Naval Medical Center
San Diego

Joint Commission Continuous Readiness

Pocket Guide

Your HEALTH is our MISSION

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NMCSD Commander's Guidance

Vision

Provide a superior experience for our patients, staff and warfighters. Be the preferred choice in compassionate and innovative healthcare.

Mission Statement

Optimize Health,
Enhance Readiness

Philosophy

Anchored in Excellence
Committed to Health!

THROUGH THESE HALLS
WALKS THE WORLD'S FINEST HEALTHCARE TEAM

"ANCHORED IN EXCELLENCE, COMMITTED TO HEALTH"

NMCSD's Command Priorities

Command Priorities

With the assistance of NMCSD's Executive Steering Council (ESC), the Commanding Officer (CO) determines and directs strategic alignment around our medical center's highest priorities. Our CO's guidance includes the following priorities:

Warfighter Readiness

- Ensure that the Sailors and Marines under our care are medically ready to deploy in support of operational military missions worldwide.
- Provide high quality care to the family members and dependents of our active duty service members, allowing them to focus on their mission, knowing that their loved ones are cared for.

Medical Force Generation

- Ensure NMCSD maintains a ready medical force to support operational military missions worldwide.
- Educate and train personnel across the spectrum to include fellows and resident physicians, nurses, and corpsmen/healthcare technicians to maintain a continuous pipeline of medical assets to support operational missions.

High Quality Healthcare

- Provide safe, quality, and compassionate health care in healing and welcoming environment for every patient every time.
- Utilize numerous quality measurement tools, patient safety practices, and process improvement strategies to continually improve the delivery of care.

The Joint Commission Survey Overview

Introduction

Every 3 years, the Department of Defense receives notice that The Joint Commission (TJC) triennial accreditation surveys will be conducted within a 9 month window. During these surveys, multidisciplinary team consisting of physicians, nurses, ambulatory, behavioral health, and life safety surveyors are on-site for one to five days depending on the size of the organization. Due to NMCSD's size, our specialists will likely be on-site for 3-4 days. The survey focuses on processes and functions related to safety/quality of care, treatment, and services using Tracer Methodology. The Survey Specialists will evaluate NMCSD's functions and processes with focus on reviewing compliance with the National Fire Protection Association (NFPA), medical gas system requirements, Life Safety (LS) standards, Environment of Care (EC) standards, and Emergency Management (EM) standards.

How to Use this Book:

This book is a general reference designed to equip you to stay continuously ready and be able to answer a litany of questions that might be directed at you by The Joint Commission (TJC) surveyors. We can be surveyed at any time. Keep this reference handy and fill in the blanks specific to your area/ department. Although this book is not all inclusive, utilizing this guide can give you the right information and principles to respond appropriately during the survey process. Thank you for your efforts and hard work

The Joint Commission Survey Overview

Tracer Methodology

An evaluation method in which surveyors select patients and use their medical records as roadmaps to move through the organization and follow the experience of the patient through the entire health care process. Surveyors will make requests for the **daily census list, operating room schedules, procedure schedules, and other data sources** to select patients for **individual tracers**.

TYPICAL PATIENTS SELECTED FOR TRACERS

√ They have received multiple complex services and usually are close to discharge (e.g. Surgery, Dialysis, Cardiac Cath)
√ They crossed different departments/services/programs (Mental Health Clinic→ER→OR→ICU→Med/Surg)
√ They are related to Infection Prevention and Control and/or extensive Medication Management issues
√ ER and Clinic patients who are prescribed antibiotics
√ Patients who are scheduled for a diagnostic imaging examination such as Computerized Tomography (CT)

HOW WILL THE SURVEYORS CONDUCT TRACERS

* Review patient's medical records with staff
* Observe direct patient care
* Observe the medication process
* Observe equipment use
* Interview patients/family
* Observe care planning
* Observe infection control and prevention processes
* Observe the environment of care and safety
* Review competencies, evaluations, and Continued Education (CE's).
* Closed records review of patients for restraints
* Discuss National Patient Safety Goals & Process Improvement projects, related patient care, and services.

How to Participate in the Survey

Keep the Conversation Professional

- Ask questions if you do not understand. NEVER argue with the surveyors. Be professional and use appropriate language and behavior.

Be Truthful

* **If you do not know an answer, say so, and tell the surveyor where or whom you would go to for the answer. Remember you may use any resources available to you, such as the intranet, policies, badge information, department resources, or supervisor.**

Keep Your Answers Focused and Specific

- Whenever possible, answer in your own words. Keep your answers short and to the point.

Support Your Co-Worker

- If you are present when someone else is being interviewed, feel free to add any relevant information without being intrusive.
- Respond to questions with confidence—you know the answers better than anyone. Speak freely about all of 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 is critical to providing excellent care for the patient!

What If the Surveyor Asks ME a Question?

DO's

- Greet the surveyor.
- 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!**
- Volunteer unrelated information.
- Let the surveyor make you feel defensive.
- **Use phrases** that will demonstrate inconsistencies such as, **"It should be", "Usually we" or "Most of the time"**

These phrases will lead the surveyors to ask more questions.

- NEVER attempt to answer a question by assuming what the documentation was intended to mean; let the record speak for itself.

DHA: my MILITARY HEALTH

myMILITARY HEALTH Anytime, Anywhere — Always

A care model designed with YOU in mind.
The Defense Health Agency is reimagining health care to fit your needs **Anytime, Anywhere – Always.**

Vison- Unrelenting pursuit of excellence

- More **convenient.**
- More **flexible** to fit seamlessly into your life.
- More **personalized** for your unique needs.

Investing in Our People, Investing in Our Future
My Military Health, not only committed to our patients, but our teammates too

- Improving professional fulfillment by elevating our team's passions and prioritizing career progression, Eliminating red tape so that our team is not hampered by unnecessary administrative burdens, and Implementing new policies and procedures that make our collective team's lives easier.

DHA: Ready Reliable Care

READY RELIABLE CARE ANYTIME, ANYWHERE | DHA Defense Health Agency ®

MHS READY RELIABLE CARE

LEARN MORE ABOUT READY RELIABLE CARE:
HEALTH.MIL/READYRELIABLECARE

ALL LEADERSHIP, STAFF, AND PATIENTS CONTRIBUTE TO MHS IMPROVEMENTS BY APPLYING THE SEVEN READY RELIABLE CARE PRINCIPLES IN THEIR DAILY WORK :

EFFORTS TO ADVANCE A READY, RELIABLE MHS ARE DESCRIBED AGAINST FOUR DOMAINS OF CHANGE :

High Reliability Organization (HRO)

"High-reliability" describes NMCSD's commitment to consistent performance at high levels of safety over long periods of time. A dominant attitude or cultural feature that all high-reliability organizations display is a "COLLECTIVE MINDFULNESS"

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.

NMCSD Executive Leadership and staff are strong supporters of patient safety. The GOAL of the Patient Safety Program is to prevent avoidable harm to patients. This 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

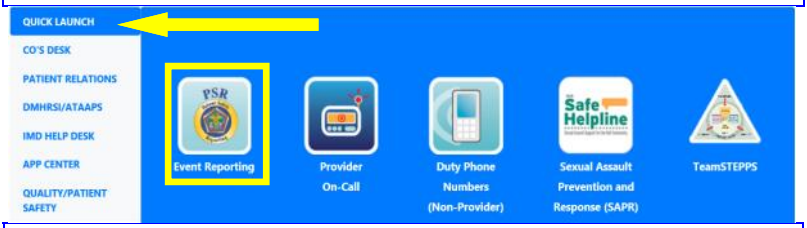
Quality & Patient Safety Resources

Quality and Patient Safety electronic links and resources are available on the NMCSD Intranet page.
Joint Commission continuous survey readiness tools and information are available by clicking on the JC—Joint Commission link.

Patient Safety Reporting (PSR)

HOW DO I REPORT AN EVENT?

Use the electronic Event Reporting (PSR) tool on the NMCSD Intranet through the Quick Launch Event Reporting icon or under “Clinical Tools”.

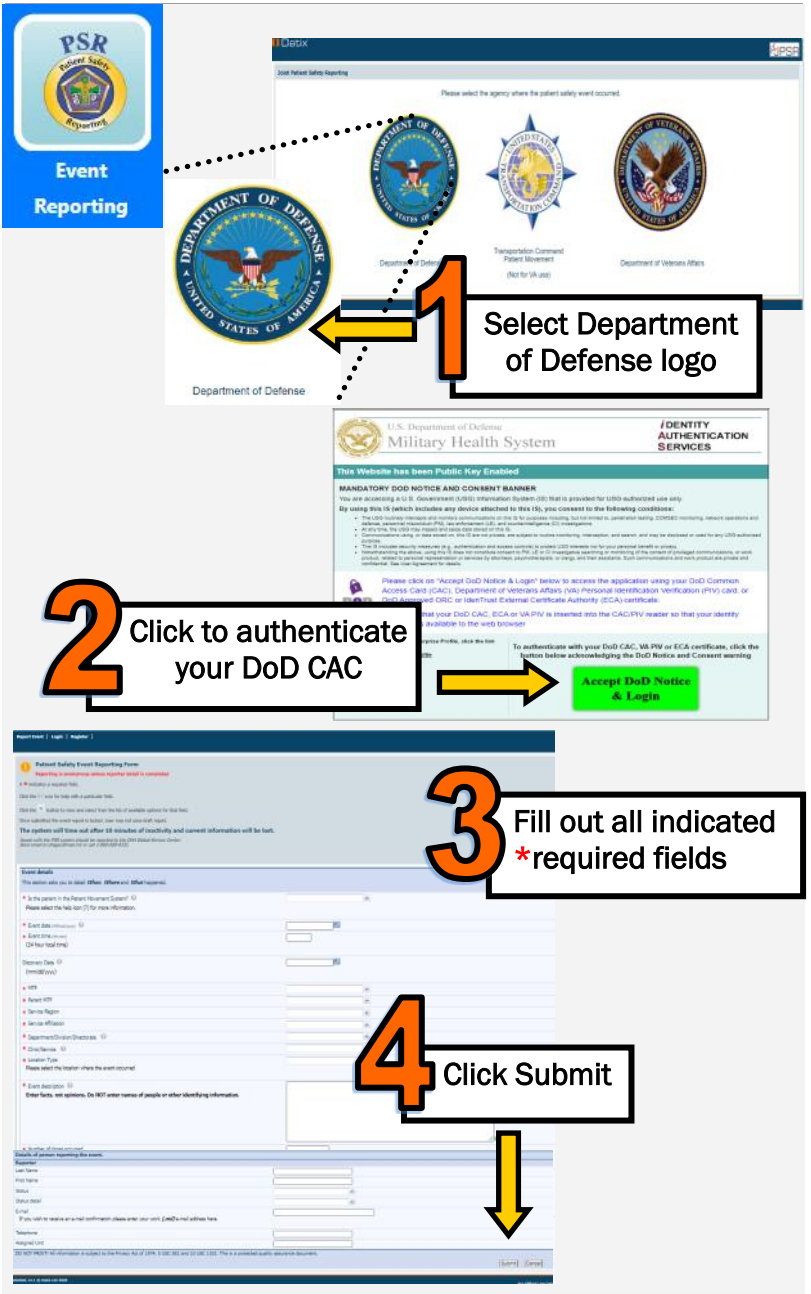


The electronic form is automatically forwarded to Patient Safety/Risk Management for review and follow-up.

Reporting is anonymous but if you would like feedback on the event submitted, you must complete the “Reporter” details section which includes your name and contact information.

Patient Safety/Risk Management
619-532-9377

Patient Safety Reporting (Event Reporting)



What Types of Incidents Should I Report?

Errors
An unintended act, either by omission or commission, or an act that does not achieve its intended outcomes.

Near Misses
A process variation that did not reach the patient but for which a recurrence carries a significant chance of a serious adverse outcome.

Hazardous Conditions
Any set of circumstances (unrelated to the patient's condition) which significantly increases the likelihood of a serious adverse outcome.

Sentinel Events
An unexpected occurrence that results in death or serious injury, or outcome unrelated to the patient's course of illness.

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".

WHAT HAPPENS TO A PSR AFTER I SUBMIT IT?

1. The Patient Safety Office reviews the event, collects any additional information needed, and assigns a severity score that determines additional review requirements, such as a Root Cause Analysis or reporting to The Joint Commission.
2. Data from event reports are analyzed, collated and shared with leadership and appropriate committees to improve patient safety.

"I ought to have known. My advisors ought to have known and I ought to have been told, and I ought to have asked."
- Winston Churchill

What Types of Incidents Should I Report?

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....*"

- To report a Good Catch, go to the Command Intranet Home page. Click on "Quality/Patient Safety" from the sidebar. Then click on the "Good Catch Reporting" link.
- One Good Catch is recognized weekly by the Commanding Officer.
- What are examples of a Good Catch?
  - A medication error that did not reach the patient
  - Recognizing trip hazards or other unsafe conditions
  - Recognizing a patient's pre-procedural information was not updated or was not accurate before performing a procedure

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A Sentinel Event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

♦Death ♦Permanent harm ♦Severe temporary harm

Employee Responsibilities in a Sentinel Event:

- Immediately notify the Patient Safety/Risk Management 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 equipment.
- Participate in the investigation of the root cause analysis if requested.
- Participate in changes made to systems/processes to reduce the risk of reoccurrence.

Sentinel Events

A Sentinel Event - is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

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 (ED)
- 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>30 mg/dl)
- Prolonged fluoroscopy with cumulative dose >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

Performance Improvement (PI)

Continuous Process Improvement (CPI)

Naval Medical Center San Diego (NMCSD) is committed to the delivery of safe, quality health care, zero preventable patient harm, and the tenets of high reliability organizations (HRO).
As a military institution, our command's critical mission priorities consist of warfighter readiness, medical force generation, and high quality healthcare. NMCSD is dedicated to achieve the three high reliability objectives of: leadership commitment to zero preventable patient harm, safety culture practiced throughout the organization, and the widespread use of robust process improvement initiatives. NMCSD supports an annual CPI Fair to showcase CPI projects performed by staff throughout the year.

- 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?

Lean Six Sigma

CPI/LSS Distribution List
usn.san-diego.navmedcensanca.list.nmcsd-cpifair@mail.mil
Office of Continuous Improvement
619-532-9160

Robust Process Improvement (RPI)

Methodologies: A variety of methodologies may be utilized towards making improvements at NMCSD depending on the complexity of the project.

BASIC

ADVANCED

Sort-Set in order-Shine-Standardize-Sustain (5S)
- Workplace organization
- May be performed by any staff member

Low Hanging Fruit (LHF)
- Obvious solution is known and takes little effort to implement
- Any staff member may perform

Just Do It (JDI)
- Cause/solution known; minimal resources needed to complete
- Often utilizes a team which may be led by any staff member
- Teams consist of staff members working on the process being improved

Plan-Do-Check-Act (PDCA)
- Examines a process utilizing the 4 steps to continuously improve each cycle
- Utilizes a team which may be led by any staff member
- Teams typically consist of subject matter experts (SMEs)

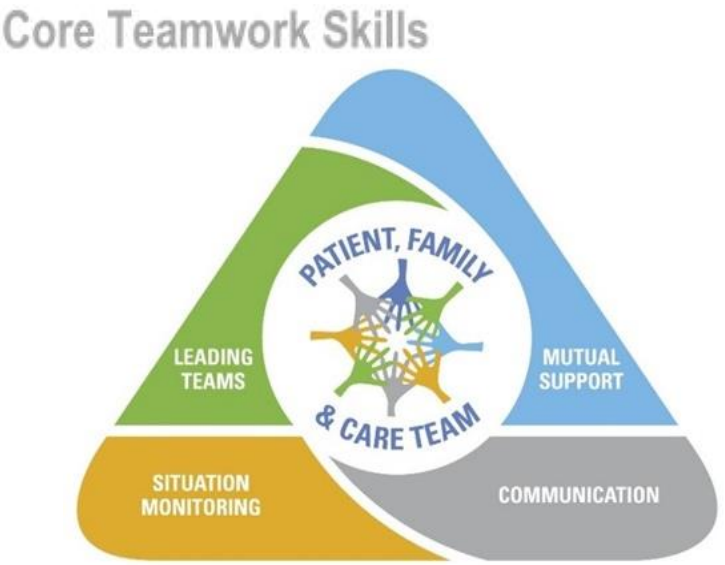
Rapid Improvement Event (RIE/Lean)
- Root cause known/solution unknown
- Reduce steps/eliminate waste
- May be led by a Green Belt (GB) or Black Belt (BB)

Define-Measure-Analyze-Improve-Control-Validate (DMAICV/Six Sigma)
- Metric needs improvement but root cause/solution unknown
- Reduces variation
- May be led by a Black Belt (BB) or Green Belt (GB) with BB mentor

TeamSTEPPS®

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 is comprised of 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 NMCSD

TeamSTEPPS Tools: SBAR & I-PASS

SBAR provides a framework for team members to effectively communicate information to one another.
Communicate the following information:

SITUATION
What is going on with the patient?

BACKGROUND
What is the clinical background or context?

ASSESSMENT
What do you think the problem is?

REQUEST/ RECOMMENDATION
What would I recommend?

I-PASS the BATON

BETTER HANDOFFS. SAFER CARE.

I — **INTRODUCTION**
Introduce yourself & your role/job (include patient)

P — **PATIENT**
Identifiers, age, sex, location

A — **ASSESSMENT**
Chief compliant, vital signs, symptoms & diagnosis

S — **SITUATION**
Current status circumstances, recent changes & responses

S — **SAFETY**
Critical lab values reports, allergies, alerts, falls, etc.

B — **BACKGROUND**
Comorbidities, previous episodes, meds & family history

A — **ACTIONS**
Actions taken or required w/rationale

T — **TIMING**
Urgency & prioritization of actions

O — **OWNERSHIP**
Who is responsible? (nurse/doctor/family)

N — **NEXT**
Anticipated changes? Plan? Contingency plan?

You are the Patient Experience (Speak Up)

SERVICE EXCELLENCE EXPECTATIONS (S.E.E.):
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

Goal 1: IDENTIFY PATIENTS CORRECLY

NPSG.01.01.01

√ 2 identifiers every time. **ALWAYS** use the patient's **Full Name and full Date of Birth (MMDDYY)** . DoD ID number should be used as a third identifier. Match treatment to patient. Identify the patient every time you provide a service or treatment **Do NOT skip safety checks.**

√ Two staff members must verify (2 patient IDs) when drawing blood for blood products AND before giving blood products. Follow the instruction.

√ **LABEL BLOOD AND OTHER SPECIMENS IN THE PRESENCE OF THE PATIENT.** Have patient verify labels when able to do so.

√ Use distinct naming for newborn patients.

Goal 2: IMPROVE STAFF COMMUNICATION

NPSG.02.03.01

√ **EFFECTIVE Communication** skills go hand in hand with patient safety.

√ When sharing information, communication should be complete, clear, brief, and timely.

√ Get critical results to provider **within 1 hour** (internal policy). Evaluate effectiveness of reporting critical results.

Goal 3: USE MEDICINES SAFELY

NPSG.03.04.01 , NPSG.03.05.01 , NPSG.03.06.01

√ **ALWAYS** reconcile, record and pass along correct information about a patient's medicines.

√ Make sure the patient knows which medicines to take when they are at home.

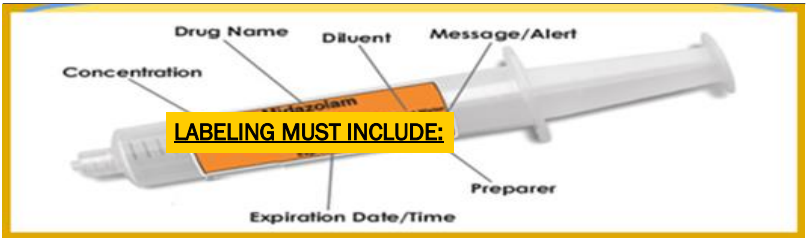
√ Before every procedure, **ALWAYS** label medicines that are out of the original container. Includes syringes, basins, or other containers.

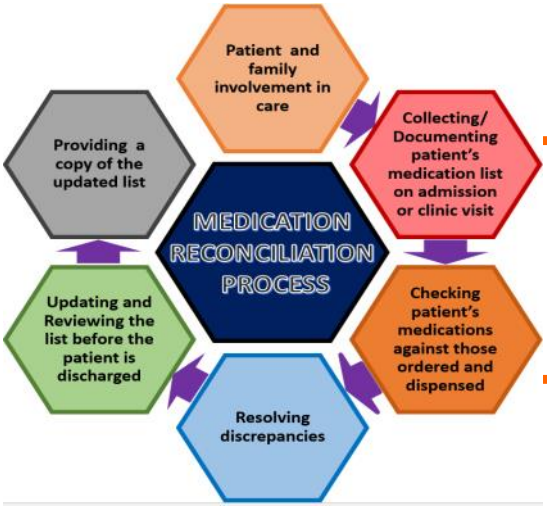
√ Use protocols when administering anticoagulant therapy.

√ **International Normalized Ratio (INR)** baseline is required prior to beginning Coumadin therapy. Subsequent INRs are obtained for use in monitoring the patient's therapy.

√ Use unit dose, prefilled syringes or premixed infusion bags when giving heparin.

National Patient Safety Goals





Pharmacy Medical Home Port (Coumadin Antico-agulant Clinic) 619-532-9495

Goal 6: USE ALARMS SAFELY

NPSG.06.01.01

- √ Clinical alarms alert staff of urgent or potentially adverse patient conditions.
- √ Alarms **MUST** be audible and offer alerts that are understood and promptly acted on by staff.
- √ Make sure alarms are audible with respect to competing noises in the unit.
- √ Always physically enter the room during an alarm and assess the patient.
- √ Do not turn off or deactivate alarm capabilities.
- √ Ensure regular preventive maintenance and testing is done.

NAVMEDCEN SDIEGOINST 5132.1

National Patient Safety Goals

Goal 7: PREVENT INFECTION
NPSG.07.01.01

√ Each year millions of people acquire an infection while receiving care in a health care organization.

√ Compliance with hand hygiene guidelines reduce health care acquired infections.

√ Implement evidence-based practices to prevent infections.

√ **Perform hand hygiene on entry to the patient room/cubicle and on exit.**

√ **Perform hand hygiene BEFORE gloving & after removing gloves.**

Goal 15: IDENTIFY PATIENT SAFETY RISKS
NPSG.15.01.01

√ LISTEN, ASK, and ACT.

√ Staff should be AWARE of the signs of and the risk factors associated with suicide.

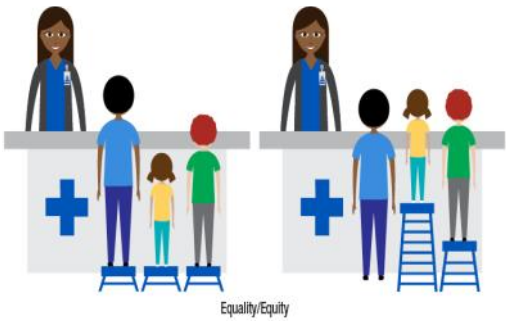
√ Suicide risk assessment of the physical environment.

Goal 16: IMPROVE HEALTH CARE EQUITY
NPSG.16.01.01

√ Identify health care disparities in the patient population such as age, race, preferred language or gender.

√ Establish a written action plan to address at least one of the identified areas

√ Annual review and brief to leadership on progress on improving health care equity



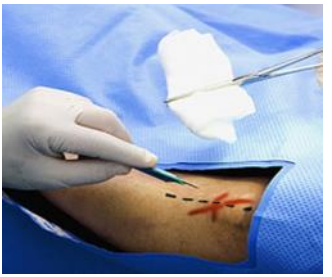
National Patient Safety Goals

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.

PRE-PROCEDURE VERIFICATION

MARK THE PROCEDURE SITE



The Joint Commission

The Universal Protocol
for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™
Guidance for health care professionals

TIME OUT PROCEDURE BY THE ENTIRE TEAM

WHERE TO DOCUMENT TIME OUT PROCDURES

- •NMCSD Universal Protocol and Procedure Safety Checklist
- •NMCSD Universal Protocol and Procedure Safety Checklist-Abbreviated

MHS GENESIS

Dental Universal Protocol DHA-PI 6410.02 Series

NAVMECEN SDIEGOINST 6010.20 series

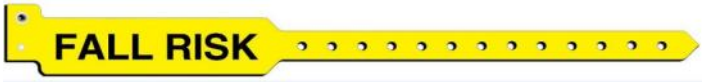
Fall Prevention & Post-Fall Management

Inpatient and ED Setting

Inpatients: Fall risk will be assessed upon admission and then every shift using the Morse Fall Risk Scale for adults and Humpty Dumpty Fall Risk Scale for pediatric patients

Yellow armbands for patients at moderate or high risk of falling

Newborns, PICU patients and pediatric patients 4 years of age and under are considered high risk for falls/drops. Yellow armband is not required. Educate parents not to sleep with babies



ED and Outpatient Setting

ED will assess all patients upon admission to triage and as needed based on condition

Outpatient clinics

Inspect environment for trip hazards

Patients having outpatient procedures or receiving medication have increased fall risk

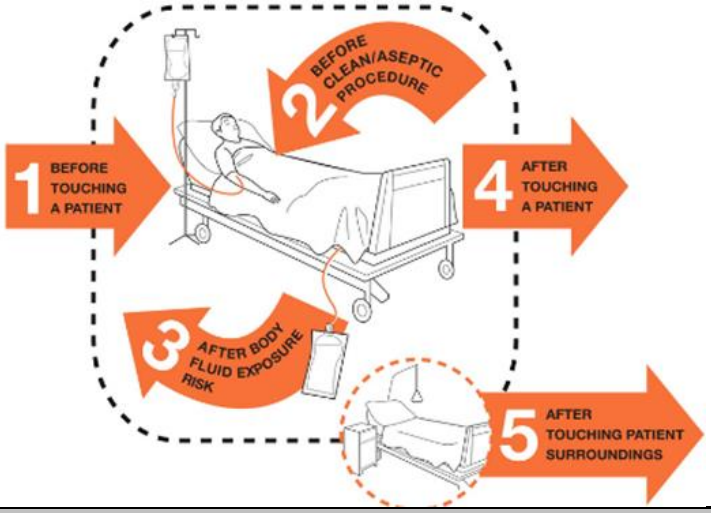
Post Fall Assessment and Evaluation

- Un-witnessed inpatient falls require Rapid Response Team (RRT) activation
- Un-witnessed outpatient falls should be evaluated and transported to ED if necessary
- Document assessment in MHS Genesis
- Consider imaging for patients at high risk for intracranial bleed like patients on anticoagulants, patients with altered mental status prior to the fall, or un-witnessed falls

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

Infection Prevention & Control—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, and when changing, or after removing 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 NMCSD?

The Infection Prevention and Control Manual, which acts as both a guide and reference is accessible on the NMCSD intranet under “Reference Materials”.

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

619-532-7486

Infection Prevention & Control
Bloodborne Pathogens

What is Your Risk?

- Do you handle contaminated items or surfaces?
- Do you come in DIRECT CONTACT with blood, mucous 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

Infection Prevention & Control
Standard Precautions

Standard Precautions

An approach to infection control which treats all body fluids and substances as if they were infectious for Bloodborne Pathogens. Use of standard precautions is determined by nature of the patient interaction and 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 of protective personal equipment (PPE): gloves, gowns, mask, and face shields.
√ Aseptic technique, including appropriate use of skin disinfectants.
√ Personal hygiene practices, particularly hand-washing and hand hygiene, and cough etiquette.
√ Appropriate handling and disposal of sharps and clinical waste.
√ Appropriate reprocessing of reusable equipment and instruments, including appropriate 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 (time the surface must remain wet) for the disinfectant that you are using?

Answer: contact time is listed on the product bottle and is different per each product.

NAVMEDCEN SDIEGOINST 5100.23 series
Infection Prevention and Control Manual

Infection Prevention & Control
Sterility and 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

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.

Infection Prevention & Control
Important Symbols

IMPORTANT SYMBOLS

Expiration Date

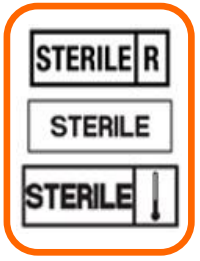
- Do not use products or medications past their expiration date.
- Develop a process for recognizing when products and medications will expire and what to do if they are close to expiration.
- What to do if there is only a month and year for expiration?
  - Good until the END of the month

Manufacturer's Date

- Indicates when the device/product medication was manufactured

Single Use

- Only use item/product once then dispose of it



Sterile (Manufacturer's Sterile)

- Sterilization destroys all microorganisms on the surface of a product or in a fluid to prevent disease transmission associated with the use of that item.
- The use of inadequately sterilized critical items represents a high risk of transmitting pathogens
- Many ways to sterilize items:
  -moist heat (steam), dry heat, radiation, ethylene oxide gas, vaporized hydrogen peroxide

Infection Prevention & Control
Point- of- use Treatment of Surgical/ Dental Instruments

⇒ During Procedure – Wipe instruments/flush lumens with H2O **(NOT Saline)** to prevent buildup and drying of bioburden.

⇒ Remove disposable sharps or single-use items and dispose of appropriately

Perform the following POU treatment steps inside exam/ patient room OR transport to designated soiled utility room

1. Open all hinged instruments and fully disassemble multi-part instruments.
2. Wipe instruments and flush lumens with H2O. (NOT Saline)
3. Place contaminated instruments in approved biohazard transport container.
4. Remove gloves, perform hand hygiene, don clean gloves.
5. Apply Prepzyme Forever Wet enzymatic spray directly onto instruments with 5-6 sweeping sprays. (If enzymatic is contraindicated – cover instruments with water-moistened [NOT Saline], single-use, lint- free, absorbent wipe).
6. Remove all PPE and perform hand hygiene.
7. Close and latch biohazard transport container and transport to decon area of SPD as soon as reasonably possible.




Infection Prevention & Control

Clostridioides difficile (C. diff)

- Number 1 infection for NMCSD in 2024
- An infectious cause of diarrhea that can cause death through dehydration, electrolyte imbalance, and sepsis.
- Transmitted by contact through oral fecal transmission
- Forms spores that are immune to common disinfectants and sanitizers
    - Therefore **bleach** must be used on surfaces and equipment after contamination
    - Hands must be washed with **soap and water** after care
    - Patient must be placed on **contact plus isolation**
    - Visitors and ancillary stuff must also comply with the isolation precautions and handwashing

Infection Prevention & Control

Sterile and Non-Sterile Ultrasound Gel
General Guidance

Background: Outbreaks due to bacterial contamination of ultrasound gel have occurred, and therefore infection mitigation strategies shall be implemented in order to minimize risk associated with its use.

Sterile Ultrasound Gel

- Invasive Procedures where a needle or device passes through tissue.
- Ultrasound examinations or procedures preformed on non-intact skin or near fresh surgical sites.
- All ultrasound examinations preformed on neonates.

Use Single-patient single-use sterile gel packets; discard after one use
Examples: ultrasound-guided peripheral IV insertion, ultra-sound guided biopsy, joint injections, needle aspirations.

Non-Sterile Ultrasound Gel

- One opened, **label the bottle with a 28 day expiration** or the manufacture expiration date, whichever comes first.
- Avoid direct contact between the tip of the bottle and any person, instrument or the transducer.
- Can only be used on intact skin
- Do not refill or top off bottles
- **Discard if contamination is suspected or bottle is opened and undated.**

Warming of Ultrasound Gel

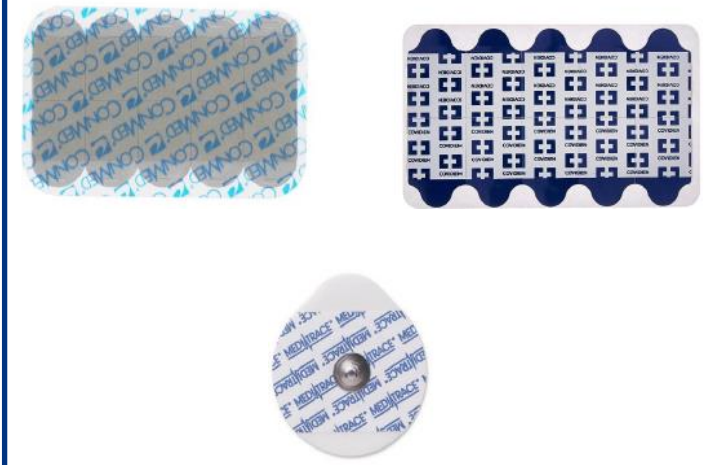
⇒ If used, follow MIFU for the warmer
⇒ Do not store gel bottles upside down

Shelf Life and Storage of Aquasonic Ultrasound Transmission Gel info can be found at: https://aquasonicgel.com/blog/shelf-life-and-storage-of-aquasonic-ultrasound-transmission-gel/
POC information for the Infection Prevention and Control team can be fount on the IPC Share Point site: https://nmcsdasintra05.med.ds.osd.mil/sites/cs/qm/IPaC/SitePages/Home.aspx

ECG ELECTRODES

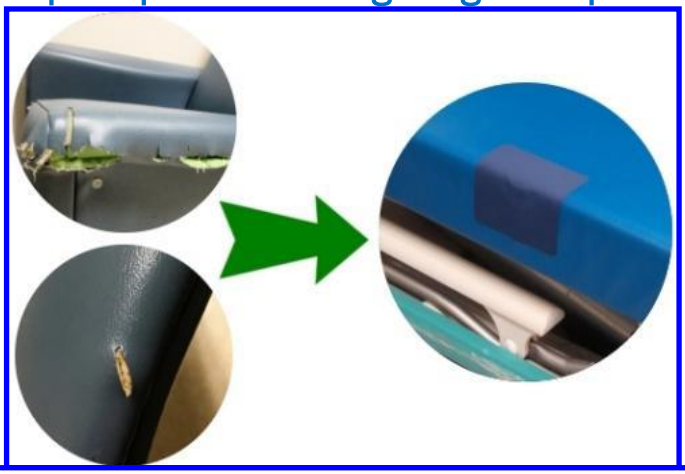
Dispose of all ECG Electrodes 30 Days after opening.

Store Open ECG Electrodes in a resealable container labeled with disposal date.



Physical Environment

Keep hospital furnishings in good repair



CLEANPATCH—FDA Approved

https://cleanpatch.ca/products/cleanpatch/

- Utilized to cover rips/tears in furnishings
- CleanPatch is recommended for use on flat and 2D surfaces. Do not use on 3D corners or if damage is more than 6 inches

Emergency Pull Cords

According to ADA accessibility guidelines, emergency pull cords should be positioned between 6-8 inches above the floor.

Leap Frog

What is Leapfrog?

When a hospital takes part in the Leapfrog Group survey, it means they are voluntarily submitting their performance on various quality and safety measures data, allowing the public to see how well they are performing compared to other hospitals. The goal of promoting transparency and driving improvements in patient care signifies their commitment to publicly reporting on their safety standards and quality of care.

What is the Hospital Safety grade?

Based on the survey data, Leapfrog assigns each hospital a letter grade (A-F) representing their overall safety performance.

The Leapfrog Hospital Safety Grade is a letter grade program that rates a hospital's patient safety measures through more than 30 national performance indicators (such as errors, accidents, injuries, and infections) as well as the systems hospitals have in place to prevent patient harm.

Naval Medical Center San Diego proudly received an "A" Leapfrog Hospital Safety Grade for Fall 2024, demonstrating NMCSD's continued commitment to safe, high-quality care and transparency.

Pain Management

PATIENTS HAVE THE RIGHT TO APPROPRIATE PAIN ASSESSMENT AND MANAGEMENT

- Pain assessment is completed in primary or specialty care

Pain Assessment Must be Conducted...

- *Upon admission to the hospital or each outpatient visit*
- *After all operative or invasive procedures*
- *Periodically and/or routinely after procedures associated with pain (e.g. every 5 minutes or 4 hours, if indicated)*
- *After any significant change in the patient's condition*
- *Patient's response to therapy (i.e. within 1 hour following any pain intervention)*
- *Prior to discharge*

Pain Assessment, Reassessment, and Documentation

- Identification of pain—how does the patient describe the pain and where does the patient localize the pain
- Assessment & measure of pain—use of pain rating scales for the appropriate age and population (examples: children, elderly, cognitively impaired)
- Intensity and quality (character, frequency, location, duration, aggravating and alleviating factors, and symptoms)
- Note vital signs
- Responses to treatment — both pharmacological and non-pharmacological treatments
- Reassessment after treatment and at regular intervals
- Reassessment should focus on the effectiveness of therapy, any side effects caused by therapy, identifying the cause of pain, and developing or modifying the pain therapy plan as appropriate
- Consider consultation with a specialist if treatment fails.
- Written and verbal pain management information will be provided at the time of discharge

NAVMEDCEN SDIEGOINST 6320.97 series

Do Not Use Dose Designations & Abbreviations

Dangerous Term	*Intended Meaning*	*Correction*
"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: 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"
Q.O.D., QOD, q.o.d., or qod	Every other Day	Write out "every other day"
MgSO4 MS MSO4	Magnesium Sulfate 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.

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

Refer to complete chart in
NAVMEDCEN SDIEGOINST 6010.1 series

Medication Management—TJC Findings

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—TJC Findings

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 NMCSD'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.

Medication Management—TJC Findings

Formulary — NMCSD uses the DHA Formulary, available on the NMCSD Intranet under QUICK LAUNCH or on the Pharmacy SharePoint site.

Individual drugs can be searched on the Tricare Formulary Search *https://info.health.mil/hco/pharmacy/FMB/SitePages/Home.aspx*

SAFELY STORE and SECURE MEDICATIONS

- Medications are maintained at temperatures according to manufacturer's recommendations.
- Complete documentation of temperatures on paper logs.
- Medication refrigerators are clearly labeled as "DRUGS ONLY: NO FOOD".
- Ensure monitoring of temperatures of medication refrigerators in areas not staffed 7 days a week.
- Check expiration dates on all medications to ensure not out of date.

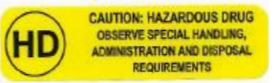
Survey Findings: Observed an open multi-dose vial without a revised expiration date.

Can an anesthesia cart containing medication be left unlocked in an operating room (OR) suite between cases? If the cart can be monitored and assure constant surveillance to prohibit access by unauthorized individuals, then locking of the cart between cases would not be required. Source: TJC Standards FAQs

Medication Management—TJC Findings

SAFELY MANAGE HIGH-ALERT (RISK) & HAZARDOUS MEDICATIONS

SAFE USE OF LOOK-ALIKE/SOUND ALIKE (LASA) MEDICATIONS



- Annually reviewed lists available on Pharmacy and Therapeutics (P&T) Committee SharePoint site
- Safety Management Strategies for NMCSD
  - Tallman lettering is used for LASA medications
  - Physically separating LASA medications in storage
  - High alert and "Look Alike/Sound Alike" medications are clearly marked with stickers and alerts on the Pyxis system

Survey Findings: Pharmacy is found compliant but not in areas outside of pharmacy. Also, non-pharmacy staff are not familiar with LASA list.

LOOK ALIKE SOUND ALIKE

buPROPion SR (Wellbutrin SR ®)
Look Alike Sound Alike Medication
Caution: This drug may be confused with another drug. Verify this drug to the original order in accordance with NMCSD P&T Committee

buPROPion XL (Wellbutrin XL ®)
Look Alike Sound Alike Medication
Caution: This drug may be confused with another drug. Verify this drug to the original order in accordance with NMCSD P&T Committee

hydraALAZINE (Apresoline ®)
Look Alike Sound Alike Medication
Caution: This drug may be confused with another drug. Verify this drug to the original order in accordance with NMCSD P&T Committee

hydrOXYzine (Vistral ® Atarax®)
Look Alike Sound Alike Medication
Caution: This drug may be confused with another drug. Verify this drug to the original order in accordance with NMCSD P&T Committee

ePHEDRine
Look Alike Sound Alike Medication
Caution: This drug may be confused with another drug. Verify this drug to the original order in accordance with NMCSD P&T Committee

EPINEPHrine
Look Alike Sound Alike Medication
Caution: This drug may be confused with another drug. Verify this drug to the original order in accordance with NMCSD P&T Committee

Medication Management— Injection Safety

What is injection safety? Injection safety or safe injection practices, is a set of measures 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.

Medication Management Manual
https://nmcsdasintra05.med.ds.osd.mil/Documents/MedicationManagementManual.pdf

Medication Management— Multi Dose Vials

Use NEW syringe

Use NEW needle

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.

Restraint & Seclusion - Safe Use of Restraints

Restraint Non-violent. 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. Examples: Patients with Dementia, Delirium or Head Injuries.

Violent/Self-destructive Restraint. Used to protect an individual from inflicting injury to self or others based on an emotional or behavioral condition. Rarely used outside the emergency department or behavioral health units.

Seclusion. The physical involuntary confinement of a patient in a room from which the patient is physically prevented from leaving. Seclusion is provided on inpatient behavioral health units only. Seclusion does not include involuntary confinement for legally mandated, non-clinical purposes, such as confining a person facing criminal charges or serving a criminal sentence.

NMCSD Policy: Restraint and seclusion have the potential to 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 serious consequences. NMCSD strives to foster an environment of least restrictive means that minimizes circumstances for restraint and seclusion use and that maximizes safety when restraint or seclusion is used. This requires allocating sufficient resources, providing initial and ongoing education and training, and integrating restraint and seclusion into performance improvement activities. The result is an approach to prevent, reduce, and

Restraint & Seclusion - Restraint Orders

RESTRAINTS ORDERS			
	RESTRAINT NON-VIOLENT	VIOLENT/SELF-DESTRUCTIVE RESTRAINTS	
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 restraint non-violent, orders need to be obtained within 12 hours of initiation	To continue violent/self-destructive restraint, orders need to 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, who is a second-year resident (PGY-2) or senior may initiate the order for patient restraint

The hospital evaluates and reevaluates the patient who is restrained or secluded.
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 or seclusion based on an individual order.
The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion.

NMCSD Workplace Violence

PROMOTE A SAFE ENVIRONMENT

It is the policy of Naval Medical Center San Diego (NMCSD) to promote a safe environment for its employees, patients, and visitors. NMCSD is committed to working with its employees, patients and visitors to maintain an environment free from "any act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assault; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."

- Workplace violence episodes should be reported to Patient Safety via the Joint Patient Safety reporting tool.
- Disruptive staff are reported to Risk Management per Command Instruction.
- Acts of aggression (physical) contact security.
- Staff injuries sustained as a result of workplace violence are reported to Occupational Safety via ESAMS.

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).

NAVMEDCEN SDIEGOINST 6320.1 series & 6010.14 series

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 NMCSD 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: DoD OF-522

A Living Will or Advance Directive/DNR

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 California 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 or higher), nurse practitioner, physician assistant, or staff physician after discussion with patient/family.

Patient resuscitation options include:

- Full Code—Code Blue, Rapid Response Team (RRT)
- Continue Life-Prolonging Treatment-No Code Blue
- Comfort Measures Only—No Code Blue, No RRT

**Refer to Command Instruction for surgical patients.*

Ethics Resources & Patient Confidentiality

Ethics Committee

NMCSD has an active **Healthcare Ethics Committee.**

- Consultant is available 24-hours.
  Call (619) 379-2369 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 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, health care organizations are to comply with the HIPAA provisions which strengthens the privacy and protection of patient medical information.

If you have questions CALL
HIPAA Compliance Specialist

619-532-6475

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, to participate in their treatment decisions, and become educated about their diagnosis and treatment plan.

Goals for patient and family teaching include:

- Patient participation and decision-making about health care 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

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

If you have questions CALL
NMCSD Health and Wellness Department

619-532-7764

Translation Services

Translation Services at NMCSD and other Branch Clinics

Three types of Translation Services available for patient patients:

1. *On-site Foreign Language Requests to include American Sign Language and Tactile Sign Language (ASL/TASL)*
2. *Over-the-Phone Interpretation (OPI) (24/7)*
3. *Document Translation Requests (Medical purpose ONLY)*

<u>Operations During Working Hours:</u>
Monday - Friday: 0730-1500
Contact Patient Administration Department at
619-532-8255 (TALK)

<u>Operations After Working Hours:</u>
Weekends, Holidays, before or after Office Hours
Over-The-Phone Interpretation (OPI) Only, please call
619-532-8255 (TALK)

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 services of an interpreter, then it should be documented in the patient's medical record.

NAVMEDCEN SANDIEGOINST 6320.101 series

Disclosure of Unanticipated Outcomes

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

Healthcare Resolutions is available at 619-726-4352 to assist 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 straightforward 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.

NAVMEDCEN SANDIEGOINST 6320.12 series

Medical Record Requirements

Important Points for MEDICAL RECORDS

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

- Timeliness—NMCSD requires that Providers complete inpatient medical records within 30 days of discharge.
- Completeness and accuracy
  - **General Rule:** The medical record reflects the care provided in a chronological manner.
- History and Physical (H&P) documented prior to procedure, not older than 30 days; Must document review of H&P within 24 hours prior to 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, timed and provider's name is printed or stamped in addition to signature
- Do not abbreviate final diagnosis
- For PCMH Certified Clinics: **Self-management goals must be identified and part of the treatment plan when warranted.**

DEPARTMENT OF DEFENSE
MHS GENESIS
MILITARY HEALTH SYSTEM

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 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 Postoperative Note/Progress Note

When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the 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 postoperative 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).**
- NMCSD 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 assigned 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 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 prior to commencement of clinical duties. Credentials are kept current and the Directorate **Medical Administrative Officers (MAO)** are the points of contact for managing the database on the Command intranet.
- Documentation will be maintained in Section V of the ITR.

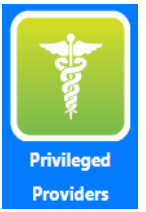
Staff Competency

Primary Source Verification (PSV)

- PSV must be conducted before expiration of current license, certification, and registration to verify renewal has occurred. If license/certification/ registration has expired, 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 **Medical Staff Services (MSS)**.
- 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.

NAVMEDCEN SDIEGOINST 1572.1 series

- Any staff member who wishes to check the privilege status of an 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 619-532-6684.



Clinical competency is documented in **Elsevier Clinical Skills or RELIAS.**

Electronic Training Records (ETR) are for all staff. Training is documented through RELIAS.

RELIAS

Staff Competency-Electronic Training Records

Position Description (PD)

All staff (except LIPs) will have a PD that accurately and completely describes the specific requirements of that position. The PD defines specific competencies, special qualifications, knowledge, and/or demonstrated skills required to adequately 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 thereafter by documenting through assignment in the LMS. 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 work and documented in the LMS in their assigned training.

Safety Orientation

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

Command Orientation/Indoctrination

All new staff members, within **30 days** of reporting aboard, will attend Command Orientation.

Equipment Safety Check

Is Your Equipment Safe for Patient Care Use?

❑ **Does your medical equipment have an Equipment Control Number (ECN)?**
If missing ECN, contact Property Accounts 532-7703

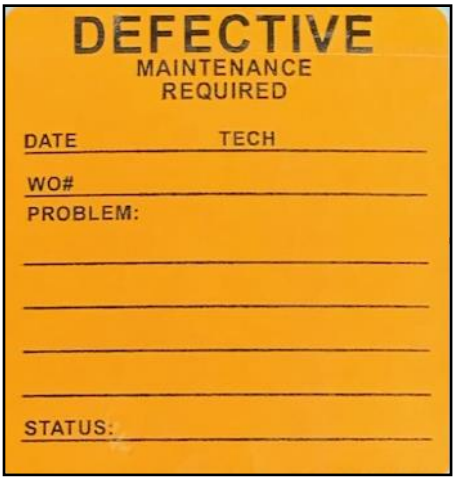
❑ **Is your medical equipment's Preventive Maintenance (PM) sticker current?**

- Verify Date, Due and By dates are current on PM sticker.
- If expired or missing, contact Biomedical Engineering Division (BIOMED) 532-8010/8011

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

Contact BIOMED 532-8010/8011 immediately to have Preventive Maintenance conducted on the equipment. If the equipment cannot be taken out of the work space, 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



Equipment Safety Check

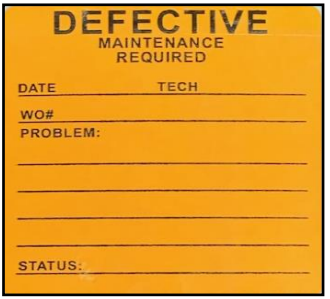
❑ Who do you contact in case of malfunctioning medical equipment?

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 work space, 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

❑ Who do you contact if medical equipment failure injures a patient or staff member?

What to do in case of medical equipment failure injury:

1) Notify Patient Safety/Risk Management at 532-9377 and BIOMED 532-8010/8011 (BIOMED DUTY After Hours) 619-453-6091.

2) Sequester the equipment and keep it removed from service.

3) Do not change any of the configuration settings.

4) Do not allow the vendor access to the equipment.

❑ Who do you contact for user training on a piece of new medical equipment?

BIOMED or Manufacturer/Vendor Representative via BIOMED 532-8010/8011.

Equipment Safety Check

❑ **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 requisitions from providers/staff?**
Use LogiCole and input all supporting documentation (NMCSD 4270/1, market research, etc.).

❑ **Is medical equipment plugged directly into an outlet and NOT a power-strip?**
*Note: In case of a power failure, only the RED electrical outlets will have power.

❑ **Who is your Area Safety Representative?**

CONTACT NUMBERS:

BIOMED: 532-8010/8011
(BIOMED DUTY After Hours) 619-453-6091
Biomedical Repair Front Desk/Trouble Ticket Email:
usn.san-diego.navmedcensanca.list.nmcsdmedrepairlist@mail.mil
Property Accounts: 532-7703
Patient Safety/Risk Management: 532-9377

Medical Waste

MEDICAL WASTE
(Biohazardous)

USE FOR:
Items that are saturated with blood or bodily fluids **BUT does not contain sharps:**
- Blood bags and tubing
- Hemodialysis tubing
- Suction Canisters
- Pleurovac or hemovac containers
- Vials or containers contaminated with blood or body fluids

- MUST BE DOUBLE GOOSE NECK CLOSED & REMOVED WHEN BAG CONTAINER IS ¾ FULL, OR PRESENTS AN ODOR
- REMOVE CLOSED BAG & TRANSPORT TO INTERIM WASTE STORAGE ROOM AND PLACE IN SECONDARY TRANSPORT CONTAINER

MEDICAL WASTE
(Sharps)

USE FOR:
Sharp objects with blood or body fluids:
- Needles/syringes contaminated

- MUST BE CLOSED & REMOVED WHEN CONTAINER IS ¾ FULL (FILL LINE) OR PRESENTS AN ODOR
- REMOVE CLOSED CONTAINER & TRANSPORT TO INTERIM WASTE STORAGE ROOM AND PLACE IN SECONDARY TRANSPORT CONTAINER

Medical Waste

MEDICAL WASTE
(Non-Pourable Chemotherapy)

USE THE YELLOW BIN FOR:

- Non-pourable chemo (<3% by weight)
- Sharps contaminated with non-pourable chemo

USE THE YELLOW BAG FOR:

- Empty chemo bags
- Gloves
- Pads
- Gowns and masks

- MUST BE CLOSED & REMOVED WHEN ¾ FULL (FILL LINE), OR PRESENTS AN ODOR OR IS A YEAR FROM START DATE ON CONTAINER OR BAG
- CONTAINER TOP MUST BE LABELED WITH "CHEMOTHERAPY WASTE"
- REMOVE CLOSED CONTAINER & TRANSPORT TO INTERIM WASTE STORAGE ROOM AND PLACE IN SECONDARY TRANSPORT CONTAINER
- WASTE MUST BE TRANSPORTED TO B-35 WEEKLY AT HOSPITAL OR INTERIM WASTE ROOMS AT OUTLYING CLINICS

MEDICAL WASTE
(Pharmaceutical Waste)

USE FOR:

Items that are used to give medications or immunizations.

- Needles and syringes
- IV bags and tubing
- Ampules, vials, or pills

- MUST BE CLOSED & REMOVED WHEN ¾ FULL (FILL LINE), PRESENTS AN ODOR, OR A YEAR FROM START DATE
- CONTAINER TOP MUST BE LABELED WITH "INCINERATE ONLY"
- OUTLYING CLINICS MUST DATE CONTAINERS TO ENSURE REMOVAL A YEAR FROM START DATE
- REMOVE CLOSED CONTAINER & TRANSPORT TO INTERIM WASTE STORAGE ROOM AND PLACE IN SECONDARY TRANSPORT CONTAINER

CONTROLLED SUBSTANCES MUST BE UNUSABLE:

- Placed in CSRX for narcotics
- Pharmacy contracted technician will remove and replace these narcotics containers.

Medical Waste

RCRA HAZARDOUS WASTE
(Hazardous Pharmaceuticals/Pourable Chemo)

- Container must have hazardous waste satellite accumulation area label on each black container and segregated to ensure compatibility.
- Must label: Hospital/Outlying Clinic name address, contents, physical state, hazardous properties, and accumulation date.

USE FOR:

- Hazardous Pharmaceuticals (Refer to Hazardous Drug List) some examples listed below:
- Insulin
- Silver Nitrate
- Pourable Chemo >3% by weight
- P-Listed hazardous drugs may only be disposed of in the 1 quart hazardous pharmaceutical container

- MUST BE REMOVED AND CLOSED WITHIN 9 MONTHS OR WHEN FILL LINE IS REACHED OR PRESENTING AN ODOR
- REMOVE CLOSED CONTAINER AND TRANSPORT TO HAZARDOUS WASTE BLDG 35 TO BE PLACED IN THE CENTRAL ACCUMULATION AREA (CAA)

SOLID WASTE
Clear (Trash) Bags

USE FOR:

- Regular household type trash
- Used & empty bedpans, urinals, & emesis basins
- IV bags & tubing without medication or visible blood that contain only:
  - Glucose Dextrose
  - Saline Electrolytes

For any questions or concerns, call NMCSD Environmental Div., Hazardous Waste

619-532-5947/6163

Do Not Use Bio Bags for Storage

Biohazard Specimen Bags should only be used for transportation of biological materials posing a threat to human health . Not for storing medical supplies.

Medical supplies should be stored in a clear bag.

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: (619) 572-9779
- Turn in lost badges to Command Badge Office/Quarterdeck

ID Badge Color Codes (Band at Top of badge):

GREEN	Issued to Commander, Deputy Commander, Directors and Command Master Chief. Provides access to all areas of the command.
RED	Issued to personnel in newborn and pediatric areas. Authorizes wearer to transport pediatric and newborn patients.
YELLOW	Issued to Operating Room personnel. Provides access to the Main Operating Room.
ORANGE	Issued to individuals on restricted status.
BLUE	Issued to most staff & allows general access
BROWN	Issued to staff and contractors requiring overhead work access.

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 Emergency Department patients will have an alert wristband placed as appropriate:
  - RED—Allergy
  - YELLOW—Fall Risk
  - PURPLE—Do Not Attempt Resuscitation (DNAR)

Social (Community) cause wristbands (e.g., purple Alzheimer's) will be sent home or covered with white tape if patient refuses to remove to avoid color confusion.

Emergency Management & CODES

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

* Where is the **Green Binder** in your area located?
* Are you wearing your Emergency Code Badge?

EMERGENCY CODES

All staff and students at NMCSD are responsible for maintaining a safe work environment. It is important to keep yourself informed and aware of the NMCSD 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 resource for the above information.

NMCSD Main Hospital Emergency Code	
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
MAGENTA	Radiation Event
BLUE	Medical Emergency
PURPLE	OB/Neonatal Emergency
RED	Fire

Emergency Management & CODES

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 NMCSD inpatient and main hospital :

1. Only staff with Red Command ID badges may transport newborn/pediatric patients without parent/guardian.
1. In the event a newborn/infant/child cannot be accounted for, Activate Code Pink by calling: NMCSD Command Code Number at 532-6911 or your NBHC representative: _____ 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 they attempt to leave the facility, do not put yourself in harm's way - contact Security.

NAVMEDCEN SDIEGOINST 5530.5 series

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 NMCSD.
3. Dial Command Code Number, 532-6911 or contact your NBHC representative:_____ to report. Describe the person, where they were last seen, what time they were last seen, their medical condition, and location headed (if known).

Emergency Management & CODES

CODE GRAY—MASS CASUALTY EVENT

NAVMEDCEN SDIEGOINST 3440.5 series

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:
  *YOUR SUPERVISOR & SECURITY at 619-532-8500
- 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 Green Binder.

Emergency Management & CODES

- 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.

- Safety Data Sheet (SDS) is a required Fact Sheet on **ALL chemicals** 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 NMCSD Command Code Number at 532-6911 or your NBHC representative: _____ and do not re-enter the area.
3. Obtain SDS sheet if aware of chemical content.

*SDS sheets can be found through the NMCSD intranet under Ref. Materials, Hazardous Drugs or searched online at: https://chemicalsafety.com/sds-search/

Emergency Management & CODES

CODE BLUE—CARDIAC/RESPIRATORY ARREST

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

- **At NMCSD:**
  Activate CODE BLUE Team
  - Dial #4444 from desk phone or (619) 532-7435 from cell phone to activate NMCSD Code Team
  - 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
  - Dial 9-911 from desk phone or 911 from cell phone
  - Specify adult or pediatric code
  - Give exact location: Building, Floor, Unit Name
  - State your name
  - Give the phone number you are calling from and remain on the phone until you are told to hang up by EMS dispatch.

Emergency Management & CODES

CODE STROKE

- Code Stroke is the emergency response mechanism for patients with stroke-like symptoms.

At NMCSD:
Activate Code Stroke Team

- Dial #4444 from desk phone or (619) 532-7435 from cell phone to activate NMCSD Code Stroke team.

CODE PURPLE—OB/NEONATAL EMERGENCY

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

At NMCSD:
Activate CODE PURPLE Team

- Dial #4444 from desk phone or (619) 532-7435 from cell phone to activate NMCSD Code Purple team.

CODE STEMI

- Code STEMI is the emergency response mechanism for patients who present with Acute Coronary Syndrome and have been identified by rapid diagnostic procedures to be having an ST-Elevation Myocardial Infarction (STEMI).

At NMCSD:
Activate Code STEMI Team

- Dial #4444 from desk phone or (619) 532-7435 from cell phone to activate NMCSD Code STEMI team.

Emergency Management & CODES

RRT—RAPID RESPONSE TEAM

- The RRT program provides early recognition and rapid intervention on hospitalized patients with evidence of deteriorating clinical conditions in an effort to improve outcomes and reduce the possibility of cardiac and/or respiratory arrests.
- The RRT can be activated by **any** staff when **any** element on the RRT call parameter list is met.
- Family members may request that an RRT be initiated.
- The RRT will assess, treat, stabilize, and when needed, transfer the patient to a higher level of care.

At NMCSD:
Activate RRT

- **For inpatient RRT, CALL Nurse of the Day (NOD) (619)-606-2839**
- Communication of the request for RRT activation will be accomplished through the Ward Charge Nurse.
- Bedside response time for members of the RRT should be less than fifteen minutes.

Workplace Violence Program

NMCSD has a workplace violence program for guidance on disruptive patients and/or staff.

Emergency Management & CODES

CODE RED—FIRE PROCEDURES

Inspirations., Healthcare. *Race/Pass Fire Safety Sign*, healthcareinspirations.com/hci_fe03_single_quantity.html?prodid=426.

What do you do in the event of a fire?

_____

Where is the nearest extinguisher and pull box?

_____

In an EVACUATION—where does your dept. muster?

_____

Stop the Bleed

Provide support for massive active shooter scenarios, mass casualty events, and to stop hemorrhaging by utilizing bleeding control kits.

- 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.
- 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 to the threats that confront us.

See Something

Do Something

Improving Survival

HELP SAVE LIVES!

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 moving to a different floor or another building.

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

NMCSD is a tobacco-free facility. NMCSD's designated smoking areas: Bldg. 34 in "D" parking lot and the pavilion on the North side of Bldg. 19 garage.

√ Keep hallways and stairwells "clutter-free" from equipment and other items.

√ Do not block fire doors, fire extinguishers, fire alarm pull stations, fire panels, and sprinklers with items or equipment.

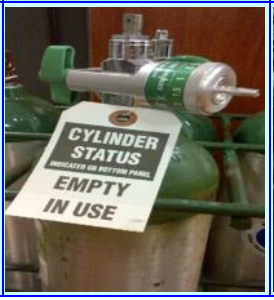
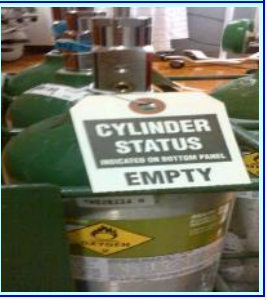
√ Make sure fire extinguishers are unobstructed.

√ **Find out who has the authority to turn off the medical gas shutoff valves in your area. The Fire Dept. and Authorized Supervising Medical Authority (Senior Medical Officer/Charge Nurse) have the authority to shut off oxygen supply for that department.**

Safety

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
		

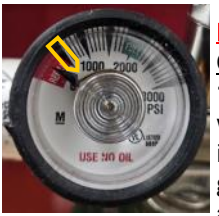
O_2 Adaptors

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.

Cylinder



Non-Crash Cart O2 Cylinder "Empty" cylinder when used with integral pressure gauges. Defined as 500 pounds per square inch (at 500 PSI, replace tank)

Crash Cart O2 Cylinder Ensure the tank pressure is > 1000 PSI, (Empty when <1000 PSI, replace O2 tank

Safety

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 (619) 532-6018

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.

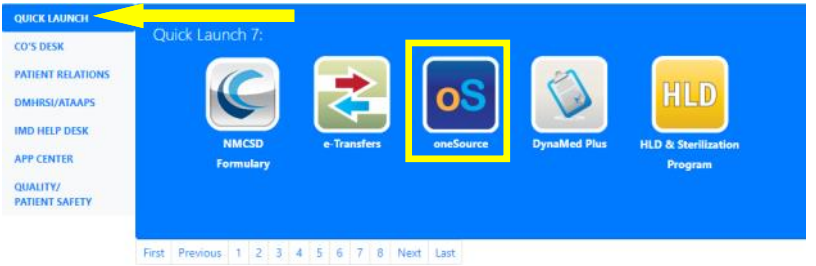
Instructions for Use (IFU)—oneSource

WHY ARE IFU's IMPORTANT?

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

oneSource is a search tool to find instructions for use. Access the oneSource link by clicking the tile on the NMCSD Intranet through Quick Launch. 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.



DRINK FROM THE IFU FOUNTAIN

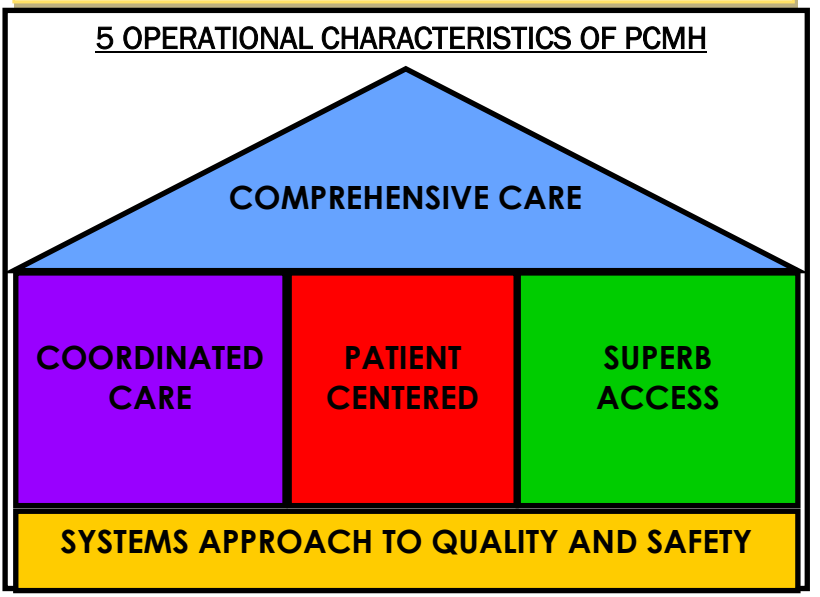
IFUs should be the main source of knowledge.

- 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 issues 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 <u>empty</u> O_2 cylinders from <u>full and partial</u> O_2 cylinders when storing
  - ☐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%

Your Department Information

Department Duties:

_____

_____

Job Description:

_____

_____

Collateral Duties:

_____

_____

Watch Assignments:

_____

Committee Memberships:

_____

BLS Expires: _____

Where is the Patient Bill of Rights? _____

How do you handle Advance Directives?

_____

Who is the Area Safety Representative?

_____

Where are the following items located?

- **Fire Alarm Pull Box:** _____
- **Fire Extinguisher:** _____
- **Medical Gas Shutoff Valve:** _____

Authorized Supervising Medical Authority (Senior Medical Officer/ Charge Nurse) for gas shutoff: _____

- **Evacuation Route:** _____

Important Phone Numbers

- NMCSD Code Blue. . . . . .#4444 (Desk Phone)
  . . . . . .619 532-7435 (Cell Phone)
- Inpatient RRT, Nurse of the Day. . . 619 606-2839
- Ambulance. 9-911
- Fire. 9-911
- NMCSD Emergency Department. . . .619 532-7427
- NMCSD Officer of the Day. 619 572-6323
- Quarterdeck. 619 532-6400
- NMCSD Security. 619 532-8500
- NMCSD Safety. 619 532-6018
- Patient Safety. 619 532-9377
- Trouble Desk/Facilities. 619 532-6135
  After Hours. 619 532-6400
- Facility Management Emergencies. . .619 532-6125

CODE RED = FIRE (NMCSD Call 9-911 desk phone or 911)
NBHC CALL: _____
Assignment _____

CODE BLUE = CARDIAC/RESPIRATORY ARREST
(NMCSD #4444 desk phone or 619 532-7435)
NBHC CALL: _____
Assignment _____

CODE PURPLE=OB/NEONATAL EMERGENCY
(NMCSD #4444 desk phone)
NBHC CALL: _____
Assignment_____

For Codes Below and next page at NMCSD
CALL : 2-6911 (Desk Phone) or (619) 532-6911 (Cell)

CODE PINK= INFANT/CHILD ABDUCTION
NBHC CALL:_____
Assignment _____

Important Phone Numbers

CODE BLACK= BOMB THREAT/EVACUATION
NBHC CALL: _____
Action _____

CODE ORANGE=HAZARDOUS MATERIAL SPILL
NBHC CALL: _____
Action _____

CODE WHITE =ARMED INTRUDER/ACTIVE SHOOTER
NBHC CALL: _____
Action_____
_____

CODE GRAY=MASS CASUALTY EVENT
NBHC CALL: _____
Assignment _____

CODE SILVER=CHILD/ADULT LOST/ELOPED
NBHC CALL: _____
Action_____

CODE GREEN=VIOLENCE/COMBATIVE PERSON/SECURITY ALERT
NBHC CALL: _____
Action _____
_____

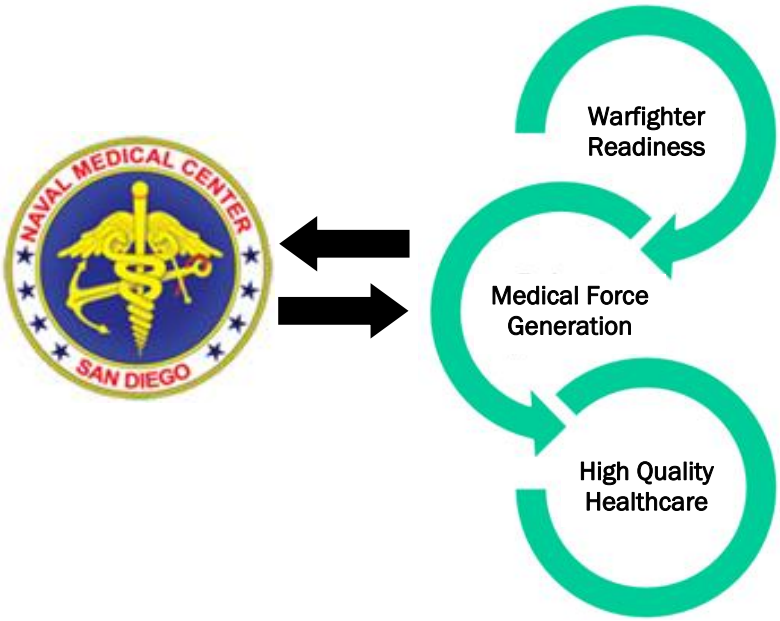
CODE YELLOW=UTILITY FAILURE
NBHC CALL: _____
Action _____

CODE MAGENTA=RADIATION EVENT
NBHC CALL: _____
Action _____

Notes

Notes

COMMAND PRIORITIES



This guide was developed by Naval Medical Center San Diego's Office of Continuous Improvement as a resource for staff to evaluate and focus on processes and functions at NMCSD.

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