

Nemours.

# **SURVEY READINESS HANDBOOK**



**Key Joint Commission Standards,  
Requirements, & Information**  
*FALL 2011*

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## INTRODUCTION

This Survey Readiness Handbook has been developed and updated to provide education regarding accreditation standards, and information about how Nemours utilizes these standards to improve processes and continually provide exceptional care, treatment, and services to our patients and their families.

Though a successful Joint Commission survey depends on a number of elements, a major key to success is the ability of our Associates to interact with the survey team and demonstrate the exemplary care they provide. Our goal is that the information contained in this document will not only prove useful in preparing for this survey interaction, but also serve as a reference guide during our ongoing journey to excellence. Please remember that every Nemours Associate plays an important role in the organization, and has an impact on the care provided to our patients.

*If you have any questions, please contact Ginni Handler at extension 6437 or Matthew Shalk at extension 6032.*



## VISION, MISSION, VALUES, & COMMITMENT

### VISION

Freedom from disabling conditions.

### MISSION

To provide leadership, institutions, and services to restore and improve the health of children through care and programs not readily available, with one high standard of quality and distinction regardless of the recipient's financial status.

### VALUES

Building and sustaining a culture of trust based on five core values:

**EXCEL | RESPECT | SERVE | HONOR | LEARN**

#### EXCEL

- Self-disciplined, passionate, and committed people: our greatest asset
- A culture of safety
- Teamwork and open communication
- Continuous improvement; exceeding limits set by prior achievement
- Setting ever higher standards in children's health and care

#### RESPECT

- Accepting and valuing one another as individuals
- Acknowledging the contributions of others
- Compassionate awareness
- Listening
- Understanding
- Being family- and patient-centered

#### SERVE

- Doing whatever it takes to deliver uniquely satisfying experiences
- Putting the needs of parents and children first
- Leadership from within
- Collaboration
- Optimism
- Determination and confidence

#### HONOR

- Honoring the memory and legacy of Alfred I. duPont and our mission
- Trustworthy, honest and ethical behavior
- High standards of quality, safety and performance
- Accountability
- Magnifying our power to make a difference in children's lives by wisely managing resources

#### LEARN

- Open to new and better ideas; flexible and adapting to change
- Continuous learning
- Analysis, inquiry and innovation
- Discovering, applying and disseminating new knowledge and best practices
- Positively influencing children, families, professionals, communities, and others



### COMMITMENT

*"I will do whatever it takes to make every contact with Nemours a uniquely satisfying experience...for our patients, parents, visitors, colleagues and business partners."*

## THE JOINT COMMISSION

Founded in 1951, The Joint Commission seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. An independent, not-for-profit organization, The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care. The Joint Commission is governed by a Board of Commissioners that includes physicians, administrators, nurses, employers, a labor representative, health plan leaders, quality experts, ethicists, a consumer advocate and educators.<sup>1</sup>

### ACCREDITATION SURVEY OVERVIEW

The Joint Commission's accreditation process seeks to help organizations identify and resolve problems and to inspire them to improve the safety and quality of care and services provided. The process focuses on systems critical to the safety and the quality of care, treatment and services.

During an on-site accreditation survey, The Joint Commission evaluates an organization's performance of functions and processes aimed at continuously improving patient outcomes. This assessment is accomplished through evaluating a compliance with the applicable standards in the accreditation manual, based on the following:<sup>2</sup>

- Tracing the care delivered to patients (See "Tracer Methodology" on page 5)
- Verbal and written information provided to The Joint Commission
- On-site observations and interviews by Joint Commission surveyors
- Documents provided by the organization

The on-site accreditation survey process is data-driven, patient-centered and focused on evaluating actual care processes. The objectives of the survey are not only to evaluate the organization, but to provide education and "good practice" guidance that will help staff continually improve the organization's performance. The on-site survey focuses on continuous operational improvement in support of safe, high quality care, treatment and services.<sup>3</sup>

### PRIORITY FOCUS PROCESS (PFP)

The **Priority Focus Process (PFP)** is a data-driven tool that helps focus survey activity on issues most relevant to patient safety and quality of care at the specific health care organization being surveyed. The PFP uses automation to gather pre-survey data from multiple sources including The Joint Commission, the health care organization and other public sources. The PFP then applies rules to 1) identify areas of priority focus relevant standards and appropriate survey activities, and 2) guide the selection of patient tracers.<sup>4</sup>

The output of the Priority Focus Process includes:

- **Priority Focus Areas (PFAs)** – The processes, systems or structures within a health care organization known to significantly impact the safety and quality of care specific to the health care organization being surveyed.
- **Clinical/Service Groups (CSGs)** – Groups of patients in distinct clinical populations for which data is collected.

PFP Reports are updated by The Joint Commission quarterly. The most recent PFP Report has identified the following PFAs and CSGs for Nemours/A.I. duPont Hospital:

Priority Focus Areas (PFAs)	Clinical Service Groups (CSGs)
<ul style="list-style-type: none"><li>■ Assessment and Care/Services</li><li>■ Credentialed Practitioners</li><li>■ Rights &amp; Ethics</li><li>■ Communication</li><li>■ Equipment Use</li><li>■ Physical Environment</li></ul>	<ul style="list-style-type: none"><li>■ General Surgery</li><li>■ Cardiology</li><li>■ Oncology</li><li>■ Gastroenterology</li><li>■ Nephrology</li></ul>

## TRACER METHODOLOGY

The cornerstone of The Joint Commission survey, the **Tracer Methodology** is an evaluation method in which Joint Commission surveyors select actual 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. As surveyors follow the course of the patient's treatment, they assess the organization's compliance with Joint Commission standards, observe and talk to staff in areas that the patient received care, and evaluate the organization's systems for delivering safe, quality health care and services.<sup>5</sup>

### **? What are the primary objectives of tracer activities?**

- To follow the course of care and services provided to the patient
- To assess relationships and hand-off communication between disciplines
- To evaluate performance of relevant processes (e.g., pain management, restraints, surgery, etc.)
- To assess and evaluate compliance with Joint Commission standards

### **? Which patients are likely to be "traced"?**

- Patients within Priority Focus Areas (PFAs) and Clinical Service Groups (CSGs)
- Patients with frequently seen diagnoses (the key populations for which we provide care)
- Patients who have received multiple and complex services (often those patients close to discharge)
- Patients who cross programs (e.g., hospital and practice)
- Patients who encounter these processes: Infection Control, Medication Management, Surgery, Dialysis, Sedation, Outpatient Care

### **? How many patients will be "traced," and how long will the tracers take?**

- The number of tracers completed can vary, but anticipate two (2) patient tracers per surveyor per day
- Tracers can take 90 minutes or more per patient
- Tracers begin in the setting where the patient is located, and move to other areas the patient has encountered or is scheduled to encounter

### **? What will the surveyor do during a tracer?**

- Review the medical record with Associates
- Observe direct patient care
- Observe the medication process
- Observe the care planning process
- Observe equipment use
- Review competencies, evaluations, and continuing education for Associates with whom the surveyor has interacted
- Interview the patient and/or family
- Review additional medical records, as needed, from other settings
- Observe Associate-level interaction
- Observe the environment of care and environmental safety
- Discuss National Patient Safety Goals and improvements made to patient care and services

## THE LIFE SAFETY CODE® SPECIALIST

In 2005, The Joint Commission added a *Life Safety Code*® Specialist to its accreditation survey team for hospitals with 200 or more licensed beds. The purpose of the *Life Safety Code*® Specialist is to focus on compliance with the National Fire Protection Association (NFPA) *Life Safety Code*®, the Statement of Condition (SOC), medical gas system requirements, Life Safety (LS) standards, and certain Environment of Care (EC) standards. Reviewing compliance in these areas was previously the responsibility of the nurse or physician surveyor.

In 2008, The Joint Commission expanded the scope of the *Life Safety Code*® Specialist to include a one-day survey for all hospitals as a component of the accreditation survey, and included a second day for the *Life Safety Code*® Specialist for hospitals with more than 750,000 square feet. Most recently, The Joint Commission announced that beginning in 2011 *Life Safety Code*® Specialists will receive more time on-site during accreditation surveys, ranging from one to three additional days, with the extra length of time depending on the size of the organization.

## HOW TO WORK WITH SURVEYORS



**KEEP THE CONVERSATION PROFESSIONAL** Ask questions if you do not understand. **NEVER** argue with the surveyors. Be professional and use appropriate language and behaviors.

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

**KEEP YOUR ANSWERS FOCUSED AND SPECIFIC TO THEIR QUESTION** Whenever possible, answer in your own words and keep your answers short and to the point. **KISS = Keep It Short and Simple**

**SUPPORT YOUR CO-WORKERS** 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!

### OTHER TIPS ON PROFESSIONAL INTERACTION WITH SURVEYORS

- Patient safety and performance improvement are always very important things to know about.
- Relax – surveyors are physicians, nurses, medical technologists, engineers, and others who have worked in hospitals. They’ve “been there!”
- Always be honest. Falsification or misrepresentation is absolutely not tolerated and can cause the organization to lose its accreditation.
- Just as in sports, *success is dependent on teamwork*. Excellent patient care is no different. Your communication and interaction with other members of the healthcare team is critical to providing excellent care for the patient!



### **DO YOU KNOW...** **Why the National Patient Safety Goals (NPSGs) aren't numbered sequentially?**

The Joint Commission established its National Patient Safety Goal (NPSG) program in 2002, and the original NPSGs were numbered sequentially. In the years following, The Joint Commission continued to add and revise the NPSGs on an annual basis.

In 2009, however, the NPSGs underwent an extensive review designed to streamline the program and focus on high priority topics related to patient safety and quality care. This included decreasing the number of NPSGs by deleting certain requirements, and incorporating other NPSG requirements into actual standards (*See “National Patient Safety Goals,” beginning on Page 8*).

To minimize confusion, requirements that remained NPSGs were not renumbered, so, for example, the same goal that was NPSG 7 in 2008 (Reduce the Risk of Health Care-Associated Infections) remained (and continues to remain) NPSG 7, even though there is no longer an NPSG 4, 5, or 6.

## PATIENT-CENTERED COMMUNICATION STANDARDS

The Joint Commission Patient-Centered Communication Standards encompass several new and revised requirements for hospitals to advance effective communication, cultural competence, and patient- and family-centered care. These new and revised elements of performance (EPs) include identifying and addressing patient and family communication needs, *including the preferred language for discussing health care*, addressing provision of language services, requiring race and ethnicity information in the patient's medical record, prohibiting discrimination in patient care, and qualifications for language interpreters and translators.

Patient-centered communication involves communicating effectively, instilling cultural competence in health care workers, and providing patient- and family-centered care. Organizations need to adapt their communication strategies to meet the unique needs of patients based on culture, including race and ethnicity, education level, physical ability, language, and other needs. The new requirements also address patient-level data collection of race and ethnicity and non-discrimination toward the lesbian, gay, bisexual, and transgender population.

New Joint Commission standard PC.02.01.21 – *“The hospital effectively communicates with patients when providing care, treatment, and services”* – emphasizes the importance of effective communication between patients and families and their providers of care, treatment, and services. Effective patient-provider communication is necessary for patient safety. Research shows that patients with communication problems are at an increased risk of experiencing preventable adverse events, and that patients with limited English proficiency are more likely to experience adverse events than English speaking patients. Further, identifying the patient and family oral and written communication needs is an essential step in determining how to facilitate an effective exchange of information during the care process.

Communication needs may also change during the course of care. Once communication needs are identified, the hospital can determine the best way to promote two-way communication between the patient and family and their providers in a manner that meets patient and family needs.



***New and revised Elements of Performance (EPs) related to Joint Commission Patient-Centered Communication Standards are included on page 44. Additional information and resources related to Patient-Centered Communication are also available on The Joint Commission website at [this link](#).***<sup>6</sup>

### **?** How does the hospital collect information to support patient- and family-centered communication?

- Information collected during patient registration
- Information collecting during the revised “Learning & Communication Assessment” and other patient and family assessments, ***including the preferred language for discussing healthcare***
- Information collected throughout the course of treatment
- Unit Leadership Rounding
- Hourly Rounding on Patients
- Family-Centered Rounds
- Bedside Change-of-Shift Reports (on some units)

### **?** How does the hospital utilize collected information to support patient and family-centered communication?

- Use of qualified and approved interpreters, including community services, trained associates, and the Language Line, for patients and families with limited English proficiency
- Translation of forms and education materials into selected languages
- Use of qualified and approved interpreters or other assistive services, including TDD phone and amplifier equipment, for patients and families with hearing impairments
- Use of visual aid devices, including Braille, and other services for patients and families with visual impairments
- See “Providing Information in a Manner Patients & Families Understand” on page 15
- See “Patient & Family Education” beginning on page 19



#### **POLICY**

Refer to policy # 60.28 (“Effective Communication with Patients, Families and Visitors with Special Communication Needs”) for additional information.

# 2011 NATIONAL PATIENT SAFETY GOALS

It is critical that ALL Associates are familiar with The Joint Commission 2011 National Patient Safety Goals (NPSGs) and related patient safety standards, and incorporate them into daily practice. The following information outlines these NPSGs and related patient safety standards, and identifies how they are addressed at the hospital and the physician practices.

## GOAL 1

## IMPROVE THE ACCURACY OF PATIENT IDENTIFICATION

NPSG.01.01.01



**Use 2 patient identifiers prior to performing procedures, tests, administering medications or blood/blood components, or collecting blood samples or specimens**

- Hospital Identifiers: Patient Name & Medical Record Number
- Practice Plan Identifiers: Patient Name & Date of Birth
- Label blood and specimen containers in the presence of the patient

NPSG.01.03.01



**Eliminate transfusion errors related to patient misidentification**

- Before initiating a blood or blood component transfusion, the blood or blood component is matched to the order, and the patient is matched to the blood or blood component during a two-person verification process
- One participant in the verification process is the qualified individual who will administer the blood or blood component. The second is qualified to participate in the verification process

## GOAL 2

## IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS

NPSG.02.03.01



**Report results of critical tests and diagnostic procedures to the licensed caregiver in a timely manner**

- CRITICAL TESTS and CRITICAL VALUES are defined
- Identify by whom and to whom critical test results are reported
- Target turnaround times are established
- Performance related to target is measured, assessed, and, if necessary, improved

IM.02.02.01



**Do not use unacceptable abbreviations, acronyms, and symbols**

- The list of prohibited abbreviations, acronyms, symbols, and dose designations includes:
  - U, u – IU – Q.D., QD, q.d., qd – Q.O.D., QOD, q.o.d, qod – µg – T.I.W.
  - MS, MSO<sub>4</sub>, MgSO<sub>4</sub>
  - No trailing zero (X mg NOT X.0 mg)
  - Use leading zero (0.X mg NOT .X mg)

Formerly  
NPSG.02.02.01  
Now An  
Information  
Management (IM)  
Standard

PC.02.01.03



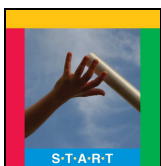
**For verbal orders and verbal reports of critical test results, write it down then read it back**

- For verbal orders, including verbal telephone orders, or for a verbal report of a critical test result, staff uses a record and "read back" process to verify the information
- When giving an order or test result, expect the receiver to *read* the order or test result back to you. When receiving the order or test result, *write it down* then *read it back* to the originator.

Formerly  
NPSG.02.01.01  
Now A  
Provision of Care (PC)  
Standard

# 2011 NATIONAL PATIENT SAFETY GOALS

PC.02.02.01



## The organization Implements a process for “hand-off” communication

- Communication occurs when transferring responsibility for a patient to another practitioner, setting, service, or level of care, including when communicating to “on-call” staff
- Process allows time to ask and respond to questions – *this is one of the most important aspects of an effective hand-off*
- Take time to provide clear and complete information about a patient’s care, treatment, current condition, and any recent changes
- S.T.A.R.T.
  - Situation, background – Current complaint or problem, succinct summary of background
  - Therapies, interventions – Update treatment, interventions and course
  - Anticipated course – Assessment of current status and anticipated course
  - Reconciliation – Discussion, adjustment of plan
  - Transfer – To another service or level of care, or discharge to home/chronic care facility

Formerly  
NPSG.02.05.01  
Now A  
Provision of Care (PC)  
Standard

## GOAL 3

## IMPROVE THE SAFETY OF USING MEDICATIONS

NPSG.03.04.01



## Label all medications, medication containers or other solutions on and off the sterile field in perioperative and other procedural settings

- Label each medication or solution as soon as it is prepared, unless it is immediately administered, even if only one medication is being used.
- Label includes medication name, strength, quantity, diluent and volume, expiration date when not used within 24 hours, expiration time when expiration occurs in less than 24 hours
- Two qualified individuals verbally and visually verify the label when the individual preparing the medication or solution is not the individual who will be administering it
- Medication containers include syringes, medication cups, and basins

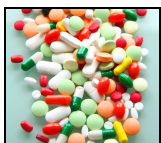
NPSG.03.05.01



## Reduce the likelihood of patient harm associated with anticoagulation therapy

- Organization implements defined anticoagulation program (active Pharmacy involvement)
- Uses approved protocols for initiation and maintenance of anticoagulation therapy (optional computerized order set developed)
- Established procedures for use of heparin and warfarin
- Organization has written policy that addresses baseline and ongoing laboratory tests
- Anticoagulation therapy education is provided to employees, patients, and families
- Anticoagulation safety practices are evaluated, improved as necessary, and effectiveness of improvements are measured

MM.01.02.01



## The organization addresses the safe use of look-alike/sound-alike medications

- The organization annually reviews and, as necessary, revises its list of look-alike/sound-alike medications
- The organization takes action to prevent errors involving the interchange of look-alike/sound-alike medications:
  - Use tallman/shortman lettering (GLUCAGOn/GLUCApHaGe)
  - Use separate storage areas for look-alike/sound-alike medications

Formerly  
NPSG.03.03.01  
Now A  
Medication  
Management (MM)  
Standard

# 2011 NATIONAL PATIENT SAFETY GOALS

## GOAL 7

## REDUCE THE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS

NPSG.07.01.01



### Comply with current Center for Disease Control and Prevention (CDC) or current World Health Organization (WHO) hand hygiene guidelines

- Clean hands before *and* after contact with patients, equipment, or use of gloves
  - use soap and water for 15 seconds *or* use alcohol-based hand sanitizer
  - use soap and water *if hands are visibility dirty*
- No artificial nail applications

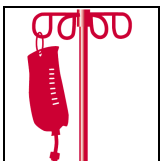
NPSG.07.03.01



### Implement evidence-based guidelines to prevent health care-associated infections due to multi-drug-resistant organisms

- Periodic risk assessments conducted for multidrug-resistant organism acquisition and transmission
- Patient and family education about health care-associated infection prevention strategies
- Policies and practices designed to reduce the risk of transmitting multidrug-resistant organisms
- Safety practices including Antimicrobial Stewardship Program, MRSA screening, and isolation

NPSG.07.04.01



### Implement evidence-based practices to prevent central line-associated bloodstream infections

- Education for employees, patients, and families about central line-associated bloodstream infections and the importance of prevention
- Participation in NACHRI collaborative (implemented evidence-based techniques)
- Policies and practices designed to reduce the risk of central line-associated bloodstream infections
  - Standardized insertion and maintenance bundles
  - Use of chlorhexadine scrub pads for all central line entries
  - Use of catheter checklist and standardized protocol for central venous catheter insertion

NPSG.07.05.01



### Implement evidence-based practices for preventing surgical site infections

- Education for employees, patients, and families about surgical site infections and the importance of prevention, including home preparation skin cleansing for patients and families
- Policies and practices designed to reduce the risk surgical site infections, including pre-screening for MRSA on targeted high-risk populations
- Surveillance data on all surgical site infections with targeted rates for spinal fusions, hernia repair, ventriculoperitoneal shunts, and appendectomies

## GOAL 8

## RECONCILE MEDICATIONS ACROSS THE CONTINUUM OF CARE

NPSG.08.01.01



### There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization

- On entry to the hospital or admission, and with patient/family involvement, the complete list of the patient's current medications, including dose, route, and frequency, is obtained and documented
- Medications ordered for the patient while under the care of the organization are compared to the list created at the time of entry to the hospital or admission
- Discrepancies – omissions, duplications, adjustments, deletions, additions – are reconciled and documented
- When the patient is transferred to another setting, service, or provider *within the hospital*, the complete and reconciled medication list is communicated, and the communication is documented

## 2011 NATIONAL PATIENT SAFETY GOALS

NPSG.08.02.01



**Provide a complete and reconciled medication list to previous and future care providers when a patient is discharged to another hospital or directly home**

- When the patient is transferred *to another hospital*, the complete and reconciled medication list is communicated to the next provider of service, and the communication is documented
- When the patient is discharged directly to his or her home, the complete and reconciled medication list is provided the patient's primary care provider, the original referring provider, and/or the next provider of care, and the communication is documented

NPSG.08.03.01



**Provide a complete and reconciled medications list directly to the patient/family, and explain the medication list to the patient/family**

- The complete and reconciled medication list is provided to and explained to the patient/family
- All medications listed on the HMAR (Home Medication Assessment & Reconciliation) form must be listed on the Discharge Instruction Form with directions to continue, modify, or discontinue each medication
- All new medications are also listed on the Discharge Instruction Form with appropriate instructions

NPSG.08.04.01



**In settings where medications are used minimally, or prescribed for short duration, modified medication reconciliation processes are performed**

- When only short-term medications are prescribed with no change to the patient's current medication list, the patient is provided a list that contains the short-term medication to continue after leaving the hospital
- The complete, documented medication reconciliation process is used when any long-term (chronic) medication is prescribed, a change in long-term medication occurs, or the patient is admitted

### REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS

PC.01.02.08



**The hospital assesses risk for falls based on patient population and setting, implements interventions to reduce falls**

- Fall reduction program, including fall risk assessment
- Fall prevention tent cards/posters developed
- Focused monitoring in identified areas or as indicated
- Fall Incident trending by location, severity, and cause

Formerly  
NPSG.09.02.01  
Now A  
Provision of Care (PC)  
Standard

### IMPROVE RECOGNITION AND RESPONSE TO CHANGES IN A PATIENT'S CONDITION

PC.02.01.19



**The hospital recognizes and responds to changes in a patient's condition**

- Organization has implemented a Rapid Response Team (RRT) that allows employees to directly request assistance from specially trained individuals when a patient's condition appears to be worsening
- Criteria for activation includes acute change in heart rate, blood pressure, respiratory rate, level of consciousness, or if any employee is concerned about the condition of the patient
- To activate the RRT, call extension 53-5555 and provide your name, extension, patient name, unit, room number, and reason for activation

Formerly  
NPSG.16.01.01  
Now A  
Provision of Care (PC)  
Standard

# 2011 NATIONAL PATIENT SAFETY GOALS

## GOAL 15

## THE HOSPITAL IDENTIFIES SAFETY RISKS INHERENT IN ITS PATIENT POPULATION

### NPSG.15.01.01



### The organization identifies patients at risk for suicide

- Risk assessment includes specific risk factors for suicide
- Addresses immediate patient safety needs and appropriate setting for treatment
- Provides information on crisis hotline to patients/families in crisis situations

## THE UNIVERSAL PROTOCOL

### The Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™



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

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

#### UP.01.01.01

#### Conduct a pre-procedure verification process

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

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

Use a checklist to assure you have...

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

#### UP.01.02.01

#### Mark the procedure site

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

#### UP.01.03.01

#### Conduct a “time out” immediately before starting the procedure

- Conducted in the setting the procedure will occur
- Is standardized, and involves the entire operative/procedural team
- Document the “time out” process



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

**GOALS & OVERVIEW:**

To recognize and respect the rights of the patient, and provide care, treatment and services in a manner that respects and fosters the patient’s dignity, autonomy, positive self-regard, civil rights, and involvement in his or her care. Care, treatment, and services are planned and provided with regard to the patient’s personal values, beliefs, and preferences.



**COMPONENTS INVOLVED:**

- Developing and Communicating Patient Rights
- Participation in Care Decisions
- Obtaining Informed Consent
- Right to Know Care Providers
- Respecting Patient Rights, including End-of-Life Care
- Patient Responsibilities

➔ Here are a few examples of Patient/Family Rights & Responsibilities:

Patient/Family Rights	Patient/Family Responsibilities
<ul style="list-style-type: none"> <li>• To be granted access to care and treatment</li> <li>• To receive an explanation of any procedures or treatments, so that you may give informed consent</li> <li>• To have pain managed and participate in how pain is managed</li> <li>• To be treated with respect and courtesy</li> <li>• To have medical record information treated as confidential</li> <li>• To expect your visit will be as safe and comfortable as possible</li> <li>• To receive complete and current information about diagnosis, treatment, and proposed future health care needs in a language you can understand</li> </ul>	<ul style="list-style-type: none"> <li>• To comfort and support your child</li> <li>• To provide accurate and complete information about past and present matters related to the child’s health</li> <li>• To be available to the health care team either in person or by telephone</li> <li>• To voice concerns to the health care team</li> <li>• To follow prescribed treatment plans and keep appointments</li> <li>• To treat staff and other families in a considerate, courteous, and cooperative manner</li> <li>• To work with the health care team to ensure the best possible treatment, rehabilitation, and discharge planning</li> </ul>

**? How are patients informed about their Rights & Responsibilities?**

- The “Rights and Responsibilities of Parents and Children” brochure is provided to the patient at the time of admission or outpatient visit.
- The “Notice of Privacy Practices” (HIPAA information) is provided to each patient at registration. Be prepared to discuss this process with surveyors.

**? What do you do if there is an ethical concern about patient care decisions?**


- Nemours has an **Ethics & Patient Rights Committee** that serves as a resource for patient care staff, patients, and families. The Committee’s role is to assist parties with differing opinions on the goals or appropriateness of treatment in situations involving complex ethical and/or moral treatment decisions.
- Patient care staff, patients, and family members can obtain an ethics consult by paging the Ethics Consult Coordinating Physician at 302-435-0256, or by advising a member of the care team of the request.
- An ethics consult may be requested at any time. The consult will be scheduled based on the urgency of the specific situation and availability of all parties.

**? Does a patient have a right to refuse treatment?**

**Yes.** Patient and family involvement in care decisions is encouraged, including the decision to refuse treatment.

## **? What is “Informed Consent?”**

- **Informed Consent** is a process that allows the patient, or the patient’s legal representative, full participation in decisions regarding the patient’s care, treatment, and services.
- Informed consent can only occur when the patient, or the patient’s legal representative, fully understands the nature of the intervention and its risks and benefits, as well as the alternatives and their risks and benefits.
- Informed consent occurs when the patient, or the patient’s legal representative, accepts or rejects a medical intervention willingly and without coercion.

 **POLICY** Refer to policy # 60.12 (“Informed Consent for Treatment of Minors”) for additional information.

## **> Advance Directives & End-of-Life Care**

### **? What is an “Advance Directive,” and who needs one?**

- An **Advance Directive** is a legal document indicating what life-sustaining treatment is to be administered, discontinued, or withheld if an individual has lost his or her ability to make medical decisions about his or her own health care.
- Patients 18 years or older are legally considered adults, and expected to make their own decisions, unless a legally recognized surrogate decision-maker is identified.
- It is our responsibility to ask all patients who are 18 years or older if they have an Advance Directive:
  - ▶ If the patient has an Advance Directive and has it present, it is copied and scanned into the medical record.
  - ▶ If the patient has an Advance Directive, but no copy is available on admission, the patient and/or family is asked to have the document brought to the hospital.
  - ▶ If the patient does NOT have an Advance Directive, the patient is offered written information about Advance Directives. Nemours encourage the patient to consider executing Advance Directives, and offer social workers and chaplains as resources for answering related questions.

### **? Have I received education about end-of-life care?**

**Yes.** Associates are required to complete the Nemours University web-based education “*Patient Rights, Ethics and Diversity,*” which addresses Advance Directives, as part of orientation to the organization. In addition, all clinical Associates are required to complete the Nemours University web-based education “*Providing Comfort and Dignity During End-of-Life Care.*”

## **> Patient Confidentiality & Protected Health Information (PHI)**

### **? Have I received education about patient confidentiality?**

**Yes.** Associates are required to complete the Nemours University web-based educations “HIP101: Health Care Information Privacy” (formerly “HIPAA Privacy – Basic”) and “Security Awareness” (formerly “HIPAA Security – Basic”).



### **? What is the proper way to dispose of Protected Health Information (PHI)?**

Place in appropriate locked shredder receptacle in your department. PHI is **never** discarded in a regular trash can.

### **? How do I ensure the patient’s right to privacy and confidentiality of his or her medical information?**

- Refraining from discussing patient information publicly or at home
- Discussing care only in the presence of the patient or in the presence of others with patient permission
- Proper disposal of Protected Health Information (PHI) in appropriate receptacles
- Covering patients during transport
- Knocking before entering a room, and keeping doors closed during treatments and times of care
- Patient information is only accessed on a “need to know” basis, whether the information is accessed from computer, paper, or by spoken word.



**Patient information should never be discussed in hallways, in elevators, in your home, in other public places, or with employees that are not involved in the patient’s care.**

## ➤ Providing Information in a Manner Patients & Families Understand

Reasonable efforts are made to tailor information to the patient's age, language, and ability to understand, as well as to the communication needs of patients and families. The learning and communication needs of patients and families are assessed during registration and throughout the course of treatment. Below are some of the services offered to provide for effective communication. Contact the Department of Patient and Family Services at extension 4230 to access interpreter services. If an in-house interpreter is not available, the Language Line service is available at all times. **The use of interpreter services – either in-person or via the Language Line – is documented in the appropriate section of the EMR.** Note: See "Patient-Centered Communication Standards" information on Page 7.



### INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY:

- The Department of Patient and Family Services maintains a list of approved interpreters (including bilingual associates and trained community volunteer interpreters). Trained bilingual associates may be utilized within their assigned work area.
- Employed Spanish-speaking interpreters
- Language Line service – provides support in over 151 languages, and is available 24/7



### HEARING IMPAIRED/DEAF INDIVIDUALS:

- Provide access to a qualified interpreter or other assistive service for patients, families, and visitors who are hearing impaired
- TDD phone and amplifier equipment are available



### VISUALLY IMPAIRED INDIVIDUALS:

- Visual aid devices including Braille and other services required by the visually impaired individual are available



#### POLICY

Refer to policy # 60.28 ("Effective Communication with Patients, Families and Visitors with Special Communication Needs") for additional information.

## ➤ Cultural & Spiritual Sensitivity

Patient rights include "respecting and acknowledging one's psychosocial, spiritual, and cultural values, and how they impact a patient's response to their care." Health care professionals are entrusted to care for patients as whole persons – body, mind, and spirit. In addition, health care professionals need to be empowered with the capacity, skills, and knowledge to respond to the unique needs of each patient and their loved ones.

### **? What cultural and spiritual sensitivity resources and education are available?**

- Associates complete the Nemours University web-based education "Patient Rights, Ethics and Diversity," which provides basic information about cultural and spiritual sensitivity.
- "Cultural and Spiritual Sensitivity: A Learning Module" and "A Quick Guide to Cultures and Spiritual Traditions" are also available to all Associates, and can be accessed via NemoursNet.



#### INTRANET

From the NemoursNet Homepage:

Clinical → [CULTURAL & SPIRITUAL SENSITIVITY](#) → [Select Cultural & Spiritual Sensitivity Resource]

### **? Who do I call if a patient or family member needs spiritual or pastoral support?**

Pastoral Care Services are available to support patients, families, and employees, and may be contacted at extension 5063, or via the Operator.

## ➤ Complaints, Concerns, & Grievances

### **? If a patient or family member has a complaint, concern, or grievance, how do I assist them?**

- Complaints, concerns, and grievances are always taken seriously, and an attempt is made to resolve them at the level closest to the patient whenever possible.
- Patients and families may express concerns to their attending physician, or any member of the health care team. Patients and families may also contact the Patient Relations Department at extension 4799.
- Patient and families may share their concerns with the State of Delaware or The Joint Commission. Contact information is provided in the "Rights and Responsibilities of Parents and Children" brochure.

## PROVISION OF CARE, TREATMENT, AND SERVICES (PC)

### GOALS & OVERVIEW:

To create and support a care process that is integrated and cyclical, and that allows care to be delivered according to patient needs, based on the plan of care, and within the hospital's scope of services. The complexity of providing care, treatment, and services through this process requires an interdisciplinary collaborative approach and a mutual effort among those who work in the organization to coordinate care in a manner that is conducive to optimal patient outcomes, quality, and safety, and to promote continuity of care when the patient is referred, discharged, or transferred.

### COMPONENTS INVOLVED:

- Assessment/Planning Care
- Discharge Planning/Continuity of Care
- Patient Education
- Providing/Coordinating Care
- Special Conditions/Seclusion & Restraints



### Patient Assessment

#### **? How are the needs of the patient known or identified?**

Information about the patient's physical, psychological, social, cultural, and spiritual needs are obtained during the initial assessment, primarily by the physician and nurse caring for the patient. Other members of the health care team – such as care managers, social workers, dietitians, pharmacists, and rehabilitation or respiratory therapists – also assist with needs identification.

Upon admission, assessments include questions geared toward identification of functional, nutritional, and spiritual needs. Based on the results of these assessments, referrals are made to the appropriate services – Therapeutic & Rehab Services, Dietitians, Social Services, Pastoral Care, etc. for further assessment.

#### **? Have I received patient abuse and neglect education?**

**Yes.** Screening for signs and symptoms of patient abuse and/or neglect is a responsibility of the organization, and important to the safety and well-being of the population we serve. Education for clinical Associates regarding the identification of, response to, and reporting of signs of abuse and neglect occurs upon hire and annually thereafter.

**NOTE:** Previously, identification of abuse and neglect training was included in the Nemours University web-based education "Assessment of Special Populations." In 2011, identification of abuse and neglect training was incorporated into the Nemours University "2011 Patient Safety" web-based education.

#### **? If I suspect a patient is a victim of abuse, what should I do?**

If an Associate, Member of the Medical Staff, or Physician-In-Training suspects child abuse, he or she **must** report his or her suspicions directly to the appropriate State's Child Abuse Hotline.

<b>Delaware Child Abuse Hotline</b>	800-292-9582	<b>Pennsylvania ChildLine</b>	800-932-0313
<b>New Jersey Child Abuse Hotline</b>	800-792-8610	<b>Maryland Child Protective Services</b>	800-332-6347

Nemours also requires prompt notification to the CARE Team of any such report by contacting the Department of Patient and Family Services Department at extension 4230. If a report is made outside of business hours, ask the operator to page the evening/weekend social worker or an on-call social worker.



#### **POLICY**

Refer to policy # 60.82 ("Child Abuse Reporting and AIDHC Care Team Process") for additional information.



### **DO YOU KNOW...**

### **Why we don't call The Joint Commission "JCAHO" anymore?**

In December 2006, The Joint Commission on Accreditation of Healthcare Organizations – frequently and officially abbreviated as "JCAHO" – announced that to better reflect its expanding scope of services it was shortening its name to just "The Joint Commission." The change was effective January 8, 2007, and served to eliminate the "JCAHO" abbreviation.

**> Pain Assessment & Management**

**? What are my responsibilities related to pain assessment and management?**

- Each health care provider is expected to aid in the management of pain based on his or her area of specialty.
- Nursing Associates should refer to Nursing Plan of Care #1.02 (“Management of the Patient with Altered State of Comfort: Pain”), which includes detailed information on pain assessment and management for both inpatient and outpatients. This Nursing Plan of Care is available via Policy Manager. In addition, there are educational materials on Policy Manager that can be provided to patient/families regarding our “Commitment to Pain Management” (EM1.02) and “How Can You Tell if Your Child is Experiencing (Having) Pain?” (EM1.04).
- The Attending Physician, Physician-in-Training, or designee may consult the Pain Management Service during the patient’s hospitalization. A consultation is initiated by entering the order in the EMR or by contacting the Pain Management Service at pager number (302) 426-4924.


**? When and how is pain assessed?**

<b>When?</b>	→ Upon admission → Every 4 hours, if indicated → Within 1 hour following any pain intervention	→ Prior to discharge → Each outpatient visit
<b>How?</b>	→ Questions to ascertain if pain is present → Assessment of nonverbal cues indicating the presense of pain → If pain is present, further evaluation and intervention is initiated	



**? What do I do if the patient does have pain?**

- Patients who report pain are further assessed by an appropriate caregiver to determine the quality, location, frequency and duration of the pain utilizing age and situation appropriate pain scales.
- The pain scales used are CRIES, FLACC, Wong-Baker FACES™, RESTORE (in PICU), N-PASS (with neonatal patients), and numeric. For more information on these pain scales, see “Specific Directions on Pain Scale Use” (in Nursing Plan of Care #1.02 “Management of the Patient with Altered State of Comfort: Pain”) in Policy Manager.
- Patient's response to comfort measures and analgesic medications are **evaluated within one hour after the intervention/medication administration.**

 **POLICY** Refer to policy # 60.31 (“Pain Management”) for additional information.

**> Interdisciplinary Care**

Nemours provides interdisciplinary care rather than multidisciplinary (“silo”) care. We communicate with our colleagues who are involved in the care of our patients – physicians, nurses, social workers, dietitians, therapists, and other members of the health care team.

**? How is a patient’s plan of care developed, implemented, and documented?**

<b>Development</b>	→	An interdisciplinary plan of care is developed based on assessed patient needs/goals
<b>Implementation</b>	→	By the health care team members, working together, utilizing the plan of care
<b>Reassessment</b>	→	When there is a significant change in the patient’s condition, diagnosis, and/or response to treatment
<b>Reprioritization</b>	→	Based on changing patient needs, even if the patient’s condition does not change
<b>Communication</b>	→	Via many avenues, including assessments, progress notes, shift report, referrals to other disciplines, case management discussions, and patient care rounds
<b>Documentation</b>	→	Interdisciplinary plan of care and progress notes

## **? How often does an RN document on the Individualized Plan of Care?**

Registered Nurses must document on the Plan of Care at admission, and at the completion of a direct care nurse's shift, or at least once every 12 hours in the event of an extended shift. That means, at a minimum, there is documentation on the Plan of Care at least twice per day, on different shifts, approximately 12 hours apart from each other. Documentation includes an evaluation ("rating") of progress of the patient's identified goals. Any unresolved items on the Plan of Care must be resolved at discharge.

 **POLICY** Refer to policy # 61.36 ("Nursing Documentation Policy") for additional information.

## **> Rapid Response Team (RRT)**

### **? Why does the Hospital have a Rapid Response Team (RRT)?**

The majority of patients who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a patient's condition by specially trained individuals – or Rapid Response Teams (RRTs) – may reduce cardiopulmonary or respiratory arrest and patient mortality. The hospital's Rapid Response Team (RRT) includes a Senior Resident, PICU RN, and Respiratory Therapist. As available, the Nursing Supervisor also responds to support team, but is not a member.

### **? How do I contact the Rapid Response Team (RRT)?**


**Who?** Any member of the health care team concerned about a patient's change in condition

**Why?** Acute change in patient status

**When?** Criteria for Rapid Response Team (RRT) Activation includes:

- Acute change in heart rate
- Acute change in blood pressure
- Acute change in respiratory rate
- Acute change in level of consciousness
- Any employee concerned about the condition of the patient

**How?** Call extension 53-5555 - Provide your name, extension, patient name, unit, room number, and reason for activation

 **RRT activation is NOT required when a change in the patient's condition is expected or is already being managed, such as in the operating room**

## **> Resuscitation/Code Carts**

When a patient or visitor medical emergency does occur, the individual finding the person in need of assistance calls the Command Center at extension 53-5555, or pushes the patient emergency button. Do not hang up with the Command Center until instructed to do so.

### **? Where is the nearest code cart to my department located?**

Ask your manager if you are unsure of the location of the nearest code cart.

### **? How often are code carts checked?**

The lock integrity, O<sub>2</sub>, suction, defibrillator, and the first expiration date are checked:

- Daily if department is open 7 days a week
- Each day of operation if department is not open 7 days a week

Internal contents are checked when the carts are exchanged for:

- Replenishment
- Equipment functionality
- Expiration dates



## Restraints

### **? What is Nemours' philosophy on restraining patients?**

Nemours recognizes the patient's right to be free from restraints that are not medically necessary. All patients are treated with the least restrictive measures, consistent with their individual safety, and the safety of others in the environment.

### **? What is the hospital's policy on the use of restraints and preventative strategies?**

Prior to restraints initiation, alternative and preventative strategies are attempted and documented. Alternative strategies may include, but are not limited to:

- providing companionship and/or supervision
- diversionary and physical activities, i.e., TV, radio, ambulation, activities of daily living (ADLs)
- reality orientation and psychosocial intervention
- decreasing environmental stimuli
- relaxation techniques, i.e., massage, warm bath
- attending to physical needs, i.e., toileting, eye glasses
- enlisting the help of the family
- assessing the patient for pain and offering PRN medications

### **? When might it be necessary to restrain a patient?**

If less restrictive alternatives are ineffective in protecting the safety of the patient or others, restraints may be necessary. Clinical justification and other requirements must be documented. **Restraints are always discontinued at the earliest possible opportunity.**

### **? What are the criteria to discontinue restraint use?**

- The patient no longer presents an immediate physical threat to him/herself or others
- Change in patient's physical condition, indicating a need for discontinuation

### **? What restraint-related education and training is important for supporting safety and Nemours endeavor to achieve a restraint-free environment?**

Individuals who are trained and deemed competent in minimizing restraint use through early identification of escalating behaviors, use of alternative interventions, and, if warranted, safely applying restraints, are vital to Nemours goal of achieving a safe and restraint-free environment. Education and demonstrated competency should include, but is not be limited to, implications of restraint use, identification/utilization of alternative strategies, safe application and removal of restraints, physical holding techniques, and, for applicable Associates, assessment skills (e.g. physical and psychological state, tolerance of restraints, skin integrity, comfort).

### **? What is a restraint debriefing?**

Debriefing is an important part of the process related to the use of behavioral restraints. The debriefing process is an opportunity for Associates to learn how they can improve the process, and potentially prevent placing the patient or other patients in behavioral restraints. A summary of the restraint debriefing is documented in the medical record by the Attending Physician or designee.



#### **POLICY**

Refer to policy # 60.21 ("Use of Restraints") for additional information.

## Patient & Family Education

### **? When are patient and family education needs determined?**

Initially at the time of admission, and subsequently throughout the patient's stay, the health care team assesses the patient and family to determine their individual education needs.

### **? How are individual patient and family education needs assessed and addressed?**

The patient and family education needs assessment includes an assessment of learning and communication preferences, **including the preferred language for discussing health care**, and any barriers to learning and communication, such as sensory impairment, language barriers, as well as cultural and religious beliefs. Learning and communication needs and preferences are documented in the Learning & Communication Assessment section of the inpatient EMR so the health care team can incorporate these needs into the plan of care. *Note: See "Patient-Centered Communication Standards" information on Page 7.*

## **? What type of education is provided to patients and families?**

Patients and families receive education and training specific to their needs and appropriate to the care, treatment, and services provided. Based on the patient's condition, assessed needs, age, and clinical situation, the patient and family are provided education about the topics below. This list is **not** inclusive.

- The patient's interdisciplinary plan for care, treatment, and services
- Patient safety
- Safe and effective use of medications
- Nutrition
- Pain (risk of, assessment of, methods and importance of pain management)
- Safe and effective use of medical equipment and/or supplies
- Smoking cessation, if indicated
- Basic health practices, including oral health, as appropriate
- Rehabilitation, as appropriate
- Other education based on patient need and situation



### **POLICY**

*Refer to policy # 60.26 ("Patient and Family Education") for additional information.*

## **? How is patient and family education documented in the medical record?**

Documentation of patient and family education occurs in the appropriate area of the medical record, determined by the discipline completing the education. These areas include the "Patient Education" section, progress notes, discharge instructions, or discipline-specific sections of the EMR.

## **? How do we address the academic needs of hospitalized children?**

Inpatients who have been out of school ten (10) days or longer (whether hospitalized or not), as well as selected outpatients, are offered educational services through the School Program. Rehabilitation patients and those patients with chronic conditions that require multiple hospitalizations are eligible for services from the first day of their admission. Patients eligible to receive academic educational services through the School Program are identified by the Department of Patient Education, or may be referred by any member of a patient's health care team.



### **POLICY**

*Refer to Patient Care policy # 60.01 ("School Program") for additional information.*



## **Verbal/Emergency Orders & Verbal/Telephone Orders**

### **? What are Verbal/Emergency Orders and Verbal/Telephone Orders, and when are they allowable?**

**Verbal/Emergency Orders** occur during a face-to-face interaction between the prescribing practitioner and the receiver, and may only be used if the order execution is required as STAT:

- Due to the patient's acute clinical condition, such as neurological instability, cardiovascular instability, respiratory instability, or behavioral issues necessitating immediate restraint
- In a Code Blue, Code Delta, Trauma Code or Code Red situation

**Verbal/Telephone Orders** are orders given verbally over the telephone, and are used as infrequently as possible. For instance, if the patient's clinical condition requires prompt action and the practitioner is not in the facility, has no remote access to the electronic medical record, does not have access to a fax machine, and/or is unable to be physically present because of another patient's acute need.

- For Verbal/Telephone Medication Orders, two Associates who are authorized to receive telephone orders listen to the order. These Associates include RNs, graduate nurses under the direct supervision of an RN, and Respiratory Care Practitioners (for respiratory care orders only).
- For Verbal/Telephone Non-Medication Orders, orders may be received by Associates within the scope of their practice.

Note: Both Verbal/Emergency Orders and Verbal/Telephone Orders must be signed in the EMR by the prescribing practitioner within 48 hours.



### **POLICY**

*Refer to policy #60.58 ("Medication and Non-Medication Orders") for additional information.*

## ➤ Discharge Planning

### **? When is discharge planning initiated?**

Discharge planning begins on admission and continues throughout the hospital stay.

### **? How is discharge planning accomplished?**

During the pre-admission or admission process, patients are assessed for potential ongoing care needs and post-discharge services. The health care team collaborates with one another and with the patient and family regarding the plan of care/treatment and the discharge plan. Patient & Family Services assists with coordinating post-discharge services.

## MEDICATION MANAGEMENT (MM)

### **GOALS & OVERVIEW:**

The safe and effective management of medications through carefully planning and implementing medication management processes based on the care, treatment, and services provided by the organization. A safe and effective medication management system addresses critical medication processes identified below.



### **COMPONENTS INVOLVED:**

- |                           |                          |              |
|---------------------------|--------------------------|--------------|
| ▪ Planning                | ▪ Ordering               | ▪ Monitoring |
| ▪ Selection & Procurement | ▪ Preparing & Dispensing | ▪ Evaluation |
| ▪ Storage                 | ▪ Administration         |              |

## ➤ Medication Security

### **? Who has access to medication storage areas?**

Access to medication storage areas is limited to authorized personnel involved in the dispensing, administration, and distribution of medications. All inpatient and outpatient locations that have medication storage areas are responsible for ensuring that only authorized individuals have access to these areas.

## ➤ Look-a-Like, Sound-a-Like Medications

### **? What are “Look-a-Like, Sound-a-Like” Medications, and how can they be dangerous?”**

According to a 2008 report by U.S. Pharmacopeia, the organization that sets the standards for medications in the United States, there are over 1,500 medications that have names so similar they have been confused with one or more other medications.

Special precautions are taken when ordering, storing, and administering these medications that have similar appearance, names, or packaging (***Look-a-Like, Sound-a-Like Medications***) in order to prevent potential medication errors that could cause harm to our patients.

- Processes have been designed to avoid mishaps with such medications, such as Tallman/Shortman Lettering (GLUCAgOn/ GLUCApHaGe) in the electronic ordering system, and separate storage areas for these medications.
- Any unit or area where look-a-like, sound-a-like medications are stocked ensures these medications are separated or clearly marked.
- A list of look-a-like, sound-a-like medications is available through the LexiComp Formulary website:



#### **From the Computer Desktop:**

NIS – NEMOURS INFORMATION SERVICES Folder → WILMINGTON Folder → **FORMULARY** Link ↴

#### **From the left menu on the [LEXICOMP FORMULARY WEBSITE](#):**

INDEXES → CHARTS/SPECIAL TOPICS → LOOK-ALIKE/SOUND-ALIKE FORMULARY

## High-Alert Medications

### **?** What are “High-Alert Medications?”

**High-Alert Medications** are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error with these medications may be more devastating to a patient.



### **?** What medications are categorized as “High-Alert Medications” at AIDHC and practice sites?

- **Insulin** (all routes of administration)
- **Digoxin** (all routes of administration)
- **Chemotherapeutic Agents** (all routes of administration)
- **Warfarin**
- **Heparin** (all concentrations, by all routes of administration, excluding pre-filled syringes of 10 units/ml)
- **Low Molecular Weight Heparin** (Enoxaparin)
- **Intravenous Hypertonic Saline** (concentrations greater than 0.9%)
- **Alteplase** (intermittent and continuous infusions, excluding 2mg/ml concentrations used as dwells)
- Any **continuous IV medication** infusing through a large volume or syringe pump as a “basic infusion” without “guardrails”
- **Parenteral Nutrition**
- **Neuromuscular Blocking Agents:** Cisatracurium, Rocuronium, Mivacurium, Succinylcholine, Pancuronium, Vecuronium
- **Controlled Substances** – continuous infusions
- **Controlled Substances** – infrequently used

### **?** What extra precautions are taken with “High-Alert Medications”?

High-Alert Medications are double-checked by two nurses to visually and verbally verify the accuracy of the dose and accuracy of the route prior to administration. Both nurses document verification in the patient’s EMR.

 **POLICY** Refer policy 60.53 (“High Alert Medications”) for additional information.

## Medication Orders


### **?** When might a medication be administered prior to the pharmacist reviewing the order?

- In an emergency
- When the resulting delay would harm the patient
- When a physician is present and controls the administration of the medication

*Note: For information on Verbal/Emergency Orders and Verbal/Telephone Orders, see page 20*

### **?** What happens if a written medication order is illegible, is missing required elements, or is unclear for any other reason, such as confusion surrounding the use of an unapproved abbreviation?

If there are difficulties entering a written order into the EMR on behalf of a practitioner, the prescriber of the order is contacted, the order is clarified or rewritten, and the order is then entered appropriately in the EMR. The patient’s contacts the original prescriber of the order, or the practitioner currently responsible for the patient, as appropriate per policy.

 **POLICY** Refer policy 60.49 (“Communication and Resolution of Concerns, Issues and Results”) for additional information.

### **?** Is “continue home medications” a valid medication order?

**No.** Each medication must be written out as a complete order.

### **?** Is it acceptable to write “resume pre-operative medications” as an order?

**No.** Each order must be re-written after a transfer from one level of care to another, or following a procedure requiring general anesthesia.

### **?** What happens to medications after they are discontinued?

Discontinued medications are returned to the Pharmacy to be verified, inventoried, and for appropriate disposition.

## ➤ Adverse Drug Reactions (ADR)

### **? What is an “Adverse Drug Reaction (ADR)”, and how are they identified and reported?**

An **Adverse Drug Reaction (ADR)** is an unexpected, unintended, undesired, or excessive response to a drug that meets at least one of the following nine (9) criteria. ANY Associate, physician, or physician-in-training can report an ADR by calling the ADR Hotline at extension 6237 (6-ADR), or by contacting the Pharmacy Department directly at extension 5702.

The nine (9) Adverse Drug Reaction (ADR) criteria include:

1. Requires discontinuation of the drug
2. Requires changing the therapy
3. Requires modifying the dose  
(*except minor dosage adjustments*)
4. Requires initial or prolonged hospitalization
5. Requires treatment or intervention
6. Significantly complicates diagnosis.
7. Negatively affects prognosis,
8. Results in temporary or permanent disability
9. Is life-threatening, or results in death

### **? What has been done to reduce the risk of medication incidents in my area?**

- Limiting the number of medications concentrations available on each unit (i.e. Heparin concentrations)
- Medication bar coding
- Double check requirement for High-Alert Medications (*See page 22*)
- Identifying patients using two unique identifiers prior to medication administration (*See page 8*)
- Identifying and addressing use of “Do Not Use” abbreviations (*See page 8*)
- Processes for managing “Look-a-Like, Sound-a-Like” medications (*See page 21*)
- Verifying written orders that are unclear prior to entering them in the EMR
- Upgrades to the Pyxis automated dispensing system for medication management

## ➤ Medication Expiration

### **? To identify the expiration date – do I write the date opened, or the last day the product may be used?**

The Joint Commission requires organizations to store all medications labeled with an expiration date, and has clarified “expiration date” to mean the *last date* the product may be used. Further, the original expiration date for all drugs is valid under the assumption the product has not been opened. For multi-dose vials, once the vial is opened or punctured, the original expiration date is no longer valid and a revised expiration date must be identified. The Joint Commission requires multi-dose vials be relabeled with the revised expiration date once the vial is opened or punctured. Therefore, the *last date* the product may be used, *not* the date the product was opened, must be identified on the label.

### **? Why do multi-dose vials now expire after 28 days instead of 30 days?**

In June 2010, The Joint Commission aligned its requirements with the revised Association for Professionals in Infection Control and Epidemiology (APIC) and the United States Pharmacopeia (USP) guidelines for expiration of multi-dose vials due to reports of multiple outbreaks of infections associated with their use. Both APIC and USP now recommend that opened or punctured multi-dose vials be used for no more than 28 days unless the manufacturer specifies otherwise. This revised timeframe is based on the U.S. Food and Drug Administration (FDA) requirement that manufacturers test the effectiveness of the bacteriostatic agent used in the multi-dose vial for a period of 28 days. Exceptions to the 28 day expiration of multi-dose vials are included below.

- The manufacturer identifies and extended 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. 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 the vaccines are stored and handled appropriately.

### GOALS & OVERVIEW:

To develop and maintain an effective Infection Prevention and Control program that addresses a wide range of situations and incorporates activities of planning, implementation, and evaluation.

### COMPONENTS INVOLVED:

- Infection Control Planning, including responsibility, resources, risks, goals, activities, and influx
- Infection Control Implementation, including activities, medical equipment, devices, and supplies, transmission of infections, and influenza vaccinations
- Evaluation & Improvement



### Hand Hygiene

The Centers for Disease Control & Prevention (CDC) indicates that the single most important step we can take to keep from getting sick and spreading illness to others is to **clean our hands**. Sometimes, however, health care workers do not follow recommended hand hygiene practices. This puts patients, families, and employees at risk.

#### **?** When should I clean my hands?

- |   |                                  |
|---|----------------------------------|
| • Before <i>and</i> after contact with patients                               | • After contact with equipment   |
| • Before <i>and</i> after wearing gloves                                      | • Before <i>and</i> after eating |
| • After contact with blood, body fluids, non-intact skin, or mucous membranes | • After using the bathroom       |
|   | • After sneezing or coughing     |

#### **?** How should I clean my hands?

You can use either soap and water or an approved hand sanitizer, depending on the situation:

- When hands are visibly dirty, contaminated, or soiled, wash them with soap and water for 15 seconds
- If hands are NOT visibly soiled, use an alcohol-based hand sanitizer for routinely decontaminating your hands.

#### **?** What is the policy regarding fingernails?

- Artificial fingernails, nail extenders, and nail applications/decorations of any type are not permitted for employees who have direct contact with patients or with the patient's immediate environment.
- Natural nails tips are kept not longer than ¼ inch long, from the tip of the finger.
- If nail polish is worn, it is clear or pale-colored and intact (without chips) so that the entire nail bed itself may be clearly visualized.



#### **POLICY**

*Refer to policy #46.05 ("Hand Hygiene, Instant Hand Sanitizers, and Nail Applications") for additional information.*



### Standard Precautions & Bloodborne Pathogens

#### **?** What are "Standard Precautions?"

**Standard Precautions** include hand hygiene, safety-engineered devices, safe work practices, and the use of appropriate Personal Protective Equipment (PPE) such as gloves, gowns, and masks, whenever touching or exposure to patient 1) blood, 2) body fluids, secretions, and excretions, except sweat, regardless of whether it contains visible blood, 3) non-intact skin, or 4) mucous membranes is anticipated. All Nemours Associates must follow Standard Precautions as part of their daily routine.

Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals by utilizing controls during the care of all patients, regardless of their diagnosis or presumed infectious status. Standard Precautions are intended to reduce your exposure to Bloodborne Pathogens such as HIV, Hepatitis B and C, and other dangerous organisms.

#### **?** What are "Bloodborne Pathogens?"

**Bloodborne Pathogens** are organisms found in blood and certain other body fluids that, if transmitted, are capable of causing disease in another person. *Examples: HIV, Hepatitis B (HBV), and Hepatitis C (HCV)*

## **? Where would I find more information about Bloodborne Pathogens and precautions?**

Refer to the Infection Control Manual on the Nemours Intranet.



**From the NemoursNet Homepage:**

Tools & Resources → Infection Prevention & Control → [INFECTION CONTROL MANUAL](#)

## **? What goes in a red bag for disposal?**

Items that are contaminated with blood or other potentially infectious materials (OPIM), including:

- Anything saturated with blood or wound damage
- Any container with bulk blood or body fluids
- Blood Transfusion tubing/bags
- Central Venous lines & arterial lines
- Dressings, cotton balls, and gauze saturated with blood or wound drainage
- Filled thoracentesis bottles
- Pleurovac
- Emptied suction canisters (bloody)
- Emptied wound drains (i.e. Hemovac, Jackson-Pratt, etc.)
- Contact Isolation waste, including disposable isolation gowns and gloves
- Gloves

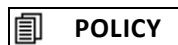
## **? What do you do if you get a needle stick?**

- Wash the site IMMEDIATELY with soap and water.
- Immediately notification of the exposure is required. Contact Employee Health Service (EHS) at extension 4425 M–F, 0700–1600, or the Nursing Supervisor during evening, night, weekend, or holiday hours.
- Provide information regarding the source patient’s risk factors for infectious diseases. Your supervisor should also be notified.
- Further information is available using the Nemours Intranet and policy resources listed below.



**From the NemoursNet Homepage:**

Tools & Resources → Infection Prevention & Control → [OCCUPATIONAL EXPOSURE](#)

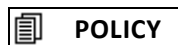


*Refer to policy # 46.31 (“Standard Precautions/Exposure Control Plan”) for detailed process information.*

## **? What is the policy regarding eating and drinking in work areas, including at nursing stations?**

Eating and drinking (as well as applying cosmetics or lip balm and handling contact lenses) is prohibited in work areas where there is a reasonable likelihood of occupational exposure, including at nursing stations.

Further, food and drinks are never kept in refrigerators, freezers, shelves, cabinets, or on countertops or bench tops where blood or other potentially infectious materials are present. Associate food and drinks are stored in designated Associate refrigerators and freezers only. Associate food and drinks are not stored in patient food refrigerators or freezers, or in medication refrigerators or freezers.



*Refer to policy # 46.31 (“Standard Precautions/Exposure Control Plan”) for additional information.*

## **? Where can I obtain isolation signs?**

Printable isolation signs for Airborne Precautions, Contact Precautions, Droplet Precautions, and C-Difficile Handwashing are available on the Nemours Intranet. The signs are available in both English and Spanish.



**From the NemoursNet Homepage:**

Tools & Resources → Infection Prevention & Control → Infection Prevention Information → [SPECIAL PRECAUTIONS](#)

## **? How do Associates learn about Infection Control?**

- New Associate Orientation
- Annual Educations/Nemours University
- Infection Control Department (extension 4692)
- Infection Control Manual



**From the NemoursNet Homepage:**

Tools & Resources → Infection Prevention & Control → [INFECTION CONTROL MANUAL](#)



***Be prepared to discuss how your patient care area or site works to reduce health care-acquired infections for your patient population.***

**GOALS & OVERVIEW:**

Management of important functions related to safety and the quality of care, treatment, and services provided by the organization is the responsibility of leaders, and includes the following:

- A culture that fosters safety as a priority for everyone who works in the hospital
- The planning and provision of services that meet the needs of patients
- The availability of resources—human, financial, and physical—for providing care, treatment, and services
- The existence of competent staff and other care providers
- Ongoing evaluation of and improvement in performance

**COMPONENTS INVOLVED:**

- Leadership Structure
- Organization Culture & System Performance Expectations
- Leadership Relationships
- Leadership Operations

**Leadership Planning/Structure**

**? What is Nemours Strategy Management System (SMS)?**

The Nemours Strategy Management System (SMS) uses the Balanced Scorecard architecture to articulate the strategy and link key processes, behaviors, and personal accountability, enabling Nemours to close the gap between where it currently is and where it needs to go. Nemours has developed and refined a strategic vision that projects to 2015. This strategic vision has four (4) strategic goals. An integral part of the SMS is the creation of Strategy Maps that shows how each strategic objective is linked to achieving desired outcomes.

**? What are Nemours’ Strategic Goals?**

1. Care for every child as if they were our own;
2. Be a leader in improving children’s health through our integrated health system, becoming a preeminent voice for children;
3. Be a great place to work; and
4. Be effective stewards of all of our assets, continually improving them to advance our Mission.

**? How do I access the Nemours Delaware Valley Strategy Map?**

The updated Nemours Delaware Valley Strategy Map is included on Page 41. The Nemours Delaware Valley Strategy Map, other Nemours strategy maps, and additional information regarding the Strategy Management System (SMS) is also available through the Nemours Intranet.



From the NemoursNet Homepage:  
Strategy → [STRATEGY MANAGEMENT SYSTEM](#)

**Evaluating the Culture of Quality & Safety**

Leaders regularly evaluate the culture of quality and safety through a variety of organization-wide and department specific measurements. One method is Associate surveys.

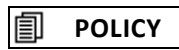
- In 2009, the bi-annual Associates Perspective Survey was administered, and included several questions relating to a culture of quality and safety. The next Associate Perspective Survey will be distributed in the spring of 2011.
- In 2010, Nemours implemented the Associate Pulse Survey, a shorter, quarterly survey which allows for a more frequent evaluation of trends and Associate feelings opinions.
- In 2010, Associates were also asked to complete the Climate of Patient Safety survey sponsored by the Patient Safety Committee. Questions on this survey included:
  - ▶ “The senior leaders in my hospital listen to me and care about my concerns.”
  - ▶ “My suggestions about safety would be acted upon if I expressed them to management.”
  - ▶ “I am encouraged by my colleagues to report any patient safety concerns I may have.”
  - ▶ “The personnel in the clinical area take responsibility for patient safety.”

**➤ Communication Processes to Support a Culture of Quality & Safety**

Leaders assist in designing communication processes to support a culture of quality and safety. Internal and National data has identified communication issues as the leading cause of near miss and adverse patient events, and Leadership has introduced multiple communication processes designed to promote patient safety.

**➤ Resolution and Communication of Health Care Team Concerns, Issues, & Test Results**

Nemours has a defined process by which any Associate, Member of the Medical Staff, and Physician-in-Training can communicate concerns, issues, or test results that might compromise patient care. These concerns are resolved, using guidance, support, and assistance from Medical Staff, Nursing and/or Administrative Leadership, as necessary.

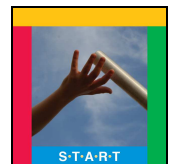


**POLICY** Refer to policy # 60.49 (“Resolution and Communication of Care Team Concerns, Issues and Test Results”) for additional information.

**➤ Hand-off Communication & The S•T•A•R•T Model**

**? What is “Hand-off Communication,” when is it used, and what is the S•T•A•R•T model?**

A **Hand-off** is a transfer and acceptance of patient care responsibility achieved through effective communication. The **S•T•A•R•T** model for hand-off communication is the formal hand-off process used by Nemours to facilitate excellent, safe communication about the care and condition of the patient during the course of transfer and acceptance.



- The process is utilized when a patient transfers to another practitioner, setting, service, or level of care, including when communicating to “on-call” staff
- The process is designed to provide clear and complete information about a patient’s care, treatment, current condition, and any recent changes
- The process allows time to ask and respond to questions – **this is one of the most important aspects of an effective hand-off**

**THE S•T•A•R•T HAND-OFF COMMUNICATION MODEL**

<b>S</b> ITUATION, BACKGROUND
<p><b>Current complaint or problem, succinct summary of background</b>  <i>H&amp;P, allergies, medications, isolation, PMH, PSH, ROS, social, etc.</i></p>
<b>T</b> HERAPIES, INTERVENTIONS
<p><b>Update treatment, interventions and course</b>  <i>Procedures, interventions, results; additional data, tests, evaluation, consults, findings; laboratory tests, EKGs, Radiographs, Audiograms, etc. completed and pending</i></p>
<b>A</b> NTICIPATED COURSE
<p><b>Assessment of current status and anticipated course</b>  <i>Organize by organ system or other format; short or long-term; Issues: considerations that may require additional attention or intervention; Risks: potential complications or adverse outcomes and their management</i></p>
<b>R</b> ECONCILIATION
<p><b>Discussion, adjustment of plan</b>  <i>May include physicians, nurses, respiratory therapy, family, ethics committee, etc.; plans, orders; short and long-term considerations</i></p>
<b>T</b> RANSFER
<p><b>To another service or level of care; or discharge to home/chronic care facility</b></p>

## ➤ Leadership Rounding

Rounding by managers and senior leaders is an opportunity for meaningful and open communication between Associates and organization leaders, and provides leaders with important information about what is going well, and what improvements can be made. Opportunities identified by Associates during rounding related to work systems, available resources, and patient care matters can help reduce risk and improve Associate, patient, and visitor safety.

## ➤ Compliance with Laws & Regulations

The commitment by leadership to comply with all applicable laws and regulations is supported by our Business Practice Standards, Compliance Program, and ongoing performance improvement activities. An important aspect to fulfilling this commitment is leadership awareness of any suspected violations. Associates should report concerns to:

- Their immediate supervisor, department manager, or another manager with whom you are comfortable
- Human Resources, or any representative of the Corporate Compliance Department
- The anonymous Compliance HOTLINE at 1-866-NEM-HOTLine or 1-866-636-4685 to seek additional information, or to report improper conduct.

## ➤ Nemours Standards of Behavior

The Nemours Standards of Behavior are drawn from our values of excel, respect, serve, honor and learn. To progress toward our strategic destination, these behaviors are vital to improve individual and organizational performance on our goals of outstanding customer satisfaction and service excellence.

Our behaviors and actions have a daily impact on our colleagues, patients, families, and business partners. The Standards of Behavior have been developed to achieve stronger collaboration and cohesion, higher productivity, and ultimately higher patient satisfaction and Associate retention. By learning, practicing, and living the Standards of Behavior our work environment will improve, and everyone will benefit.

The Nemours Standards of Behavior are included on page 42, and are also available through the Nemours Intranet:



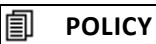
**INTRANET** From the NemoursNet Homepage:  
Strategy → [STANDARDS OF BEHAVIOR](#)

## ➤ Behaviors that Undermine a Culture of Quality & Safety

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive behaviors such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages, condescending language or voice intonation, and impatience with questions. These types of behaviors undermine team effectiveness and compromise the safety of our patients.

Nemours does not tolerate intimidating, disruptive, or unprofessional behavior, and has identified the following expectations:

- Associates conduct themselves in accordance with the “Code of Business Practice” policy and the “Associate Conduct and Corrective Actions” policy.
- Members of the Medical Staff and Physicians-In-Training conduct themselves in accordance with the “Medical Staff Code of Conduct” policy.
- Associates should report concerns regarding disruptive behaviors via any of the following channels, without fear of retaliation:
  - ▶ Contact your immediate supervisor, department manager, or another manager with whom you are comfortable
  - ▶ Contact Human Resources, or any representative of the Corporate Ethics & Responsibility
  - ▶ Contact the anonymous Compliance HOTLINE at 1-866-NEM-HOTLine or 1-866-636-4685 to seek additional information, or to report disruptive behavior.
  - ▶ Other alternative reporting options are outlined in “Code of Business Practice” policy.



**POLICY** Refer to policy #1.5.4.1 (“Code of Business Practice”), policy #2.1.34 (“Associate Conduct and Corrective Actions”), and policy #57.68 (“Medical Staff Code of Conduct”) for more information.

## PERFORMANCE IMPROVEMENT (PI)

### GOALS & OVERVIEW:

To improve safety and quality of care by collecting and analyzing data to identify trends, patterns, and performance levels that indicate opportunities for improvement, supporting improvements, and monitoring the improvements to ensure the desired changes are achieved and sustained.



**COMPONENTS INVOLVED:** ■ Data Collection ■ Data Analysis ■ Performance Improvement

### ? What Performance Improvement model does the organization use?

The organization has established a logical process to help Associates identify what can be improved, and how it can be improved. The SAFER Performance Improvement Model represents the following process:

### THE SAFER PERFORMANCE IMPROVEMENT MODEL

#### Select

**SELECT performance measures.** Involves identifying top priorities for improvement, data to be collected, and individuals responsible for various performance improvement tasks.

#### Analyze

**ANALYZE the data.** Involves gathering and analyzing data to determine if a process is producing the desired results. Are we doing the right thing? Are we doing the right thing well?

#### Find

**FIND opportunities for improvement.** Involves identifying what processes need to be fixed or redesigned, and determining possible causes of identified issues in these processes.

#### Execute

**EXECUTE actions.** Involves developing action plans, assigning responsibilities, providing education, and putting actual improvements in place.

#### Reevaluate

**REEVALUATE performance.** Involves monitoring improvements to ensure they are effective, and may involve making additional changes to achieve the desired outcome.

### ? How do Associates participate in Performance Improvement?

The following are examples of how Associates participate in Performance Improvement activities:

- Participation in hospital-wide, department, site, or unit-based committees or teams established to measure and/or improve performance of patient care and/or business processes.
- Collect and analyze data, and implement actions to:
  - ▶ Reduce infection rates
  - ▶ Reduce occurrence of risk incidents
  - ▶ Reduce patient complaints/grievances
  - ▶ Impact effective utilization of resources
  - ▶ Improve patient health and outcomes
  - ▶ Decrease patient wait times
  - ▶ Improve patient satisfaction (using Press Ganey results and other surveys)
- Participation in enterprise-wide obesity (BMI) initiative to capture height and weight for provider use
- Participation in NACHRI collaborative to eradicate catheter-associated blood stream infections (CABSIs)
- Participating in Telebox initiative (scripting, monitoring impact of no-show rates)
- Collect and analyze data, and implement actions in response to measures submitted to comparative databases such as MMP, NACHRI, NDNQI, NISQUIP, and Society for Thoracic Surgery Congenital Heart Defects.



**No matter what your position, you play an important role in helping the organization improve performance and provide quality patient care!**

## **?** How does the organization identify and reduce adverse events and safety risks?

One method utilized is the *Failure Mode and Effects Analysis* (FMEA). An FMEA is a team-based, systematic, and proactive approach for analyzing a high-risk process and identifying ways the process can fail, why it might fail, and how it can be made safer. Its purpose is to prevent problems before they occur. The focus of an FMEA is “something can go wrong and let’s fix it before it does,” rather than “nothing can go wrong” or “something has already gone wrong.”

FMEAs completed by the hospital over the past few years: Medical Gas System, Chemotherapy, Mislabeled Specimens, Bar Coding, Patient Flow from Emergency Department to Inpatient, and IV Medication Infusions.

## **?** What is my responsibility as an Associate for improving care, services, and safety?

- Participate in performance improvement activities, as assigned. Ensure your supervisor is aware of your commitment so that he/she can support your attendance at team meetings.
- Submit your ideas for improvement, and report any safety risks or concerns.
- Report all unanticipated events in accordance with the incident reporting and sentinel event policies.



### **POLICY**

Refer to policy # 12.1.1 (“Incident Reporting”) and policy # 1.75 (“Sentinel Event”) for additional information.



## **Sentinel Events & Root Cause Analysis (RCA)**

### **?** What is a “Sentinel Event?”

A **Sentinel Event** is an event involving unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition, including the following events:

- Suicide of any individual receiving care, treatment or services in an around-the-clock care setting, or within 72 hours after discharge
- Unanticipated death or major permanent loss of function related to a healthcare-associated infection
- Death associated with the use of restraints
- Abduction of any individual receiving care, treatment, or services
- Discharge of an infant to the incorrect family
- Unanticipated death of a full-term infant
- Severe neonatal hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Unintended retention of a foreign object in an individual after surgery or other procedure
- Criminal Event (Rape/Assault/Homicide)
- Surgical and nonsurgical invasive procedure on the wrong patient, wrong site or wrong procedure
- Permanent loss of limb or function

### **?** What is a “Root Cause Analysis (RCA),” and how is it used to address a Sentinel Event?

- A **Root Cause Analysis (RCA)**, as defined by The Joint Commission, is “a process for identifying basic or causal factor(s) underlying variation in performance, including the occurrence or possible occurrence of a sentinel event.” In other words, a Root Cause Analysis (RCA) is a problem solving method aimed at identifying the root causes of problems or events so they can be addressed, corrected, or eliminated, as opposed to only addressing the immediately obvious or superficial symptoms of a problem.
- A structured Root Cause Analysis (RCA) is conducted to identify and address the basic and causal factors that resulted in the Sentinel Event.
- One important goal of a Root Cause Analysis (RCA) is to identify improvements to systems or processes in order to decrease the likelihood of the event reoccurring.



### **POLICY**

Refer to policy # 1.75 (“Sentinel Event”) for additional information.

**Environment of Care (EC) • GOALS & OVERVIEW:**

To promote a safe, functional, and supportive environment so that quality and safety are preserved. The environment of care is made up of three (3) basic elements:

- The building or space, including how it is arranged and special features that protect patients, visitors, and staff
- Equipment used to support patient care or to safely operate the building or space
- People, including those who work within the organization, patients, and anyone else who enters the environment, all of whom have a role in minimizing risks

**COMPONENTS INVOLVED:**

- Planning
- Implementation
- Staff Demonstrate Competence
- Monitor & Improve

**Life Safety (LS) • GOALS & OVERVIEW:**

Focuses on the importance of a fire-safe environment and buildings, and facility design and related features that help prevent, detect, and suppress fires, considering several options for fire protection, including creating safe areas (smoke compartments) that allow people to remain in their locations and “defend in place,” moving people to safe areas within the building, and, as a last resort, moving people out of a building.

**COMPONENTS INVOLVED:**

- Statement of Conditions
- Interim Life Safety Measures
- Building Requirements
- Building Services
- Special Provisions
- Means of Egress Requirements
- Protection
- Operating Features

**Emergency Management (EM) • GOALS & OVERVIEW:**

Emergencies can be threats to any health care organization, and can adversely impact patient safety and the hospital’s ability to provide care, treatment, and services for an extended length of time. Power failures, water and fuel shortages, flooding, and communication breakdowns are just a few of the hazards that can disrupt patient care and pose risks to staff and the hospital.

It is paramount that the organization creates plans to respond to the effects of potential emergencies that fall on a continuum from disruptive to disastrous. The four phases of emergency management are mitigation, preparedness, response, and recovery. They occur over time; mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.

**COMPONENTS INVOLVED:**

- Foundation for the Emergency Operations Plan
- Plan for Response & Recovery
- Evaluation

**Safety & Security**

**? How are Associates educated about safety?**

Safety education is provided during New Associate Orientation, annual Nemours University web-based educations, department meetings, Environment of Care rounds, and through various other methods as new and revised processes are implemented and education needs are identified.

**? How can Associates access Environment of Care management plans?**

Environment of Care management plans are available on the Nemours Intranet at the path below. Key information is also available in the color-coded Emergency Response Guides located throughout the hospital and at the Practice Plan sites.



**From the NemoursNet Homepage:**

Tools & Resources → Workplace Safety → **ENVIRONMENT OF CARE MANAGEMENT PLANS**

## **? What are my security-related responsibilities?**

- Report any suspicious or threatening persons promptly to the Security Department.
- Associates have the responsibility to immediately bring any threat of violence made to themselves, others, or the facility to the attention of the Security Department.
- Associates are required to wear their Nemours identification badges at all times while at work. Badges must be displayed photo side out and above waist level.
- Security alerts and other security tips communicated to Associates related to personal, patient and organizational security are taken seriously.
- To request assistance, contact the Security Department 24/7 at extension 5560

## **? What is a 'Code Silver?'**

'Code Silver' means an active shooter is in the building. An active shooter is defined as "an armed person who has used deadly physical force on other persons and continues to do so while having unrestricted access to additional victims."

In an active shooter incident, victims are usually selected at random, the event is unpredictable and evolves quickly, and law enforcement is usually required to end the situation.

## **? What should I do if there is a 'Code Silver?'**

If possible:

- Call 911, then 53-5555 if you are on the Nemours/Alfred I. duPont Hospital for Children campus.
- Escape from the area immediately. Follow emergency escape routes, and go to designated safe areas.
- Notify others of the danger.
- If you are able to find a safe area, stay on the line and continue to provide the emergency dispatcher with updated information.

If you are unable to escape immediately:

- Call 911 and tell the dispatcher where you are and what is happening.
- Look for any means of possible escape or self-defense.
- Get to an office or room as far away from the shooting as possible.
- Lock the door and cover any windows facing the hallways.
- Keep quiet and do not answer the door unless you are sure it's the police.



## **Medical Equipment**

### **? What are the requirements and process for inspection of medical equipment?**

- All medical equipment, regardless of ownership, must be inspected by Clinical Engineering prior to first use.
- Contact Clinical Engineering at extension 4927 to request acceptance testing. If it is after hours, contact the Operator to page the on-call Clinical Engineer Tech.
- Inspected and approved equipment displays both an inventory ID bar code number and an inspection sticker.

### **? What happens if a piece of medical equipment malfunctions?**

If you find a piece of medical equipment that is not working properly, do the following:

- Remove the defective equipment from service, and tag with a "Do Not Use" sticker.
- Assess the patient. Based on patient assessment, contact Supervisor, or Nursing Supervisor, and Patient's Physician, as appropriate.
- Collect and secure all evidence, and complete an Incident Report.
- In the event of a patient injury, notify Risk Management immediately at extension 4843 or extension 5552, and notify Clinical Engineering as soon as practical. The equipment is impounded, and labeled "Defective Do Not Use" by the Department Manager or Supervisor. No action to repair or dispose of the device, supplies, or accessories is made until an investigation by Risk Management and Clinical Engineering is completed.
- Otherwise, contact Clinical Engineering for repairs at extension 4927 or, if after hours, by calling the Operator and requesting he or she page the on-call Clinical Engineering Tech.



## Hazardous Materials & Waste

### **? What should I do if a hazardous materials spill occurs?**

- Direct patients, employees, and/or visitors away from the area.
- Notify your supervisor and facilities management person for your site immediately.
- Review the hazards of the material (MSDS); know what you are working with.
- **If you are comfortable**, get the proper PPE and clean-up materials or kits, and clean up the spill. Many Associates work with hazardous materials daily and are trained on how to clean up hazardous material spills. So, if you have been trained on hazardous material cleanup, proceed if you are comfortable with the situation.
- **If you are NOT comfortable cleaning up the spill**, call the Command Center at extension 53-5555 for emergency response (AIDHC), or contact facilities at your site for immediate clean up (other locations).
- **Complete an Incident Report and forward to the Risk Management Department**

### **? What is a Material Safety Data Sheet (MSDS)?**

A **Material Safety Data Sheet (MSDS)** is a document that contains detailed information about a specific chemical, including, but not limited to, its hazards, safe-handling procedures, control measures (PPE), and how to respond to exposure and spills.

### **? How do I access Material Safety Data Sheets (MSDS) Information?**

- MSDS information is available online in the 3E Healthcare MSDS Database, which is accessible through the Nemours Intranet or from the computer's desktop. The paths are included below.
- MSDS information is also available by calling the MSDS emergency line at 1-800-451-8346.



#### **From the NemoursNet Homepage:**

'HELP ME TO ACCESS: Material Safety Data Sheets (MSDS)' at the bottom of the Homepage or Tools & Resources → Workplace Safety → [MATERIAL SAFETY DATA SHEETS](#)



#### **From the Computer Desktop:**

NIS - NEMOURS INFORMATION SERVICES Folder → MSDS → [MSDS SITE](#)

### **? How do I access the Hazardous Materials & Chemicals Inventory list for my area or location?**

Location-specific chemical inventory lists are posted, and are also available on the Nemours Intranet site.



#### **From the NemoursNet Homepage:**

Tools & Resources → Workplace Safety → [CHEMICAL INVENTORY – DEPARTMENT SPECIFIC](#)

### **? How are chemicals stored?**

- Chemicals such as acids, bases, and alcohols used in labs must be stored in separate cabinets designed to handle these types of chemicals.
- Special flammable cabinets are available for storing flammable chemicals.
- It is not recommended that you transfer chemicals from one container to another. If you must transfer a chemical from one container to another, the new container must be labeled, and the label must include the product name, all warnings, and the manufacturer's name and address.

### **? What is a "Hazardous Waste Manifest?"**

A *Hazardous Waste Manifest* is a required shipping document that travels with hazardous waste from the point of generation, through transportation, to the final treatment, storage, and disposal facility. Each party in the chain of shipping, including the generator, signs and keeps one of the manifest copies, creating a "cradle-to-grave" tracking of the hazardous waste. A copy of the Hazardous Waste Manifest ('Initial Generator Copy') is signed by a representative of the company picking up the waste and a representative of the hospital or Practice Plan Site generating the waste, and left at the site when the waste is removed.

A final copy of the Hazardous Waste Manifest ('Designated Facility to Generator Copy') is returned to the hospital or Practice Plan Site, or is available electronically, once the hazardous waste has been destroyed by the designated facility. These two (2) copies are reconciled and maintained together at the hospital or Practice Plan Site for **no less than three (3) years** to ensure that no load has been lost, misplaced, or disposed of in an inappropriate manner.



## Physical Environment

Everyone who works in the organization is responsible for safety and the successful management of risks in the physical environment. The most well-designed plans and procedures are of no value if those who work in the organization do not know how to follow them. It is important for you to know how to identify and minimize risks, what actions to take when an incident occurs, and how to report it.

It is important that the physical environment is functional and promotes healing and caring. Certain key physical elements in the environment are significant in their ability to not only improve patient safety, but to also positively influence patient outcomes and satisfaction. These elements can also contribute to creating the positive feel and function of space which patients, families, visitors, and Associates experience in the service delivery system.

Everyone at Nemours is responsible for maintaining a safe and functional environment by:

- Eliminating and/or addressing propping of doors or use of door wedges and door stops
- Making sure exits, fire extinguishers, and fire alarm pull stations are not blocked
- Making sure items/supplies are stored on pallets (not sitting on floor)
- Emptying/reporting overflowing garbage cans or reporting overflowing needle boxes to housekeeping
- Making sure nothing is stored within 18" of ceilings or sprinklers
- Reporting stained ceiling tiles
- Keeping furnishings and equipment safe and in good repair, and ensuring areas used by patients are clean and free of offensive odors
- Reporting temperature or humidity levels issues deemed unsuitable for care, treatment, and/or services
- Reporting lighting issues deemed unsuitable for care, treatment and services
- Identifying and reporting barriers related to interior space accommodations for use of equipment, such as wheelchairs, necessary to the activities of daily living

### **? How do I report any unsafe condition?**

Unsafe conditions are reported to the Command Center at extension 53-5555.

### **? Who is the Safety Officer?**

Mark Lorenz, Associate Administrator, is the Interim Safety Officer, and can be reached at extension 4030.

## EMERGENCY CODES

Emergency Codes are used to communicate promptly with associates when an organized response is necessary for a medical emergency, fire, bomb threat, active shooter, missing or abducted child, or an external or internal disaster.

The following page includes an ***Emergency Codes – Quick Reference Guide*** that identifies the various types of emergency codes and their meanings, and the immediate action necessary. Additional information is also included on NemoursNet, using the path included below, and in the Emergency Response Guides located throughout the hospital and at the Practice Plan locations.

Associates are responsible for knowing their role in emergency situations. It is common for a surveyor to ask an Associate, "Tell me what you would do in the event of a fire?" or "What are your responsibilities in the event of a disaster?" Be prepared to respond! Once you have reviewed the available resources, if you are still not sure, refer any questions to your supervisor or the Safety Officer, Mark Lorenz.



**From the NemoursNet Homepage:**

**HOW DO I... RESPOND IN AN EMERGENCY** → Nemours/Alfred I. duPont Hospital for Children →  
[Select Event/Emergency]

**Emergency Codes – Quick Reference Guide**

<b>CODE DELTA LEVEL 1</b>	<b>Emergency or event has occurred in the community. 25 or more casualties coming to ED.</b>
<b>CODE DELTA LEVEL 2</b>	<b>Emergency or event has occurred in the community. Less than 25 casualties coming to ED.</b>
<ul style="list-style-type: none"> <li>• Immediate staff response is the same for Code Delta Level 1 and Code Delta Level 2</li> <li>• Code Delta is announced and Incident Command System is activated.</li> <li>• Unless designated to report to Labor Pool or ED, staff should complete current duties, limit phone use and await further instructions.</li> <li>• PICU, 3N, 3E &amp; 3F units immediately send 1 RN each to ED</li> <li>• 2B, NICU &amp; 3CS units send 1 RN each to Labor Pool.</li> <li>• All inpatient and outpatient units drop off a completed Disaster Information Form to the Labor Pool.</li> </ul>	
<b>CODE DELTA LEVEL 3</b>	<b>Operations or Utility Failure, internal or external in origin, affecting the organization. (e.g. loss of power, computers, telephones, water, severe weather, hazardous materials spill, etc.)</b>
<ul style="list-style-type: none"> <li>• Code Delta 3 is announced and Incident Command System is activated.</li> <li>• Staff should complete current duties, limit phone use &amp; await instructions</li> <li>• All inpatient and outpatient units send a clerk/aide to Labor Pool with a completed Disaster Information Form and then return to their units.</li> </ul>	
<b>CODE BLUE</b>	<b>Medical Emergency</b>
All personnel are responsible to summon help in a medical emergency. To initiate a Code Blue, activate the nearest code blue button or contact the Command Center at extension 53-5555. The primary Code Blue Response Team responds to location of the Code Blue.	
<b>CODE RED</b>	<b>Smoke and/or fire on hospital premises</b>
<p>Practice <b>RACE</b> to respond to a fire</p> <ul style="list-style-type: none"> <li><b>R</b> Rescue persons directly threatened by the fire</li> <li><b>A</b> Alarm by pulling closest fire alarm and calling the Command Center at extension 53-5555</li> <li><b>C</b> Contain the fire by closing doors and windows</li> <li><b>E</b> Evacuate the zone or area, or Extinguish fire if safe to use a fire extinguisher</li> </ul> <p>Practice <b>PASS</b> to use a fire extinguisher</p> <ul style="list-style-type: none"> <li><b>P</b> Pull the pin on fire extinguisher</li> <li><b>A</b> Aim at base of the fire</li> <li><b>S</b> Squeeze the handle</li> <li><b>S</b> Sweep from side to side at the base of the fire until fire is out or the extinguisher is empty</li> </ul>	
<b>CODE TAG ALERT</b>	<b>Missing, eloped, or abducted patient</b>
<p>Ensure each inpatient is banded with a security band. When an inpatient approaches an exit, the tag alert alarm is automatically activated.</p> <ul style="list-style-type: none"> <li>• Upon activation of a Code Tag Alert, an overhead Code Tag Alert announcement with location is made and CCTV surveillance cameras pan to specific exit to aid in identification.</li> <li>• Inpatient units immediately check to ensure all their patients are accounted for and then call the Command Center with results of census/bed check.</li> <li>• Security responds to location of Code Tag Alert.</li> <li>• Report any suspicious activity to the Command Center at extension 53-5555</li> </ul> <p>If a Tag Alert has not activated but you realize that a patient is missing:</p> <ul style="list-style-type: none"> <li>• Contact the Command Center at extension 53-5555 to initiate a Code Tag Alert.</li> <li>• Security deploys to main gate, back gate, main lobby, and reporting department.</li> <li>• All staff must monitor their department/work area and report any suspicious activity to the Command Center at extension 53-5555.</li> </ul>	
<b>CODE ORANGE</b>	<b>Bomb Threat</b>
Immediately report a bomb threat to your Manager, Nursing Supervisor, and the Command Center at extension 53-5555.	
<b>CODE SILVER</b>	<b>Active Shooter</b>
Call 911, then the Command Center at extension 53-5555 if you are on AIDHC campus. Escape from the area immediately. If you are unable to escape immediately, look for any means of possible escape or self-defense. Get as far away from the shooting as possible. Find a safe area, lock the door and keep quiet. Do not answer the door unless you are sure it's the police.	
<b>CODE DECON</b>	<b>Patient(s) in ED Requiring Decontamination</b>
Code Decon activates the Decontamination Team, which responds to the ED to begin the decontamination process. Code Decon may be followed by a Code Delta 1 or 2, depending on the number of victims.	
<b>CODE GREEN</b>	<b>Situation has returned to normal</b>
Previously announced Code is canceled and systems have returned to normal. Return to normal job duties.	

★ Further information on Emergency Codes and response procedures is included in the color-coded **EMERGENCY RESPONSE GUIDES** located throughout the hospital and at the Practice Plan sites, specific policies (policy #92.29 – *Code Silver - Active Shooter*, policy #60.03 – *Code Blue Response Team - Cardiopulmonary Response Team*, policy #1.42 – *Code Tag Alert*), and on NemoursNet by selecting **HOW DO I... RESPOND IN AN EMERGENCY** from the NemoursNet homepage.

**➤ Responding to a Fire - RACE**

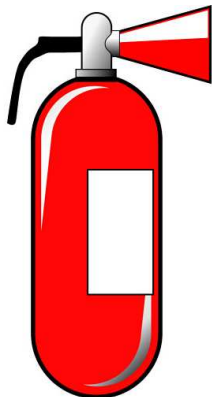
If you discover a fire, remember the acronym **RACE**.



- R** **Rescue** persons directly threatened by the fire.
- A** Activate **Alarms**
- C** **Contain** the fire by closing doors and windows
- E** **Evacuate** the zone or area

**➤ Using a Fire Extinguisher - PASS**

To use a fire extinguisher safely, stand six (6) to eight (8) feet from the fire with your back to an unblocked exit and use the **PASS** procedure:



- P** **Pull** the safety pin at the top of the extinguisher. (Some units have latches or levers instead.) This will allow you to operate the extinguisher.
- A** **Aim** the nozzle, horn or hose at the base of the flames. This is where the fuel is. Hold the extinguisher vertically to ensure the unit will have enough pressure.
- S** **Squeeze** or press the handle to release the pressurized extinguishing agent. Contents empty fast.
- S** **Sweep** from side to side at the base of the fire and at least six inches past the edges of the flames until completely extinguished. Start using the extinguisher from a safe distance away, then move forward as the fire diminishes.

**HUMAN RESOURCES (HR)**

**GOALS & OVERVIEW:**

To establish and verify employee qualifications, orient employees, and provide employees with training needed to support the care, treatment, and services provided, and to assess employee competence and performance.

- COMPONENTS INVOLVED:**
- Employee Orientation, Training & Education
  - Competence
  - Evaluation of Performance



**❓ How am I provided education and training, and oriented to my job and job responsibilities?**

- New Associate Orientation
- Department/Unit-Specific Orientation
- Nemours University Educations (web-based training)
- The following areas are covered, as appropriate. This list is not inclusive.
  - ▶ Mission, Vision, Values, and Organizational Goals
  - ▶ Nemours policies and procedures, including Infection Control
  - ▶ Program/department/unit-specific policies and procedures
  - ▶ Job-specific duties and responsibilities
  - ▶ Key Safety Content, including Environmental Safety, Associate Safety, and Patient Safety
  - ▶ Patient Rights and Ethics
  - ▶ Diversity and Cultural Competence
  - ▶ HIPAA Privacy & Security

## **? What are my other education and Human Resources responsibilities as an Associate?**

- Renewing license, registration, and/or certification prior to the expiration date, if required by law, regulation, or position description.
- Participating in continuing education and training provided to enhance competency related to your role, patient population served, new technology, and safety practices.
- Providing documentation of your participation in external educational programs to your supervisor.
- Integrating the Core Value of “Learn” into your personal development plan.
  - ▶ Open to new and better ideas; flexible and adapting to change
  - ▶ Continuous learning
  - ▶ Analysis, inquiry, and innovation
  - ▶ Discovering, applying, and disseminating new knowledge and best practices
  - ▶ Positively influencing children, families, professionals, communities, and others

## **? What type of education have I received related to team communication, collaboration, and coordination of care?**

All Associates have received Nemours Standards of Behavior training, and applicable personnel have received S.T.A.R.T training to facilitate effective hand-off communication and coordination of care.

*For more information about Nemours Standards of Behavior, see page 28 and page 42.*

*For more information about hand-off communication and the S.T.A.R.T. model, see page 27.*

## **RECORD OF CARE, TREATMENT AND SERVICES (RC) • INFORMATION MANAGEMENT (IM)**

### **GOALS & OVERVIEW:**

To provide timely access to complete and accurate health information needed to aid in clinical decision making and continuity of care, and to ensure information used by the hospital is categorized, filed, and maintained in a manner to ensure its privacy, security, and integrity.

### **COMPONENTS INVOLVED:**

- |   |  |
|---|--|
| ■ Identification of Information Needs   | ■ Knowledge-Based Information              |
| ■ Information Management Planning       | ■ Record Completion/Retention              |
| ■ Clinical Record Components            | ■ Monitoring Data/HIM Processes            |
| ■ Capturing, Storing, & Retrieving Data | ■ Protecting Privacy of Health Information |

## **? How are medical records secured?**

The paper medical record is maintained in secure areas at all times. The electronic medical record is secured by several different methods, access is based on the Associates role and security, through screen savers, auto timeout, and by logging off the workstation.

## **? How is the confidentiality of patient information protected?**

- Patient’s privacy is maintained, whether the information is written, verbal, or electronic
- Computerized systems are password protected, and access is position specific
- A confidentiality agreement is signed during orientation
- “HIP101: Health Care Information Privacy” (formerly “HIPAA Privacy - Basic”) and “Security Awareness” (formerly “HIPAA Security – Basic”) education is mandatory for all Associates
- Requests for release of information are directed to the HIM department where a team of qualified ROI staff review and process the requests according to Federal and State regulations

## **? How are information needs of Associates met?**


- Based on job function, appropriate access is provided to data, reports, and other information.
- Knowledge-based information (reference books, professional journals, library resources, etc.) are available. Outdated references books should be removed from the work area.

## ➤ Summary List for Ambulatory Patients

A summary list containing the following components is initiated for patients receiving continuing ambulatory care. ***This list is initiated by the third visit.***

- Any significant medical diagnoses or conditions
- Any significant operative and invasive procedures
- Any adverse or allergic drug reactions
- Any current medications, over-the-counter medications, and herbal preparations



 ***The patient's summary list is updated whenever there is a change in diagnosis, a newly identified allergy to a medication, and whenever a procedure is performed. The summary list is available via the "Snapshot" view in the EMR.***

## MEDICAL STAFF (MS)

### GOALS & OVERVIEW:

The Medical Staff provides oversight of the quality of care, treatment, and services provided, and is responsible for the ongoing evaluation of the competency of practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners, and providing leadership in performance improvement activities within the organization.

### COMPONENTS INVOLVED:

- |   |  |
|---|--|
| ▪ Medical Staff Bylaws                          | ▪ Credentialing, Privileging, Appointment, & Reappointment |
| ▪ Structure/Role of Medical Executive Committee | ▪ Evaluation of Practitioners                              |
| ▪ Oversight of Care, Treatment, and Services    | ▪ Acting on Reported Concerns/LIP Health                   |
| ▪ Performance Improvement                       | ▪ Continuing Education                                     |



### **? Who is classified as Medical Staff Member?**

The Medical Staff consists of physicians, dentists, clinical psychologists, advanced practice nurses, and physician assistants.

### **? How do I know if a Medical Staff Member has privileges to perform a procedure?**

Individual physician privileges can be found using the Physician Privileges Portal search feature on NemoursNet. A list of Medical Staff Members with sedation privileges is also available.



**From the NemoursNet Homepage:**

Clinical → Physicians → [click LICENSES AND CREDENTIALING on the main PHYSICIANS page] → **PHYSICIAN PRIVILEGES** or **PROVIDERS WITH SEDATION PRIVILEGES**



**From the Nemours.org Homepage:**

For Health Professionals → Medical Staff Services → **PHYSICIAN PRIVILEGES** → Providers with Sedation Privileges

## ➤ Medical Staff Impairment

### **? What is "Medical Staff Impairment?"**

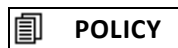
- Impairment is any physical, mental, or behavioral condition that interferes with a Medical Staff Member's ability to practice medicine with reasonable care and safety.
- Impairment may be caused by alcohol abuse, drug abuse, mental or emotional illness, dementia, effects of advancing age, or any other factor that may impact a Medical Staff Member's ability to provide care in a safe and competent manner.
- Impairment may also imply a decreased ability and/or willingness on the part of the affected individual to acknowledge the problem or to seek help to recover.

**? What is the policy regarding “Medical Staff Impairment,” and what are my responsibilities as a Medical Staff Member or Associate?**

- Medical Staff Members who have an actual or possible impairment have an obligation to report themselves to the Medical Staff’s Medical Staff Member Health Program (MSMHP).
- Medical Staff Members who are under investigation for suspected impairment at another health care facility, are obligated to self-disclose that investigation to their Medical Staff Department Chair.
- Medical Staff Members, Associates, or other concerned individuals have an obligation to report Medical Staff Members they know or suspect have an impairment to the Medical Staff Member Health Program (MSMHP).
- Through the Medical Staff Member Health Program (MSMHP), the Hospital will attempt to assist Members who have an actual or possible impairment to receive evaluation and appropriate treatment with the goal of continued performance of their privileges and membership.

**? How do I report a concern, and what happens after I report a concern?**

- Medical Staff Members, Associates, or other concerned individuals can report concerns by contacting the Medical Director (extension 5895), or by using the Medical Staff Member Referral Form which is available from Medical Staff Services (extension 5608) or from the Nursing Supervisor. Referrals can also be made through the Nemours Employee Assistance Program (EAP) hotline at 1-888-NEMOURS (1-888-636-6877).
- All referrals remain confidential except on a need-to-know basis or as required by law, and all good faith reports of possible impairment can be made without fear of retaliation.



**POLICY**

*Refer to policy # 57.35 (“Medical Staff Member Health Program: Medical Staff Members with Suspected or Known Impairment”) for additional information.*

**NURSING (NR)**

**GOALS & OVERVIEW:**

The quality of nursing services is built upon the leadership of a nurse executive and the work of a qualified staff. The nurse executive promotes quality by incorporating current nursing research findings, nationally recognized professional standards, and other expert literature into policies and procedures governing the provision of nursing care, treatment, and services.

**COMPONENTS INVOLVED:**

- Nurse Executive Role & Authority
- Establishing Guidelines for Nursing Care Delivery
- Directing Nursing Services
- Providing Nursing Care, Treatment, and Services



**? Does the Chief Nurse Executive (CNE) have authority to speak on behalf of the Department of Nursing?**

**Yes.** The Chief Nurse Executive (CNE) has the authority to speak on behalf of the Department of Nursing to the same extent that other leaders speak for their respective disciplines, departments, or service lines. The CNE functions at the executive level of the organization. The following is a sample of established executive-level meetings attended by the CNE:

- Nemours Leadership Council
- Medical Executive Committee
- Hospital Board of Managers
- Administrative & Joint Administrative Council

**? Who is responsible for developing nursing standards, policies, and procedures?**

The Chief Nurse Executive (CNE) has ultimate responsibility for nursing standards, policies, and procedures, though they are developed collaboratively with input from nursing and other healthcare team members, as well as through the use of supportive literature.

**? How do I access nursing policies and procedures?**

Policies and procedures are available on the Nemours Intranet via Policy Manager, or in the Nursing Department Policy & Procedure Manual.

## WAIVED TESTING (WT)

### GOALS & OVERVIEW:

Test results that are used to assess a patient condition or make a clinical decision about a patient are governed by the federal regulations known as the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). CLIA '88 classifies testing into four complexity levels: high complexity, moderate complexity, provider-performed microscopy (PPM procedures, a subset of moderate complexity), and **waived testing**.

Waived testing is the most common complexity level performed by caregivers at the patient bedside, or point of care. The Joint Commission standards apply to staff using instruments owned by staff, owned by the organization, or owned by the patient in performing waived laboratory tests.

### COMPONENTS INVOLVED:

- Policies & Procedures
- Identification of Staff Performing and Supervising Waived Testing
- Competency of Staff Performing Waived Testing
- Performance of Quality Control Checks
- Recordkeeping

## ➤ Waived Testing & Point-of-Care Testing (POCT)

### **? What is a “Waived Test”?**

As defined by The Joint Commission, a **Waived Test** is a test that meets the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) requirement for waived tests and is cleared by the Food and Drug Administration (FDA) for home use. These tests employ methodologies that are so simple and accurate that the likelihood of erroneous results is negligible, or they pose no risk of harm to the patient, resident, or individual served if the test is performed incorrectly.

### **? What is “Point-of-Care Testing (POCT)”?**

As defined by The Joint Commission, **Point-of-Care Testing (POCT)** is analytical testing performed at sites outside the traditional laboratory environment, usually at or near where care is delivered to individuals. Testing may be categorized as waived, moderate, or high complexity under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). Testing may range from simple waived procedures, such as fecal occult blood, to more sophisticated chemical analyzers.

### **? Are all Point-of-Care Tests considered Waived Tests? Aren't they the same thing?**

**No.** Though these terms are often erroneously used interchangeably, not all point-of-care tests are waived tests. Some point-of-care tests are considered moderate or high complexity under CLIA '88. However, most of the point-of-care tests performed at the hospital and the Practice Plan sites are waived.

### **? Which Point-of-Care tests are performed in my area?**

Some examples include: FLEXX (blood glucose testing), Hemoglobin A1C, and urine dipstick. If you are unsure of what point-of-care tests are performed in your area, please review them with your manager.

### **? Have I received training to perform Point-of-Care Tests?**

Associates who perform point-of-care tests are required to complete competency training and demonstrate proficiency specific to each point-of-care test they perform.

Each Associate is required to **annually** complete two (2) methods of competency assessment for **each** point-of-care test he or she performs. The first method is the Nemours University web-based education for the specific point-of-care test. The second method is a competency checklist completed by the individual (or qualified designee) responsible for supervising point-of-care testing on the Associate's unit, area, or Practice Plan site.

Policies, procedures, and information for each point-of-care test are located on the Nemours Intranet at the path below. The Point of Care Testing Coordinator is also available to provide assistance at extension 4324.



INTRANET

**From the Nemours Intranet Homepage:**

Clinical → Laboratory Services → Collection, Reporting, and Procedures →

**POINT OF CARE TESTING INFORMATION (INPATIENT AND OUTPATIENT)**

**? What are quality control (QC) procedures, and how are they accomplished for Point-of-Care Tests?**

- QC procedures ensure patient results are accurate, precise, and reliable.
- At least two levels are performed each day of patient testing, unless otherwise noted by the manufacturer, and are completed by those performing the test.
- Must also be run if a new reagent is opened, or if unexpected results are obtained.
- Each level must be within the QC reference ranges provided by the Clinical Laboratory. If the quality control is not within these ranges, it is to be repeated.
- If it is still unacceptable, the Point of Care Testing Coordinator at extension 4324, or the Clinical Laboratory must be notified, and the necessary troubleshooting measures will be taken.
- All corrective action is recorded on the QC log sheet.
- Patient testing is not to be performed on testing devices that do not pass quality control testing.

CITATIONS & NOTES	
1	The Joint Commission. (2010, March 15). <i>Facts about the Joint Commission</i> . Retrieved from <a href="http://www.jointcommission.org/facts_about_the_joint_commission">http://www.jointcommission.org/facts_about_the_joint_commission</a>
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4	The Joint Commission. (2010, September 1). <i>Facts about the Priority Focus Process</i> . Retrieved from <a href="http://www.jointcommission.org/facts_about_the_priority_focus_process">http://www.jointcommission.org/facts_about_the_priority_focus_process</a>
5	The Joint Commission. (2010, September 1). <i>Facts about the Tracer Methodology</i> . Retrieved from <a href="http://www.jointcommission.org/facts_about_the_tracer_methodology">http://www.jointcommission.org/facts_about_the_tracer_methodology</a>
6	The Joint Commission. <i>Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care [Topic Library Items]</i> . Retrieved from <a href="http://www.jointcommission.org/Advancing_Effective_Communication">http://www.jointcommission.org/Advancing_Effective_Communication</a>

**1. BE IN THE MOMENT**

- Be punctual; respect others' time and give your time to others.
- Remain open minded; respond and adapt to change.
- Maintain all expected Nemours and career specific certifications.
- Focus undivided attention on the current task or interaction.
- Listen actively to ensure understanding.
- Turn off 'autopilot' by pausing and choosing the appropriate response in situations.

**2. BE AUTHENTIC AND HUMANISTIC**

- Acknowledge and recognize the contributions of others in the work environment.
- Recognize and appreciate diversity.
- Demonstrate honesty and integrity with all people in all situations.
- Show sincere interest in people and their opinions, issues and/or concerns.
- Speak in a manner that maintains or enhances the self-esteem of others.
- Encourage 'balance' when it comes to work—and family-life issues.

**3. VOLUNTEER DISCRETIONARY EFFORT CONSTANTLY**

- Look for opportunities of improvement and make appropriate recommendations.
- Anticipate the needs of others, offer services before they are requested.
- Anticipate and resolve issues in a timely manner.
- Display initiative in all work activities.
- Take accountability for helping other individuals and departments be successful—ask yourself, "What more can I do to help or support you?"
- Routinely suggest creative ideas and solutions to help Nemours succeed.

**4. MODEL HIGH PERFORMANCE — DESIRED BEHAVIORS THAT DRIVE DESIRED RESULTS**

- Follow all policies and procedures regarding safety and quality.
- Be collaborative and supportive by working in a cooperative manner.
- Demonstrate individual leadership, ingenuity and initiative in doing the right thing by using ADET: Acknowledge, Introduce Self, Duration, Explanation, Thank You.
- Proactively take action(s) to continuously improve yourself and the systems/processes with which you work.

**5. RESPECT AND LEVERAGE SEPARATE REALITIES**

- Apply the values of Nemours in everyday work.
- Be aware and respectful of the life situation of others and treat them with compassion, empathy and consideration.
- Be collaborative and supportive by working in a cooperative manner.
- Recognize that your 'reality' is not superior to others and that you can learn from them.
- Compensate for potential personal 'blind spots' by soliciting diverse ideas and opinions.

**6. BE CURIOUS VS. JUDGMENTAL**

- Communicate with others in an open and appropriate manner.
- Listen and respond with empathy to all.
- Encourage analysis, inquiry, collaborations and innovation across disciplines.
- Ask questions to better understand the thoughts/beliefs and behaviors of others.
- Create a safe environment for people to say what they think and feel.

**7. LOOK IN THE MIRROR FIRST — BE ACCOUNTABLE**

- Know, accept and understand the responsibilities of your job.
- Accept responsibility for continued self-improvement.
- Meet deadlines and follow up on issues and requests.
- Behave with the mindset that 'I own Nemours, including its successes and opportunities for improvement.'
- Ask yourself, 'How am I contributing to what is or has happened? — take corrective action when necessary.
- Solicit feedback from others routinely and act on it when appropriate.

**8. HAVE COURAGEOUS CONVERSATIONS**

- Be conscious of budget impact of decisions; conserve resources when possible.
- Coach in private; commend in public.
- Communicate with others in an open and appropriate manner.
- Utilize all of these Standards when confronting difficult situations, people, or when you are going to express an unpopular idea or opinion.
- Address concerns or disagreements with the appropriate person in a timely manner—refrain from 'triangulation.'

**9. PROVIDE TIMELY, CLEAR & SPECIFIC PERFORMANCE EXPECTATIONS & FEEDBACK**

- Coach in private; commend in public.
- Encourage analysis, inquiry, collaborations and innovation across disciplines.
- Listen and respond with empathy to all.
- Utilize all of these Standards to communicate performance expectations and feedback in a timely manner.

**10. TEACH, COACH & MENTOR — SPEND AT LEAST 1/2 OF YOUR TIME DEVELOPING OTHERS**

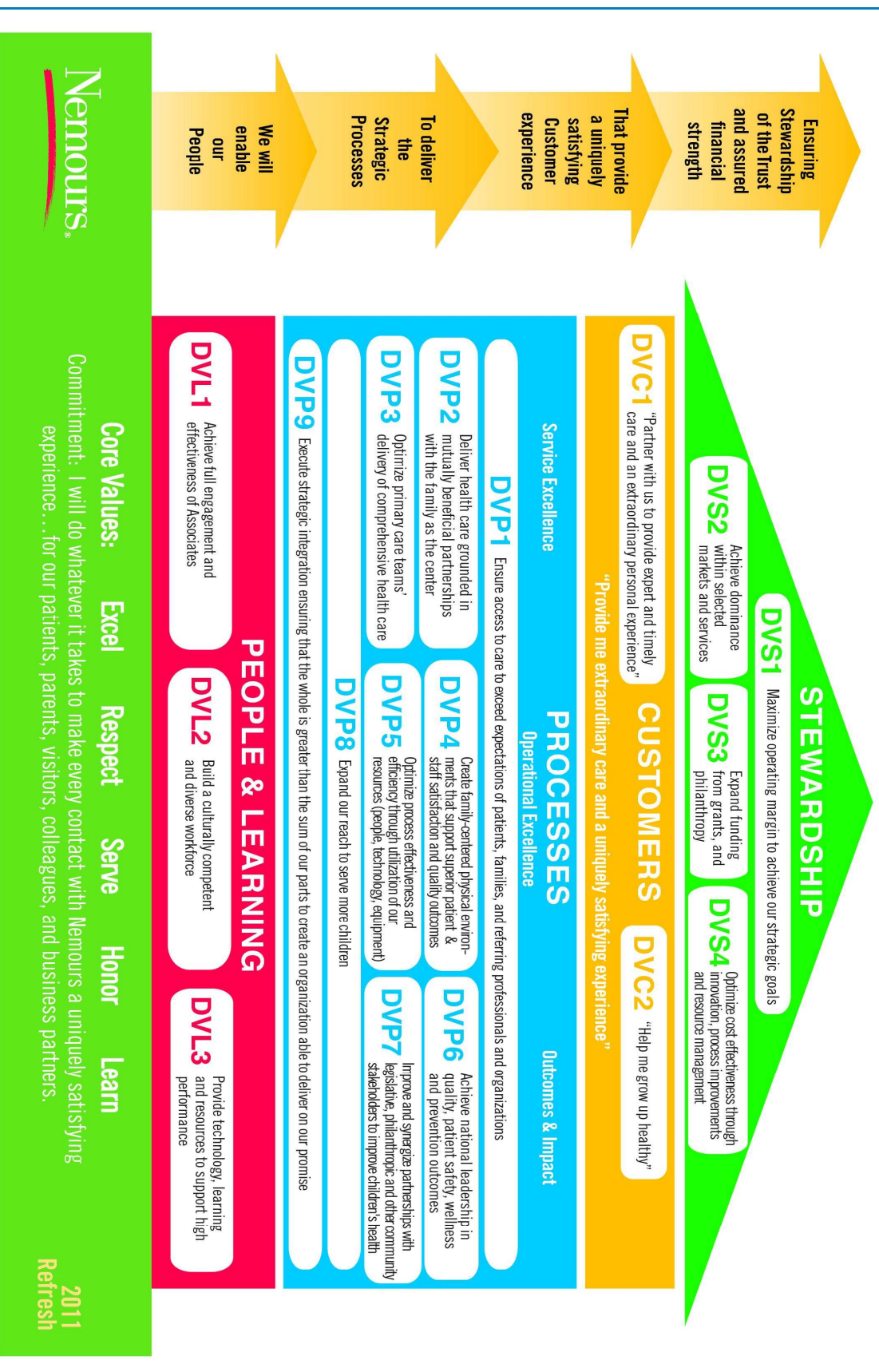
- Strive to learn through educational opportunities provided by Nemours.
- Promote an environment in which personal growth and learning are encouraged.
- Focus on confidentiality when speaking about a patient and/or family.
- Utilize these Standards to be a high performance role model for others.

*The examples under each Standard are not all-inclusive, rather some example thought-starters.*

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“To become a leading child health system in the nation by 2015, defined as being in the top 5% for patient satisfaction and targeted quality and health outcomes.”

## Delaware Valley Strategy Map



# PATIENT-CENTERED COMMUNICATION STANDARDS

New & Revised Joint Commission Requirements <sup>7</sup>

<p><b>HR.01.02.01</b> The hospital defines staff qualifications.</p> <p>EP1 The hospital defines staff qualifications specific to their job responsibilities.</p> <p><i>Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964.</i></p>	<p>EP28 <i>The medical record contains the patient's race and ethnicity.</i></p>
<p><b>PC.02.01.21</b> The hospital effectively communicates with patients when providing care, treatment, and services.</p> <p>EP1 <i>The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1)</i></p> <p><i>Note 1: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.</i></p> <p>EP2 <i>The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. (See also RI.01.01.03 EPs 1-3)</i></p>	<p><b>RI.01.01.01</b> The hospital respects, protects, and promotes patient rights.</p> <p>EP28 <i>The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.</i></p> <p><b>Note 1:</b> <i>The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EPs 6-8.)</i></p> <p>EP29 <i>The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.</i></p>
<p><b>RC.02.01.01</b> The medical record contains information that reflects the patient's care, treatment, and services.</p> <p>EP1 The medical record contains the following demographic information:</p> <ul style="list-style-type: none"> <li>- <i>The patient's communication needs, including preferred language for discussing health care (See also PC.02.01.21, EP 1)</i></li> </ul> <p><i>Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the medical record.</i></p>	<p><b>RI.01.01.03</b> The hospital respects the patient's right to receive information in a manner he or she understands.</p> <p>EP2 <i>The hospital provides language interpreting and translation services. (See also RI.01.01.01, EPs 2 and 5; PC.02.01.21, EP 2; HR.01.02.01, EP 1)</i></p> <p><i>Note: Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.</i></p> <p>EP 3 <i>The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. (See also RI.01.01.01, EPs 2 and 5; PC.02.01.21, EP 2)</i></p>

<sup>7</sup> This list includes only new and revised requirements, identified in *italics*. Not all Joint Commission standards relevant to Patient-Centered Communication are included.

 **Additional information and resources related to Patient-Centered Communication are also available on The Joint Commission website at [this link](#).** <sup>6</sup>