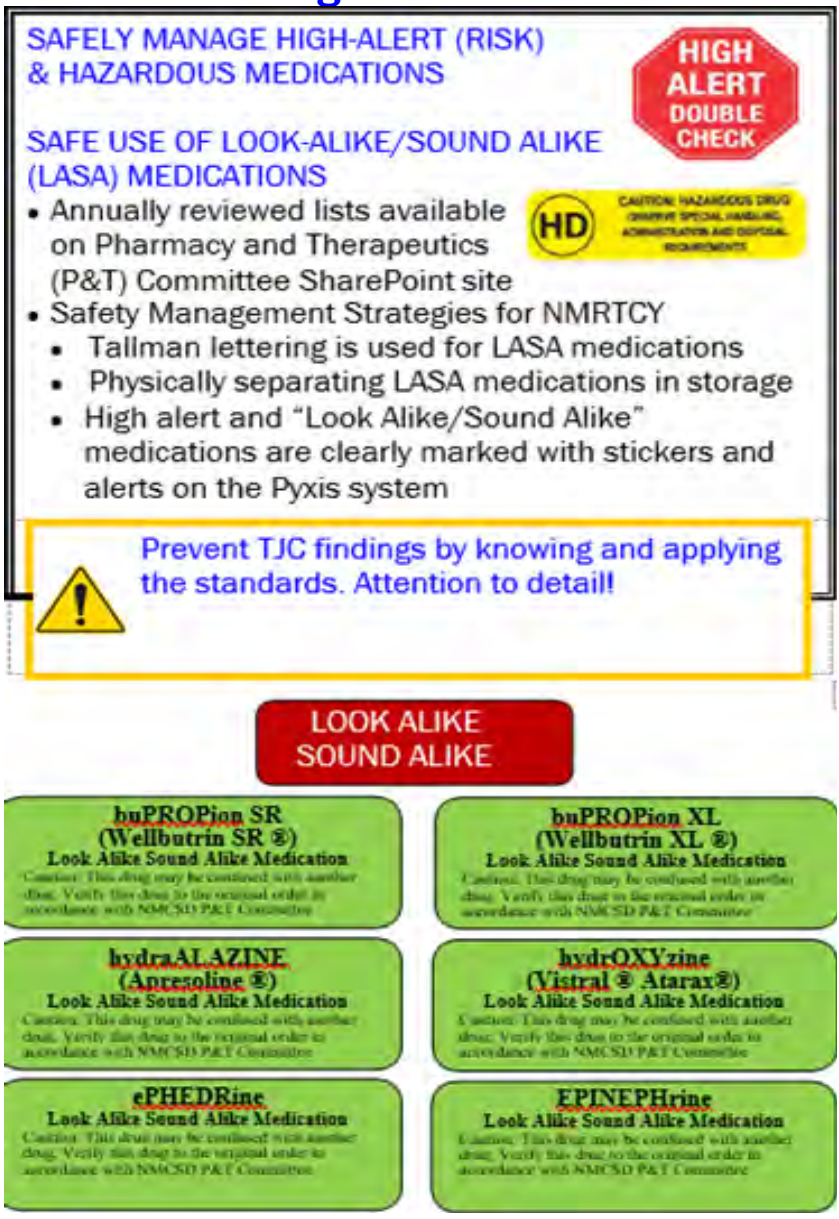
Start nitroglycerin infusion at 5 mcg/min IV. Titrate by 5 mcg/min every 5 minutes to keep SBP less than 160 mm Hg and greater than 110 mm Hg. Max dose 200mcg/min. Contact LIP if unable to titrate, SBP 90 mmHg, or continued chest pain or EKG changes.

Medication Orders

A medication may be administered prior to the pharmacist reviewing the order when:

1. In an emergency
2. The resulting delay would harm the patient
3. A physician is present and controls the administration of the medication

Medication Management



Medication Administration

7 Medication Administration Rights:

1. Right Patient (2 identifiers: name and DOB)
2. Right Drug (name and concentration)
3. Right Dose
4. Right Route
5. Right Time

Additional 2…

6. Right Reason (indication present in PRN orders)
7. Right Documentation

Other Medication Administration Standards:

Examine medication for particulates or discoloration.
Ensure medication is not expired.
Review history for reactions or allergies.
Label all medication (syringe, containers) with expiration date.
Verify medication: 1. When pulling the medication, and 2. At bedside.
Assess patient and family's understanding of reasons for

The following medications require 2 RN verification 

- All pediatric medications
- High Alert Medications (HAM): Insulin, opioids including PCA, cardiac meds, sedative agents, concentrated electrolytes, anticoagulants.
- Anytime drug calculation feature used on Alaris pump.
- Medications not routinely used in department.

Medications Hospital Corpsman Staff Cannot Administer:

1. IV push, titratable drips
2. IV antibiotics: Vancomycin, Gentamicin
3. Concentrated electrolytes
4. TPN/PPN
5. Opioids and controlled substance
6. Meds through PICC or arterial lines

**Any IV piggyback administered by HM's must be checked for accuracy by RN and initialed by RN on medication label.*

Range Orders

RANGE ORDERS

Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status

REQUIRED ORDER COMPONENTS

The required order component and implementation is determined by the organization's policy requirements. Please refer to NMRTCY's policies and Medication Management Manual for compliance.

⚠ Survey Findings: Inconsistent interpretation of how to carry out the range order.

SAFELY MANAGE EMERGENCY MEDICATIONS

Readily accessible

- Ensure Crash cart meds and supplies are not expired

Unit dose, age specific, ready to administer

- Crash carts are stocked with amps/vials when available from the manufacturer as prefilled syringes or premixed bags

Resupply after use as soon as possible

- Used or opened crash carts that were removed from patient care areas need to have fully stocked replacements

⚠ Survey Findings: Pediatric carts have missing or outdated Broselow Tapes.

Injection Safety

What is injection safety?

Injection safety or safe injection practices is a set of measurements taken to perform injections in an optimally safe manner for patients, healthcare personnel, and others.

Source:
https://www.cdc.gov/injectionsafety/providers/provider_faqs.html

A SINGLE-DOSE VIAL (SDV) is approved for use on a **SINGLE** patient for a **SINGLE** procedure or injection.

SDVs typically lack an antimicrobial preservative. Do not save left over medication from these vials. Harmful bacteria can grow and infect the patient.

DISCARD after every use!

SDVs and MDVs can come in any shape and size. ***Do not assume*** that a vial is an SDV or MDV based on size or volume of medication.

A MULTIPLE-DOSE VIAL (MDV) is recognized by its FDA-approved label.

Although MDVs can be used for more than one patient when aseptic technique is followed, **ideally even MDVs are used for only one patient.**

MDVs typically contain an antimicrobial preservative to help limit the growth of bacteria. Preservatives have no effect on bloodborne viruses (i.e. hepatitis B, hepatitis C, HIV).

DISCARD MDVs when the beyond-used date has been reached, when doses are drawn in a patient treatment area, or any time the sterility of the vials are in question!

Medication vials should always be discarded whenever sterility is compromised or questionable.

Multiple Dose Vials

Apply Aseptic Technique within 28 Days of Opening MDVs

①Scrub the rubber septum with an approved antiseptic swab.

②Allow to dry.

③Insert a new needle attached to a new syringe for each entry.

MDVs that do not require reconstitution may be used for multiple patients if:
Doses are not drawn in "immediate patient treatment areas" including the O.R., procedure rooms, anesthesia/procedure carts, patient rooms, or bays.

Medications reconstituted in an injectable MDV:

- Expires one (1) hour from reconstitution unless prepared and labeled by pharmacy.
- Must be labeled with diluent, concentration, expiration date, and time.

Exceptions to the 28-day expiration of MDVs:

- The manufacturer identifies & extends the expiration date in the product packaging, indicating the manufacturer has conducted testing beyond the minimum required 28 days.
- The manufacturer identifies an expiration date earlier than the 28-day expiration date, in which case the earlier date must be used.
- Currently, vaccines are exempted from this requirement.

(Source: CDC)

The Centers for Disease Control and Prevention (CDC) Immunization Program states that vaccines are to be discarded per the manufacturer's expiration date. The Joint Commission has applied this approach to all vaccines (whether a part of the CDC or state immunization program, or purchased by healthcare facilities) with the understanding that vaccines are stored and handled appropriately.

Do Not Use Dose Designations & Abbreviations

Do Not Use	Potential Problem	Use Instead
"Trailing Zeros"	Example: Dose of 1mg written as 1.0mg	Never use a "trailing" zero! Warfarin 2 mg
"Naked Decimals" or Lack of Leading Zero	Example: A dose of 0.5mg written as .5mg	Never use a "naked" decimal! Always use a zero before a decimal. Morphine 0.5mg
U or u	Unit	"Unit has no acceptable abbreviation. Write out "unit".
µg	Microgram	Use "mcg" or "micrograms"
Q.D., QD, q.d., qd, or Q/D	Every Day or Daily	Write out "every day" or "daily" MS
Q.O.D., QOD, q.o.d., or qod	Every other Day	Write out "every other day"
MgSO4	Magnesium Sulfate	Use complete spelling for drug names.
MS MSO4	Morphine Sulfate	Use complete spelling for drug names.
I.U. or IU	International Unit	Write out "International Unit"
T.I.W.	Three times a week	Write out "three times a week"
SS	Sliding Scale or 1/2 (apothecary)	Write out "sliding scale" Use "one-half" or 1/2

Exception: "Trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for lab results, imaging studies that report lesion size, or catheter/tube sizes.

A Full List of Medical Abbreviations can be searched at: https://www.medabbrev.com/index.cfm

Restraint Orders

Non- Behavioral Restraint. Ordered when a patient exhibits altered mental status secondary to physiological changes or a physical condition. Medical restraints support healing and are used as an adjunct to planned care.

Behavioral Restraint. (“Twice as tough” cuffs-non locking) Used to protect an individual from inflicting injury to self or others based on an emotional or behavioral condition. They are rarely used outside the emergency department or behavioral health units.

Forensic. The involuntary physical confinement of a patient includes involuntary confinement for legally mandated, non-clinical purposes, such as confining a person facing criminal charges or serving a criminal sentence.

NMRTC Yokosuka Policy

Restraints can produce serious consequences, such as physical and psychological harm, loss of dignity, violation of a patient’s rights, and even death. Vulnerable populations such as emergency and pediatric patients, patients with a history of mental, physical, or sexual abuse, and those who are cognitively or physically challenged are at a higher risk for these severe consequences. NMRTC Yokosuka strives to foster an environment of using the least restrictive means that minimize circumstances for restraint use and maximize safety when restraint is used. This requires allocating sufficient resources, providing initial and ongoing education and training, and integrating restraint into performance improvement activities. The result is an approach to prevent, reduce, and eliminate restraints.

NAVHOSPYOKO Instruction 5370.5B

Restraint Orders

RESTRAINT ORDERS			
TYPE OF RESTRAINT *OLD VERBIAGE*	**NON-BEHAVIORAL** *MEDICAL/SURGICAL/ NON-VIOLENT*	**BEHAVIORAL** *BEHAVIORAL/VIOLENT*	
TIME LIMITS	Up to 24 hours from the time the original order was written	18 years and older	Up to 4 hours
		9-17 years old	Up to 2 hours
		Younger than 9 years old	Up to 1 hour
EMERGENCY SITUATIONS	To continue non-behavioral restraints, orders must be obtained within 24 hours of initiation.	To continue behavioral restraint, orders must be obtained within 1 hour of initiation.	
MONITORING AND ASSESSMENT	Patients will be assessed at a minimum of every 2 hours, with frequency adjusted as required by patient condition	Patients are under continuous observation. Reassessment is documented every 15 minutes	

A healthcare provider, LIP or physician, may initiate the order for patient restraint

The hospital evaluates and reevaluates the patient who is restrained.

A physician or other licensed practitioner evaluates the patient in-person within one hour of initiating restraint or seclusion for violent or self–destructive behavior.

The hospital initiates restraint based on an individual order.

The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint.

Restraint Considerations

- Circumstances leading to the use of restraint, including the Consideration/failure of nonphysical interventions.
- The rationale for the type of physical intervention.
- Provider's orders.
- Each in-person evaluation/reevaluation of the patient.
- Each 15-minute assessment of the status of the patient.
- Continuous monitoring of the patient.
- Preexisting medical conditions, physical disabilities, and abuse placing the patient at greater risk during restraint.
- The patient and family were informed and notified of the restraint policy.
- The patient was informed of the behavior criteria for discontinuing restraint use.
- Debrief with the patient following the episode of restraint.
- Any injury and treatment of the injury.

Restraint – Location

5B (Multi-Service Ward) and Emergency Room

Code Green is a combative person or is potentially a harm to self or others.

How to Respond?

- Call QD to relay the Code Green: 156
- QD page for trained personnel (security) to assist at the scene.
- The hospital's therapeutic containment and restraint procedure is in line with the Prevention and Management of Disruptive Behavior-Military's (PMDB-M) framework. When security is not present for an imminent need of restraint only PMDB-M certified staff members should participate in containment and restraint.
- Call QD to secure Code Green when scene is controlled and safe.
- QD makes overhead page to secure Code Green.

Patient Safety Report (PSR)

A PSR is submitted for all Code Green and restraint implementation. It is not required to note "PSR submitted" on the patient's record.

Patient Rights & Informed Consent

HOW ARE PATIENTS INFORMED OF THEIR RIGHTS?

- All patient care areas will prominently display the Patient Bill of Rights.
- This bill of rights applies to all patients of all ages. Patients need to know that we respect and protect these rights and that they are entitled to make decisions regarding their care including the decision to accept, refuse, or discontinue treatment.

THE RIGHTS OF THE CAREGIVER

Explains the rights and responsibilities of staff members whose cultural, ethical, or religious beliefs and/or practices conflict with specific aspects of patient care (e.g., sterilization, blood transfusions.

DHA PI 6025.10 Patient Rights and Responsibilities

Informed Consent

Prior to submitting to medical treatment, patients have the right to be informed of the nature of the treatment and procedures, the risks, anticipated benefits, available alternative treatments including probable or expected consequences of a failure to accept treatment. It is the provider's responsibility to discuss this information with the patient in language the patient can understand.

Witness for Informed Consent

- Should be a health care employee of NMRTC who is not participating in the procedure/treatment
- Does not need to be present when the patient signs but needs to verify the patient's signature and voluntary consent.

Informed consent documentation: DHA Form 195 (Dental) OF 522 (Surgical/Medical)

Living Wills & Advanced Directives

An Advance Directive allows patients to decide how to handle health decisions in the event of a life-threatening condition or terminal illness. Examples of Advance Directives include: A Living Will or Durable Power of Attorney. Witnesses for these documents cannot be hospital employees.

HOW ARE PATIENTS INFORMED OF THEIR RIGHTS REGARDING ADVANCE DIRECTIVES?

Upon admission, same day surgery pre-admission, or at the patient's request, patients who are 18-years of age or older, are given information which includes their rights under law to accept or refuse medical or surgical treatment and to formulate an advance directive.

- If the patient has already executed an advance directive, the patient should provide a copy at the time of admission
- Inpatient personnel should document follow-up reminders to family of patients who do not bring a copy of the advance directive upon admission.

DO NOT ATTEMPT RESUSCITATION

In a life-threatening emergency, all inpatients will receive full life-sustaining therapy unless otherwise ordered by a resident physician (PGY-2 higher), nurse practitioner, physician assistant, or staff physician after discussion with patient/family.

Patient resuscitation options include:

- Full Code – Code Blue
- Continue Life-Prolonging Treatment – No Code Blue
- Comfort Measures Only – No Code Blue
  *Refer to Command Instruction for surgical patients

NAVHOSPYOKO Instruction 6320.19I

Ethics & Patient Confidentiality

Ethics Committee

NMRTCY has an active Healthcare Ethics Committee.

- A consultant is available 24 hours. Call 315-243-8647 to facilitate orderly, consistent, and effective dialogue associated with ethical dilemmas.

How is Information Kept Secured?

- Only authorized individuals who need information have access to patient data. Easily readable patient charts, lab reports, etc., should not be left on counters or chart racks.
- Patient records and medical information are secured and managed to ensure the information is viewed only by authorized individuals.
- Patients are NEVER discussed in elevators, cafeterias, or other public areas.
- Names should not accompany diagnoses.
- Computer Security:
  - CAC cards are not left unattended in computers.
  - Office computer screens do not face a doorway.
  - Computer screens should not be left unattended with patient information displayed.

HIPAA—Health Insurance Portability & Accountability Act

Since 2003, healthcare organizations are to comply with the HIPAA provisions that strengthen the privacy and protection of a patient's medical information.

NAVHOSPYOKO Instruction 5421.1H

Patient & Family Education

Patient Education is the process of influencing behavior and producing changes in knowledge, attitudes, and skills needed to maintain and improve health. Patients are encouraged to ask questions about their care and medications, participate in their treatment decisions, and become educated about their diagnosis and treatment plan.

Goals for patient and family teaching include:

- Patient participation and shared decision-making about healthcare options
- Increased potential to follow the health care plan
- Development of self-care skills
- Improved patient/family coping
- Increased participation in continuing care
- Safe and effective use of medications
- Adopting a healthy lifestyle
- Patient learning needs are assessed to address cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication as appropriate

NMRTCY offers a variety of patient education topics including nutrition, cholesterol, childbirth and diabetes, tobacco cessation, and weight management.

If you have questions CALL NMRTCY Health and Wellness Department at 315-243-9775

Translation Services

Translation Services at NMRTCY and other Branch Clinics

- **Over-the-Phone Interpretation (OPI) (24/7)**
  - Step 1: Phone numbers
    - *Option #1: +1 (833) 961-0093*
    - *Option #2: +1 (703) 774-1167*
    - *Option #3: +1 (614) 929-4175*
  - Step 2: Select the language
  - Step 3: Provide PIN: 4179518

Operations During Working Hours:
Monday - Friday: 0800-1600
Contact Patient Administration Department at **315-243-5252**

Operations After Working Hours:
Weekends, Holidays, before or after Office Hours Over-The-Phone Interpretation (OPI) Only, please call **090-4422-2082**

SPECIAL NOTES:

- Staff, family, or friends who are not trained or certified as healthcare interpreters should not be used to interpret or translate.
- If a patient declines the services of an interpreter, then it should be documented in the patient's medical record.

Disclosure & Resolutions

Disclosure is informing the patient and, when appropriate, the patient's family of unanticipated care outcomes. The unanticipated outcome may be positive or negative. The primary provider or their supervisor should expeditiously notify the appropriate hospital representatives of unanticipated adverse outcomes.

Healthcare Resolutions assists the primary provider in deciding who/how to make the disclosure. Ordinarily, the primary provider will make the disclosure. However, the facts and circumstances of each case are different and may dictate that another hospital representative make the disclosure.

- Disclosure should be made as promptly as possible, given the patient's clinical condition.
- The nature, severity, and cause, if known, of the unanticipated outcome/ adverse event should be presented in a straightfor- ward and non-judgmental fashion. Disclose only what is known at the time of the discussion. Stick to the facts. Do not speculate.
- Do not feel compelled to answer all questions at the first meeting. Disclosure usually occurs over a series of conversations.
- Title 10, U.S. Code Section 1102 states that information will not be provided to the patient and/or family.
- If the unanticipated outcome requires further medical intervention, describe what can be done and what actions will be taken to begin this process. A patient needs all information to make an informed decision for future care.
- The disclosure of an unanticipated outcome to a patient/patient's family should be documented in the chart. However, DO NOT write details of the disclosed event in the medical records. Details of the disclosed event should be documented on a QA event report form or as part of the RCA process. The note should be factual along with a brief summary of the conversation & plan of care.

Medical Record Requirements

Important Points for MEDICAL RECORDS

What are the most critical aspects of a JC survey from the medical records perspective?

- Timeliness—NMRTC requires that Providers complete inpatient medical records within 30 days of discharge.
- Completeness and accuracy
- General Rule: The medical record reflects the care provided chronologically.
- History and Physical (H&P) are documented before the procedure, not older than 30 days; it must document the review of the H&P within 24 hours before the procedure.
- Confidentiality

Other Medical Record items of interest include:

- Pain Assessment, Control, & Reassessment
- Multidisciplinary Documentation (e.g., Nutrition, Chaplain, Pharmacy, Social Work)
- Advance Directives
- Completed Discharge Instructions
- Handwritten records are legible, dated, and timed with the provider's name printed or stamped in addition to a signature
- Do not abbreviate the final diagnosis
- For PCMH Certified Clinics: Self-management goals must be identified and part of the treatment plan when warranted.

Patient Assessment, Care, & Treatment

Pain Assessment

All patients are assessed for pain at the time of admission. Clinicians must reassess and evaluate pain management interventions, documenting the effectiveness using an appropriate pain scale.

History and Physical

The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

- The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure with anesthesia services.
- For a medical history and a physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services

Interdisciplinary Plan of Care (IPOC)

All care providers should work as a team to plan and evaluate the effectiveness of care. Communicate progress towards goals to the patient/family. Document the plan of care, date of initiation, and target goals.

Anesthesia/ Deep Sedation/ Moderate Sedation

A licensed independent practitioner must reevaluate the patient immediately prior to induction. Document the assessment.

Brief Post-Operative Note / Progress Note

When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care and should include the following: name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and post-operative diagnosis.

Staff Competency

Competency Requirements

- All staff members, including volunteers and student trainees (except Licensed Independent Practitioners), must have an Individual Training Record (ITR) to document training and competency. Licensed Independent Practitioners (LIPs) document command, department/unit, and life safety orientation; collateral duty appointment letters and annual update training are placed in the Clinical Activity File (CAF).
- NMRTCY sponsored trainees (i.e., Interns, residents, and fellows) - ITRs remain in the individual's permanently assigned area. Personnel who work in areas other than their primary designated work center will have an ITR created/maintained in the secondary work center as if they are permanently assigned staff.

Initial Competency Assessment

- This review helps ensure that employees have the necessary education, training, or experience for the position. A critical component of initial competency assessment is Primary Source Verification (PSV) to confirm that an individual possesses a current valid license, certification, or registration to practice a profession when required by law and regulation.
- The respective Department Head will ensure the PSV is completed before the commencement of clinical duties. Credentials are kept current, and the Medical Staff Services Office (MMSO) is the point of contact for managing the database.
- Documentation will be maintained in Section V of the ITR.

Primary Source Verification

- PSV must be conducted before the current license, certification, and registration expires to verify renewal has occurred. If the license/certification/ registration has expired, the member may not continue to work.
- LIPs, Registered Nurses, and Dental Hygienists have PSV of required credentials completed and maintained in their Individual Credentials file by the MSSO.

- Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source, or reports from Credentials Verification Organizations (CVOs) that meet Joint Commission requirements.
- Any staff member who wishes to check the privileged status of a LIP can do so by going to the Command Home Page Quick Launch and clicking on the Privileged Provider button or contacting Medical Staff Services at 315-243-8649.

Clinical competency is documented in the ITR, Elsevier Clinical Skills, or RELIAS.

Electronic Training Records (ETR) are being developed but not enterprise-wide. Training is documented in the ITR or RELIAS.

RELIAS

DHA-PM 6025.13 Volume 4

Training Records

Position Description (PD)

All staff (except LIPs) will have a PD that accurately describes the specific requirements of that position. The PD defines specific competencies, special qualifications, knowledge, and demonstrated skills required to perform the job. A copy of all PDs for each Department should be maintained in the respective Standard Operating Procedure (SOP) for reference.

- Employee Review - All personnel must initially review their PD with their supervisor indicating they understand the requirements of their position, and annually review their PD after that by documenting through an assignment in the Training Record. All newly appointed supervisors will conduct a PD review with all staff within 120 days and complete the PD review the same as above.

Unit Orientation

All staff will be oriented to relevant command-wide departmental policies and procedures to each department/work center they are assigned to and documented in their Training Record.

Safety Orientation

Staff members will receive an orientation to key safety content of their designated work center before providing care, treatment, or services and documented in their assigned training.

Command Orientation/Indoctrination

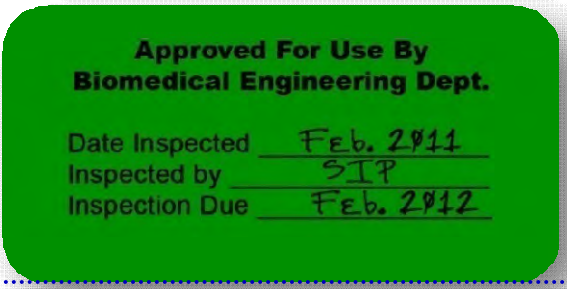
All new staff members will sign in for Command Orientation within 30 days of reporting onboard and will attend no late than 60 days of reporting onboard.

Biomedical Equipment

Is Your Equipment Safe for Patient Care Use?

- Does your medical equipment have an Equipment Control Number (ECN)?
- If missing ECN, contact Property Accounts at 315-243-2629

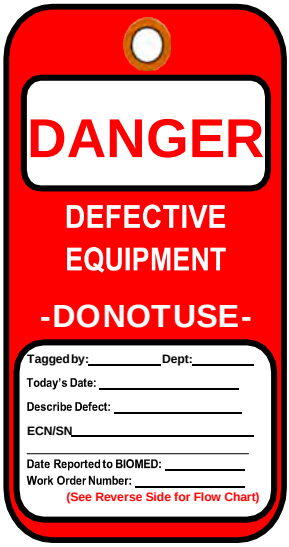
- Is your medical equipment's Preventive Maintenance (PM) sticker current?
- Verify Date, Due, and By are current on the PM sticker.
- If expired or missing, contact Biomedical Engineering Division (BIOMED) at 315-243-7147 / +8180-5005-4829

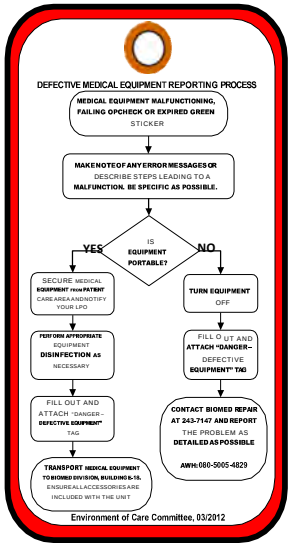


☐ Do you have equipment with overdue Preventive Maintenance? How do you take it out of circulation?

Contact BIOMED 315-243-7147 / +8180-5005-4829 immediately to have Preventive Maintenance conducted on the equipment. If the equipment cannot be taken out of the workspace, coordinate with BIOMED to have a BMET place a DEFECTIVE sticker with the following information:

- Date
- Technician Initials (Tagged By)
- Work Order Number
- Description of the problem
- Status





Who do you contact in case of malfunctioning medical equipment?

- BIOMED 532-8010/8011
- BIOMED DUTY After Hours 619-453-6091
- How do you take it out of circulation?
- How is it marked?

Contact BIOMED immediately to have the equipment inspected. If the equipment cannot be taken out of the workspace, coordinate with BIOMED to have a BMET place a DEFECTIVE sticker with the following information:

- Date
- Technician Initials
- Work Order Number
- Description of the problem
- Status

What to do in case of medical equipment failure injury:

- Notify Patient Safety/Risk Management at 243-8691 and BIOMED 243-7147 / (BIOMED DUTY After Hours) +81 80- 5005-4829
- Sequester the equipment and keep it removed from service.
- Do not change any of the configuration settings.
- Do not allow the vendor access to the equipment.

Who do you contact for user training on new medical equipment?

- BIOMED or Manufacturer/Vendor Representative via BIOMED 243-7147

☐ Where do you submit Test and Evaluation (T&E) for new equipment user tests? -- Property Accounts via BIOMED.

☐ Do you have input on what equipment to buy? Yes, submit a request on LogiCole for review by Property Accounts with approval by the Equipment

- Program Review Committee (EPRC).

☐ How are providers/staff trained to use demo medical equipment? -- BIOMED or Manufacturer/Vendor Representative via BIOMED.

☐ How does the command document requisition from providers/staff? -- Use LogiCole and input all supporting documentation (Procurement Package, market research, etc.).

☐ Is medical equipment plugged directly into an outlet and NOT a power strip?

- *Note: Only the RED electrical outlets will have power in an electrical failure.

CONTACT INFORMATION

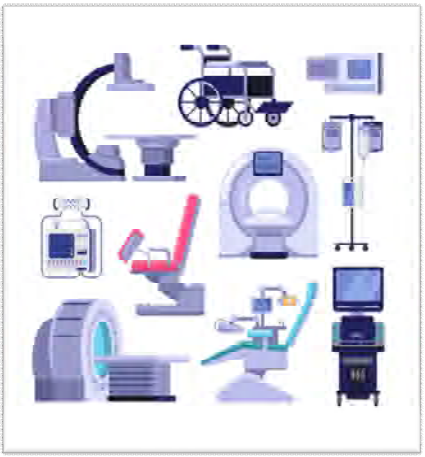
BIOMED: 243-7147

BIOMED DUTY (After Hours): +81 80-5005-4829

BiomedicAL Repair Front Desk/Trouble Ticket Email: mailto:usn.yokosuka.navhospyokosukaja.list.nh- yokosuka-med-repair@health.mil

Property Accounts: 243-2629

Patient Safety/ Risk Management: 243-8691



Medical Waste

MEDICAL WASTE vs REGULATED MEDICAL WASTE

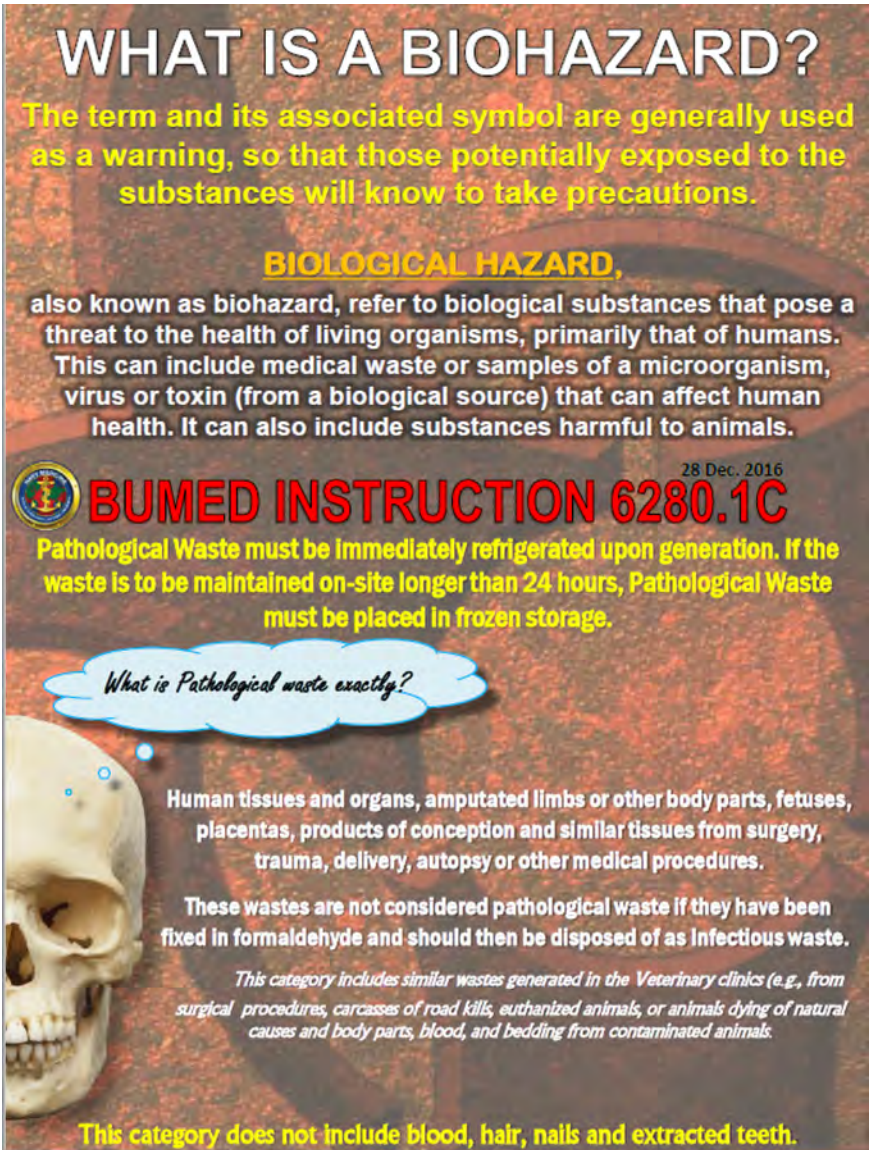
America provides a "grey area" in regard to disposing of lightly blood soiled (not caked on or dripping) items as normal solid waste. This leniency to RMW does NOT apply here in Japan.

Two types of Medical Waste (MW) in Japan are categorized as

Infectious Medical Waste

& **Non-Infectious Medical Waste**.

Medical Waste



Medical Waste

Medical Waste

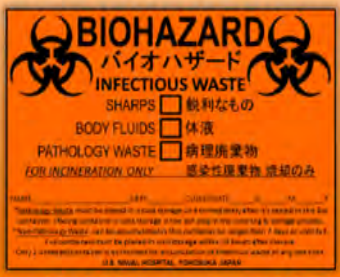
BIO WASTE DECALS

Bio decals must be properly filled out and attached to any MW container when in use.
This includes all Sharps containers of various sizes and all Bio Bins.

Keep in mind any amount of Pathology MW must be placed in frozen storage immediately after generation.

All Bio decals have the time limitations written at the bottom for convenience of reference.

Top of decal under full line



Decal attached to top of lid

Do Not block the sharps view at the full line

Be sure to fully close all corners of the lid

KEEP YOUR MWSA CLEAN

1. Keep heavy Bins on the bottom & lighter on top.
2. Dispose of PPE and use Hand Hygiene.
3. Stack them straight, balanced & uniform so as to prevent tipping, falling and/or spilling.

KEEP CALM you're in BIOHAZARD ZONE

Medical Waste

MW PROCEDURES

Regardless of high or low generation rates MWAP (Bio Rooms) must be kept clean. each Bio bin must be taken to the MWSA freezer immediately following each procedure.

MW Bio carts can be used to aid in the transportation of medical waste. MW carts used for transporting full or new MW Bio Bins to and from the MWSA and departmental MWAPs and must be disinfected after each use. MW carts can not be used for transporting Medical Supplies or Medical Equipment at any time.

Bio Bins, Sharps containers, Red Bags or any other MW must always be handled with exam gloves regardless of how clean the outside may appear. **Bio Bins containing Pathology waste can NOT be stored in MWAPs for any period of time.**

Non-Infectious Blue Bag Medical Waste must have the opening closed with the Goose Neck procedure as performed when closing Red Bags before being transported to the MWSA.

Medical Waste

PPE FOR TRANSPORT & DROP OFF

1. GLOVES are required when handling & transporting Medical Waste bins.
2. Practice proper hand hygiene at the MWSA after MW drop off.
3. Lab coat or other protective garment is recommended. NO CIVILIAN CLOTHES.

STOP & 100%

SURE THAT YOUR BIO BINS ARE CLEAN ON THE OUTSIDE BEFORE YOU'RE SEEN HANDLING OR TRANSPORTING THEM.

Staff handling MW must complete annual Bloodborne Pathogen (BBP) training.

"CODE ORANGE" HAZARDOUS SPILL

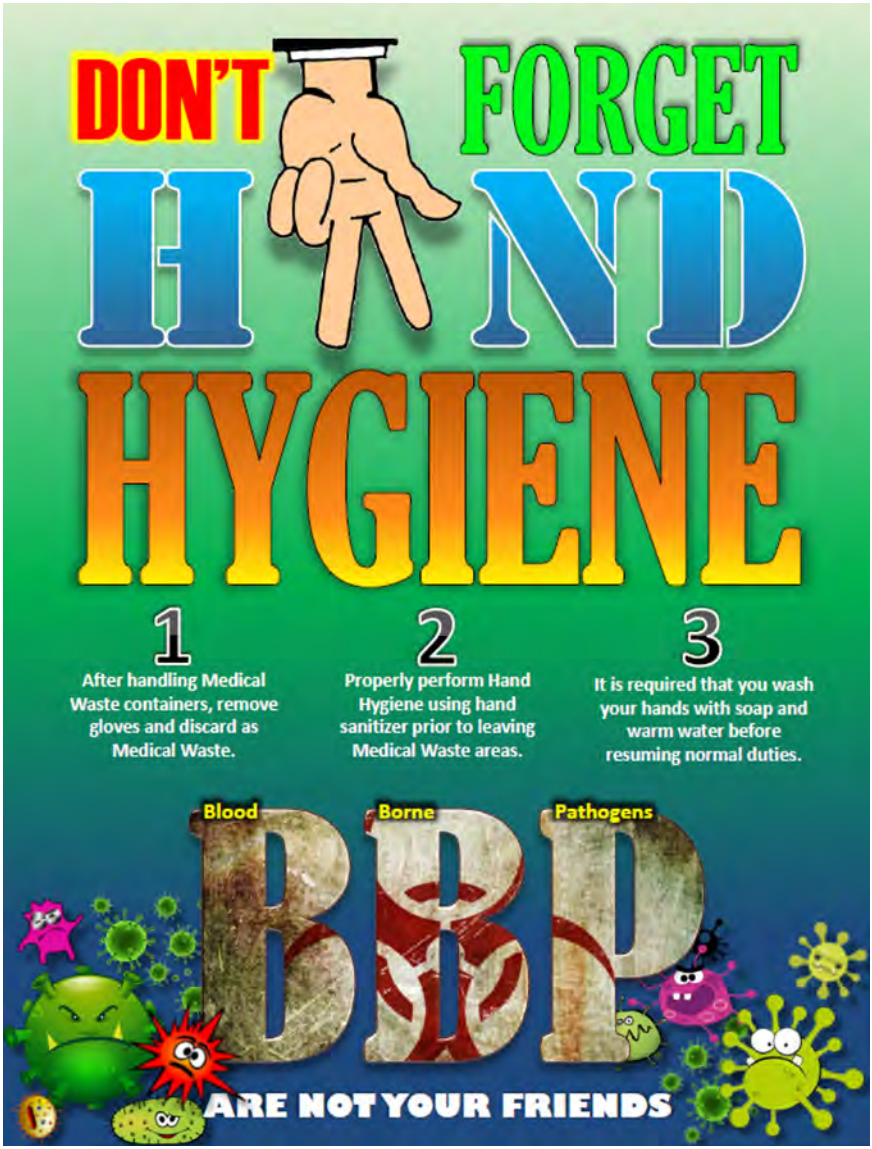
1 = Prevention
OF SPILLS BEFORE THEY HAPPEN BY SAFE AND PROPER HANDLING.

2 = Containment
OF SPILLS BEFORE THEY REACH DRAINS AND BECOME WIDESPREAD.

3 = Notification
TO THE QUARTERDECK, CDO, SPILL RESPONSE AND ENVIRONMENTAL

Spill Kits are located at a MWAP near you

Medical Waste



Medical Waste

HAZARDOUS WASTE DISPOSAL

What is HAZARDOUS WASTE?

A "**HAZARDOUS WASTE**" can be any one or more of the following...

- Already Expired Hazardous Materials
- Partially used or left over Hazardous Materials no longer needed
- Un-useable Hazardous Materials/Obsolete Chemicals
- Spilt Hazardous Materials
- Clean up or absorbent materials from a **CODE ORANGE (Hazmat Spill)**
- Empty containers that contain residual/trace amounts of Chemicals

BASICALLY ANY HAZARDOUS MATERIAL THAT IS BEING DISCARDED.

Medical Waste

Common types of HAZARDOUS WASTE

Some of these below items might surprise you. Keep in mind that our Hospital is required to handle HAZARDOUS WASTE (HW) in such a manor that ensures staff, patient and the environment are keep safe. The USNH's high generation rate of these special kind of waste streams can be a challenge. Naturally, we set our standards higher than other commands & continue to do the right thing because we Care.

Where can I find the right HAZARDOUS WASTE SDS?

1. Every department that uses Hazardous Material (HM) is required to have printed copies on hand of each HM item's SDS on their own Authorized Use List (AUL).
2. SDS's can be found at HM "Right To Know" locations. Look for this sign to learn more about the HM you & your department use.
3. In the event a SDS can't be located, please contact Safety at 243-9914 for guidance.

Medical Waste

GHS
The
Globally Harmonized System
of Classification and Labeling of Chemicals

1. GHS stands for the Globally Harmonized System of Classification and Labelling of Chemicals. GHS defines and classifies the hazards of chemical products and communicates health and safety information on labels and safety data sheets. The goal is to set the same rules for classifying hazards, with the same format for labels and safety data sheets (SDS) to be adopted and used around the world. An international team of hazard communication experts developed GHS for all of us to use. This SDS must be handed over together with the waste item being discarded.

2. GHS covers all hazardous chemicals and may be adopted to cover chemicals in the workplace, transport, consumer products, pesticides and pharmaceuticals. The target audiences for GHS include workers, transport workers, emergency responders and consumers.

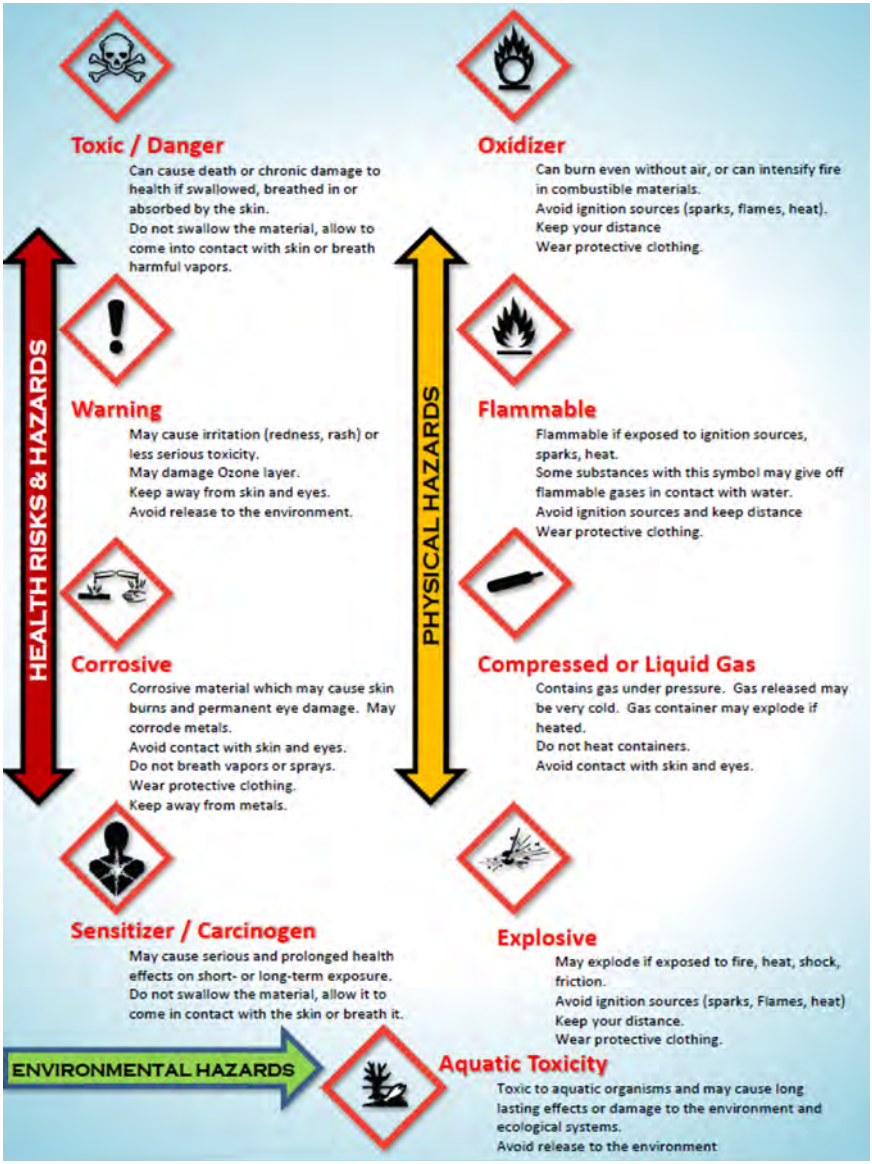
3. There are three (3) major hazard groups:
   1. **Health Risks & Hazards.**
   2. **Physical Hazards.**
   3. **Environmental Hazards.**

HWAP

Hazardous Waste Accumulation Point:

HW can be accumulated here up to 9 months or less than 55 gallons of HW and up to one quart of an Acute HW with proper procedures. An HWAP is operated by the tenant command it is supporting. All HW can be brought here for the disposal process along with a proper SDS. HW turn over must be done with the HWAP Manager by appointment only (no dropping off or abandoning HW items). There is no disposal fee charged to your department for this service.

Medical Waste



Medical Waste

HAZARDOUS WASTE ACCUMULATION POINTS

Below are a few examples of authorized HWAP locations. These HWAPs have two specialty qualified staff members designated to manage the proper accumulation, segregation and disposal of many different types of HW.

Never dump, abandon or leave HW at these sites without the HWAP Manager's direction for any reason. Violators of HM procedures will be brought to the attention of the Department Head for disciplinary action. Guaranteed.

CODE ORANGE HAZARDOUS MATERIAL or WASTE SPILL

#1	#2	#3
Prevention	**Containment**	**Notification**
OF SPILLS BEFORE THEY HAPPEN BY SAFE AND PROPER HANDLING	OF SPILLS BEFORE THEY REACH DRAINS AND/OR BECOME WIDE SPREAD. KEEP OTHERS AWAY	OF SPILLS TO THE CDO FOR SPILL RESPONSE BY A CODE ORANGE IF HELP IS NEEDED AND ALWAYS NOTIFY ENVIRONMENTAL

HW spills can create many challenging situations. Knowing your department's Hazardous Material and what to do in the event of a spill is of the upmost importance. Understanding how to respond to a spill with the correct equipment keeps other Staff members and our patients SAFE. Below are a few examples of Spill response kits available in various locations.

Medical Waste

BATTERY WASTE

ALKALINE, LITHIUM, Li-ion, NiCd, NiMH & Lead Acid-Pb

All batteries like the ones listed above, but not limited to, must be disposed of as Hazardous Waste. All used dry cell battery waste must be accumulated in this brown container located at all Bio/Hazardous Waste Accumulation points in each department and various admin spaces as well.

All batteries pose many risks; however, properly handled are normally considered Safe. For disposal of large batteries such as Lead Acid types, please contact Materials Management Department (MMD) @ 243-3660

Reduce
Reuse
Recycle

PURELL HAND SANITIZER WASTE

FLAMMABLE LIQUID

USED, EMPTY or EXPIRED SANITIZER WASTE

All hand sanitizer waste must be collected and disposed of as Hazardous Waste due to its flammable and eye irritant properties. Waste must be kept in a approved Safety locker or Yellow waste can.

For disposal of these items please contact Materials Management Department (MMD) @ 243-3660

Security

Command ID Badges

- Must be worn at all times by all hospital personnel

(e.g., military, civilian, student, contractor, volunteer, etc.)

- Security is EVERYONE'S Responsibility!
- "STOP" personnel without a badge.
- Report lost badges immediately by calling: (315) 243-6177
- Turn in lost badges to Command Security Office/Quarterdeck

ID Badge Color Codes (Band at Top of Badge)

GREEN	Issued to temporary personnel and visitors. These badges require escorts throughout the command.
RED	Issued to Commander, Deputy Commander, Directors, and Command Master Chief. Provides access to all areas of the command.
TEAL	Issued to Sexual Assault and Prevention Response Victim Advocate personnel.
ORANGE	Issued to personnel in facilities management.
BLUE	Issued to most staff & allows general access
PINK	Issued to personnel in newborn and pediatric areas. Authorizes wearer to transport pediatric and newborn patients.

Uniform Color-Coded Patient Alert Wristbands

Navy Medicine has standardized the color codes for patient alert wristbands which serve as a visual trigger to remind staff about a patient alert. The medical record contains definitive information regarding the alert. All inpatients and ED patients will have an alert wristband placed as appropriate:

- Red—Allergy
- Yellow/Green—Fall Risk
- Purple—Do Not Attempt to Resuscitate
- Orange—Retain for objects. OB after a PPH.

NAVHOSPYOKO Instruction 5512.1A

Emergency Management

The NMRTCY Emergency Management Procedures contains action information for command emergency codes. Some of the information is listed on the following pages.

- Where is the RED BINDER in your area located?
- Are you wearing your Emergency Code Badge?

EMERGENCY CODES

All staff and students at NMRTCY are responsible for maintaining a safe work environment. You must be informed and aware of the NMRTCY Main Hospital emergency codes and their appropriate responses. Phone numbers for Emergency Codes are listed on hospital and NHBC Emergency Code Badges.

TIP Your Employee Hospital Badge is a valuable source for the above information.

NMRTCY CODE CALL	
PINK	Infant/ Child Abduction
GREEN	Combative Person
GRAY	Mass Casualty Event
BLACK	Bomb Threat
ORANGE	Hazardous Material Spill
SILVER	Child/Adult LOST/ELOPED
WHITE	Armed Intruder/ Active Shooter
YELLOW	Utility Failure
NOVEMBER	Radiation Event
BLUE	Medical Emergency
PURPLE	OB/ Neonatal Emergency
RED	Fire
TRAUMA	Major Trauma

Emergency Management

CODE PINK – INFANT / CHILD ABDUCTION

All Clinical Departments are required to have an SOP directing actions in the event of a missing or stolen newborn, infant, or child (up to age 18).

What actions do you take in the event of a missing newborn, infant, or child?

For NMRTCY inpatient and main hospital:

1. Only staff with PINK Command ID badges may transport newborn/pediatric patients without parent/guardian.
2. In the event a newborn/infant/child cannot be accounted for, Activate CODE PINK by calling: NMRTCY Quarterdeck at 243-7144. Provide a description of the patient and suspected abductor, if known.
3. Report to assigned CODE PINK Station
4. If you see a suspicious individual(s), try to detain them but if the attempt to leave the facility, do not put yourself in harm's way – **contact Security.**

NAVHOSPYOKO Instruction 5500.1C

CODE SILVER – LOST OR ELOPED ADULT

1. CODE SILVER is called when an adult patient has wandered away or run away from their treatment area.
2. Perform a rapid search of the local area at NMRTCY.
3. Dial **NMRTCY Quarterdeck at 243-7144** to report or contact OPMAN at 243-6177. Describe the person, where they were last seen, what time they were last seen, their medical condition, and location headed if known).

Emergency Management

CODE GRAY – MASS CASUALTY EVENT

NAVHOSPYOKO Instruction 3440.1

Provides guidance in the event of external or internal disasters. Departmental responsibilities and plans are found on the Intranet under "Resources", select "Disaster Preparedness/ Emergency Management Plan".

Immediate response to your mass casualty station is required when a CODE GRAY is announced.

CODE BLACK – BOMB THREAT

Bomb threats usually come in by telephone.

If you receive a bomb threat or any type of threatening phone call, DO NOT HANG-UP! Listen carefully to the caller and obtain as much information as you can.

ASK…

1. **When** is the bomb going to explode?
2. **Where** is the bomb located?
3. **What** kind of bomb is it?
4. **What** does the bomb look like?
5. **Where** are you calling from?

- IMMEDIATELY NOTIFY: Quarterdeck at 243-7144, or OPMAN at 243-6177.
- Turn off handheld radios and cell phones.
- Evacuate when directed.
- Telephonic Threat Compliant worksheet should be posted close to your telephone.

*Refer to the Telephonic Threat Complaint worksheet within **Red Binder.***

Emergency Management

- You have the "***Right to Know***" what hazardous materials you work with and/or are exposed to in your area. This includes any material that is labeled flammable, corrosive, poison, or irritant and should be approached with caution.

ALL chemicals

- Safety Data Sheet (SDS) is a required Fact Sheet on used in your area.
- **ALL containers must be clearly labeled** as to their content and hazards.
- SDS are typically kept in a binder or manual in your area.
- **The SDS Manual in your area is located:**

CODE ORANGE – HAZARDOUS MATERIAL SPILL

What should you do if you have a hazardous spill in your area?

1. If the spill is small and can be cleaned with a "spill kit" while not posing a threat to personnel or the environment, Refer to SDS!!
2. If a spill is major, evacuate all personnel and seal off the area as best as possible – call the NMRTCY Quarterdeck at 243-7144, **or OPMAN at 243-6177** and do not re-enter the area.
3. Obtain SDS sheet if aware of chemical content.

**SDS sheets can be found through the Safety Department or Hazardous Waste Manager at 243-8691/ 5182.*

Ref. Materials, Hazardous Drugs or search online at:
https://chemicalsafety.com/sds-search/

CODE YELLOW

Failures of

Electrical power failure (partial/total), **Water** outage, **Leak** of Pipe or Sprinkler, **Clog** of Drainage/Sewer, **Fire Alarm** System Trouble, **Public Address** System Trouble, **Computer** System Trouble**, Telephone** Trouble, **Medical Gas** Failure, **Heating & Cooling** Trouble, **Elevator** struck between floors/out of service.

Prevention / Preparation

- Know your spaces and facilities
- Contact facilities at the first sign of malfunction

Emergencies

- **Facilities Officer** (during work hours) 243-5448 Cell: 080-9088-2220
- **Public Works Branch** (24 hours) 243-7282 / 9246

Emergency Management

CODE BLUE – CARDIAC RESPIRATORY ARREST

1. Initiate **Basic Life Support (BLS)** Measures
2. Call for Help

- **At NMRTCY:**
  Activate CODE BLUE Team
  - Dial 911 outside of hospital, or call 156 inside
  - Specify adult or pediatric code
  - Give exact location: **Building, Floor, Unit Name**
  - Give the **phone number** you are calling from
  - State **your name**
  - Stay on the phone until told to hang up by the Emergency Department or EMS dispatch

- **At Naval Branch Health Clinics:**
  INITIATE CLINIC RESPONSE SYSTEM
  - Pick up phone and verify dial tone
  - Dial clinic overhead intercom number: _____
  - In a clear, raised voice say: "CODE BLUE" and give location; then repeat announcement.
  - Hang up phone

  INITIATE EMS
  - Pick up phone and verify dial tone
  - Specify adult or pediatric code
  - Give exact location: **Building, Floor, Unit Name**
  - State **your name**
  - Give the phone number you care calling from and remain on the phone until you are told to hang up by EMS dispatch.

Emergency Management

CODE TRAUMA

- Code TRAUMA is the emergency response mechanism for patients with major traumatic life-threatening injury.

At NMRTCY:
Activate Code TRAUMA Team

- Dial 243-7144 from desk phone to activate NMRTCY Code TRAUMA Team

CODE PURPLE – OB/NEONATAL EMERGENCY

- Code PURPLE is the emergency response mechanism for an OB patient emergency.

At NMRTCY:
Activate Code PURPLE Team

- Dial 156 from desk phone or 243-7144 from cell phone to activate NMRTCY Code PURPLE Team

CODE NOVEMBER - RADIATION EXPOSURE

- Code NOVEMBER alerts radiation safety officer of a radioactive contamination or patient injury requiring specialized decontamination and treatment in ED or specified location.

At NMRTCY:
Activate Code NOVEMBER Team

- Dial 156 from desk phone or Quarterdeck at 243-7144 for NMRTCY Code NOVEMBER Team

Emergency Management

CODE BROWN – SEVERE WEATHER ADVISORY

NAVHOSPYOKOINST 3440.1, HSA 2 (Severe Weather)

Review the following storm conditions and take action as directed. Review HSA 2 of the Command Emergency Operations Plan in the share drive under Emergency Management.

Tropical Cyclone Condition of Readiness (TCCOR)

CONDITION	WIND SPEED	ACTIONS
TCCOR 5	>58 MPH **<96 Hours**	**Dept Heads:** Assess travel and inform those on LV/TAD
TCCOR 4	>58 MPH **<72 Hous** (>50 knots)	**CDO/MEM** announces and emails "NH Yokosuka-All" **Dept Heads** survey their areas, secure or remove missile hazards. Ensure their essential personnel are identified, notified, and recalls accurate. **All**: Assist Dept Head/SEL as directed. Have Personnel gas up cars to FULL and stock up on water and 72 hours of shelf stable food.
TCCOR 3	>58 MPH **<48 Hours** (>50 knots)	**Dept Heads** ensure 2 – 3 days of essential supplies in patient care areas. Assess & mitigate risks for expectant mothers & elective surgeries. **All**: Assist Dept Head/SEL as directed
TCCOR 2	>58 MPH **<24 Hours** (>50 knots)	**Dept Heads** assess berthing capacity/needs for patients & staff. **Directors** meet with Commanding Officer at 3B10. **All**: No travel outside Yokosuka without Directorate clearance. Assist Dept Head/SEL as directed.
TCCOR 1	>58 MPH **<12 Hours** (>50 knots)	**Dept Heads** re-schedule patients as appropriate **Directors** meet with Commanding Officer at 3B10 **All**: Assist Dept Head/SEL as directed.
I Caution	39-56 MPH **<12 Hours** (34-49 knots) gusts occurring	**Non-essential personnel** secured until "All Clear **Essential personnel** report for / stay on duty **Dept Head** 3AOB gives a list of high-risk pregnancies and 36+ week patients. **All**: Outdoor activity is limited to emergency and essential services.
I Emergency	>58 MPH gusts occurring (>50 knots)	**Caregivers** move patients and staff away from windows **All**: Gates to the base may be closed if weather conditions warrant. Only official and emergency vehicles on the road.
Recovery	<58 MPH gusts occurring (<50 knots)	**Dept Heads/Directors** report damages to the CDO. **All**: General public stay indoors
"All Clear"	Reduced winds gusts occurring	Declared by **COMNAVFORJAPAN**. Storm is over. Safe to go outdoors **All**: Resume normal activity

Workplace Violence Program

NMRTCY has a workplace violence program for guidance on disruptive patients and/or staff.
NAVHOSPINST 5370.4A

CODE WHITE – ARMED INTRUDER/ ACTIVE SHOOTER

In the event of a weapon, real or potential threat of serious physical violence or destruction of property:

CALL 911/156. "The hospital has a CODE WHITE at _____, info and who (your rank, name, a& phone #). Stay on the line.

Note: ED/Quarterdeck distress button requires immediate 911 call by quarterdeck to CFAY Security. **Promptly provide information below to 911 as it becomes available.**

Nature of incident and current situation:	*Location*
	Weapons
	Injuries

Description of subject(s) involved:	
Sex	*Weight*
Race	*Hair color, length*
Age	*Clothing*
Height	*Name*

How to Respond:

RUN

HIDE

FIGHT

- Have an escape route and plan ahead (if in patient care area, shelter your patients with you).
- Leave your belongings/patients belongings behind and lock the doors behind you.
- Keep your hands visible (if intruder is in area).
- Silence your cell phone and wait for further instructions from the PA system or Law Enforcement.
- Do not stop to ask security personnel for help or direction when evacuating.
- Once in a safe area (outside or in office) do not come out or go back in the building until told to do so by competent authority

Security Officer: 243-8636 / 8637 / 6177
CDO Cell phone: 090-6135-1041

Emergency Management

CODE RED – FIRE EMERGENCY

If you discover or suspect a fire:

R escue endangered persons to safety. If the patients cannot be moved, stay with them and notify evacuating personnel that you are "defending in place". (Endangered includes handicapped persons).

A larm - Activate nearest fire alarm, CALL 911 & Quarterdeck "The hospital has a CODE RED at _____; provide your rank, name, & phone number".

C ontain the fire, close doors and windows. Secure medical gas if assigned by CDO/CFAY Fire Department.

E vacuate the area per Fire Station Bill posted above the alarm station. DO not use elevators. The Senior Person/Fire Warden in the space should take charge of the scene and ensure all staff and patients are accounted for and tha any personnel "defending in place" are reported to the CDO staff (Simulate in fire drills)

How to use a fire extinguisher (in a small, early stage fire)

P – PULL the pin.

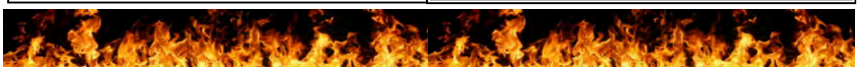
A – AIM the nozzle at the base of the fire

S – SQUEEZE the handle.

S – SWEEP across the base of fire.

More Information

- **NMRTCY Safety Office** 243-8691 / 9914 Cell: 080-5973 2020
- **CFAY Fire Department** 243-7351
- **Fire Safety Information** on the Command Sharepoint "Safety/CoZAR/EoC" – "FIRE SAFETY" including 100% of the command authorized electronic MSDS



Emergency Management

Stop the Bleed

Support active shooter scenarios and mass casualty events by utilizing bleeding control kits to stop hemorrhages.

- With very little training and equipment, the individuals closest to the scene of an accident or mass casualty situation can control bleeding until first responders arrive to take over treatment.
- This is a call to action for every person to take responsibility for learning the basics about how to respond to uncontrolled bleeding and to put those lessons into use when circumstances have placed them in a position to help.
- A national plan of action regarding how to maximize survivability for victims of a mass casualty situation has the potential to increase the resilience and readiness of our nation for the threats that confront us.

Environmental Health & Safety

Fire Safety

Fires in healthcare settings require a rapid, efficient response to limit injury and damage. Each inpatient nursing unit is physically designed to confine smoke or fire to a "smoke compartment" to minimize injury or damage.

If necessary, how do you evacuate employees and patients?

Two ways to evacuate:

1. Horizontal evacuation is the preferred method for departments located in buildings that are constructed to "Defend in Place". Move to a safe location on the same floor – past the next set of fire doors.
2. Vertical evacuation involves mobbing to a different floor or another building.

*Elevators should not be used during a fire emergency. If evacuation sin needed, the fire department will know how to use elevators safely.

NMRTCY is a tobacco-free facility. NMRTCY's designated smoking areas:

Closest designated area is in front of PSD BLDG 1555.

Cylinder Status

- Cylinders should be segregated and properly tagged.
- "FULL" and "IN USE" O_2 cylinders must be kept separate from "EMPTY" O_2 cylinders.

FULL	IN USE	EMPTY
Sealed	No Seal	No Seal
No Regulator	Regulator On	No Regulator
Tagged as FULL	Tagged as IN USE	Tagged as EMPTY
		

O_2 Adaptors

- O_2 adaptors are for single use/single patient use ONLY.

Fit Testing

- Clinical staff who have direct exposure to patients are required to be fit tested on an annual basis.

Eye Wash and Emergency Shower Stations

Eye wash and shower stations must be:

- Unobstructed
- Have protective covers in place
- Tested and logged weekly by the department in which they are located

EYEWASH TEST

- Hold tester 1&1/2 inches below apex.
- If streams hit both bullseyes at the same time and fill parallel lines, the eyewash meets the standard.
- Look for clean and even water streams.
- Document discrepancies in eyewash log and submit work request for repairs.
- Safety Office temperature tests eyewashes annually for 60-100 degree F window.

Safety Office (315-243-8691)

Did you know that...

Positive pressure rooms allow air to flow **OUT** of the room instead of in so that any airborne micro-organisms are kept away from the patient. **Negative pressure rooms** maintain a flow of air **INTO** the room keeping contaminants and pathogens from reaching surrounding areas.

Instructions for Use (IFU)

WHY ARE IFU's IMPORTANT?

- Without the latest IFU's, you increase the risk of Hospital Acquired Infections.
- Eliminate the guesswork and the risk.
- Critical for patient safety.

One Search is a search tool to find instructions for use. Access the OneSource link by clicking the tile on any NMRTCY desktop. By typing the instrument's catalog/model number or keywords, OneSource filters and finds the IFU you are looking for.

**Note: Not all IFUs are listed in OneSource. Refer to your manufacturer. **

IFU's should inform the processes that you do on daily, weekly, and monthly maintenance tasks that ensure the proper function of your areas key equipment.

IE: Sterilizers in SPD, Autoclaves, etc.

DRINK FROM THE IFU FOUNTAIN

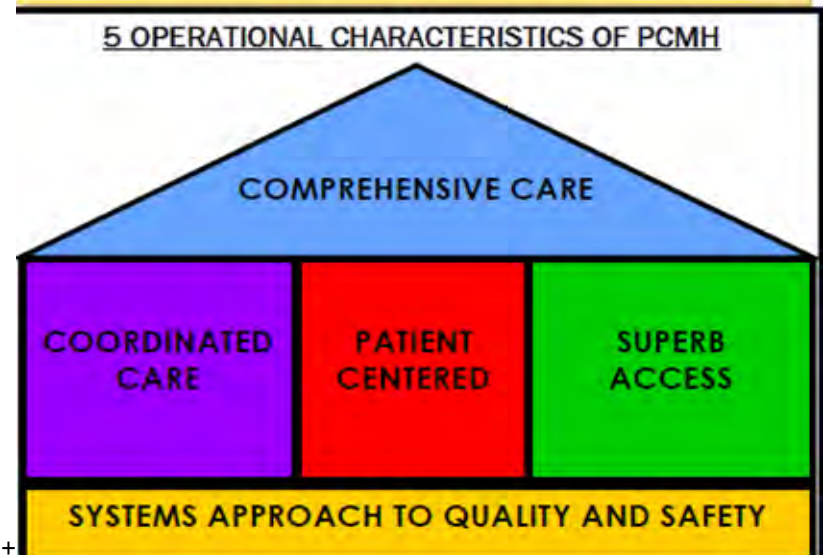
IFUs should be the main source of knowledge.

- Scrutinize your source. Where did it come from? Is there something you do not know? i.e. How do you clean your instruments or equipment?
- It doesn't matter how good your process is but if you/your team cannot articulate who, what, why, and how the process works, then the surveyor can still walk away with questions and concerns.

Primary Care Medical Home (PCMH)

Primary Care Medical Home (PCMH) certification focuses on care coordination, access to care, and how effectively a primary care clinician and interdisciplinary team work in partnership with the patient. PCMH certification option also focuses on education and self-management by the patient.

- Self-management goals must be identified and be part of a treatment plan when the patient is diagnosed and/or a visit is warranted.
- Provide information about PCM credentials & educational backgrounds.
- Patients' health literacy must be identified (learning needs assessment must be performed).
- 24/7 ACCESS TO:
  - * Same day or next day appointment
  - * Prescription renewal
  - * Clinical advice for urgent issues



++

Final Check!

- ☐ Perform **suicide risk** assessment of the physical environment where patients at high risk for suicide are cared for. The suicide risk assessment must identify features in the physical environment that could be used to attempt suicide.

- ☐ Perform **infection prevention** related surveillance to minimize, reduce, or eliminate the risk of infection:
  - ☐ Torn mattresses; blood-stained equipment/supply
  - ☐ Dirty items in clean areas and vice versa
  - ☐ Adhesive tape residue on surfaces
  - ☐ Report substances that look like mold
  - ☐ Follow guidelines related to high level disinfection and sterilization
  - ☐ Report rust issued on medical equipment, instruments, storage, and IV poles

- ☐ Perform **environmental checks** within your areas:
  - ☐ Respond to your area emergency call systems
  - ☐ Know who is allowed to shut off oxygen in your area in the event of a fire
  - ☐ Segregate empty O2 cylinders from full and partial O2 cylinders when sorting
  - ☐ Check expiration dates on supplies
  - ☐ Wear hospital ID badges while on duty
  - ☐ Follow manufacturer's recommendation when performing daily checks on high-risk equipment such as defibrillators, ventilators, AED's, etc.

- ☐ Pay attention to detail with all forms of **documentation**:
  - ☐ Ensure daily checks are done on code carts; keep only one month's worth of log and archive the rest
  - ☐ Label multi-dose vials with the appropriate modified expiration dates
  - ☐ Eye wash station checks documentation at 100%
  - ☐ Hydrocollator cleaning documentation at 100%

Important Phone Numbers

CODE Numbers

RED = FIRE	911 of 156
BLUE = CARDIAC/RESPIRATORY ARREST	911 or 156
PURPLE = OB/NEONATAL EMERGENCY	156 or 243-7144
BROWN = TCCOR/WEATHER EMERGENCY	243-7144
PINK = INFANT/CHILD ABDUCTION	243-7144
BLACK = BOMB THREAT/EVACUATION	243-7144
ORANGE = HAZARDOUS MATERIAL SPILL	243-7144
WHITE = ARMED INTRUDER/SHOOTER	243-7144
GRAY = MASS CASUALTY EVENT	243-7144
SILVER = CHILD/ADULT LOST/ELOPED	243-7144
GREEN = VIOLENT/COMBATIVE PERSON	243-7144
YELLOW = UTILITY FAILURE	243-7144
NOVEMBER= RADIATION EVENT	243-7144
TRAUMA - MAJOR TRAUMA	243-7144

Other Key Numbers

Quarter Deck	243-7144
Security	243-8871
Safety	243-8691
Facility Management	243-8687
Patient Safety	243-8638
Infection Control	243-5893
Risk Management	243-9194
Quality Management	243-9223
Emergency Department	243-8595