

Agency Nursing Staff Orientation Packet

2009-2010



Nursing

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TABLE OF CONTENTS

Welcome.....	3
Security and ID Badges.....	3
Parking.....	3
Clocking In and Out.....	3
Important Phone Numbers.....	4
Map.....	4
AAMC mission, vision, values, philosophy.....	5
Job description & Expectations.....	5
Competencies.....	6
Confidentiality.....	9
Patient rights.....	9
Environment of care/safety management.....	10
Emergency Incident Plan.....	15
Patient safety.....	23
Behavioral Restraints/Seclusion.....	23
Fall Prevention.....	23
Safe Patient Handling and Lifting.....	23
Cultural sensitivity.....	25
Age-specific care.....	25
Corporate compliance.....	27
Infant/pediatric security.....	28
Infection control.....	30
Incident reporting/4PTS hotline.....	32
Medication administration.....	32
Pain Management.....	35
Abuse & domestic violence.....	37
Emergency response/code blue/rapid response.....	39
Advance directives.....	39
Peak Census.....	39

WELCOME TO ANNE ARUNDEL MEDICAL CENTER

The information in this booklet is designed to help orient you to the standards and routines that apply to most of the nursing units at AAMC. However, standards for specialty areas vary. Please consult the clinical educator or clinical director for questions or clarification.

Nurses at AAMC maintain primary responsibility for the care of our patients and are expected to comply with AAMC's standards of care, policies and procedures.

SECURITY AND ID BADGES

All agency nurses must wear photo IDs provided from AAMC's Human Resource department. HR is located in the Wayson Pavilion, Suite 350. Call 443-481-1950 for more information.

PARKING

Agency nurses working Monday through Friday 7:00 AM – 3:00 PM must park in the Annapolis Exchange lot (located across from the Medical Park campus on Jennifer Road) and take the shuttle to the main campus. The shuttle runs every 10 minutes. During evening and night shifts, staff may park in the main garage, except in spots designated for physicians or patients. Parking stickers are not distributed to agency staff.

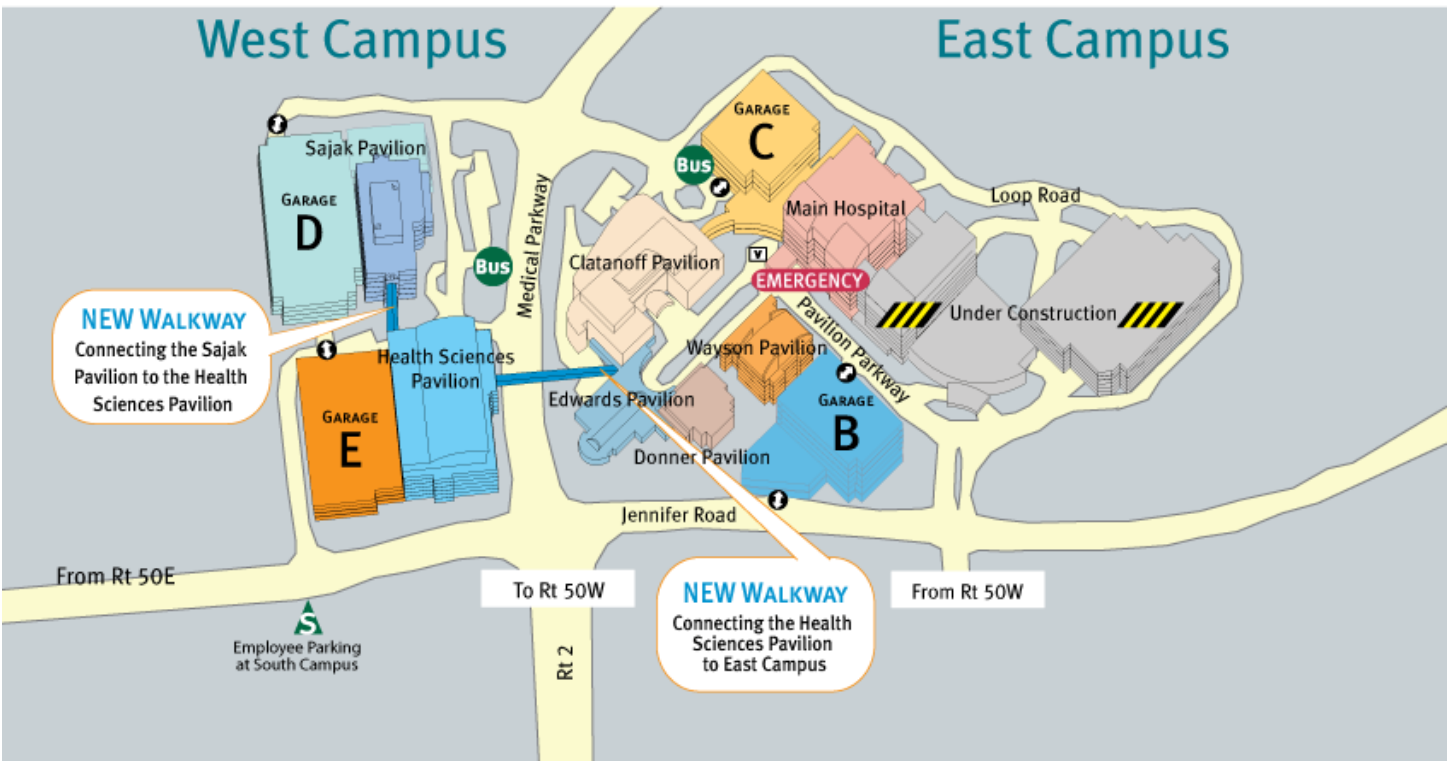
CLOCKING IN & OUT

1. Dial x5259
2. Enter Social Security number then press the # key
3. Enter PIN number then press the # key (a 4-digit number determined by you)
4. Press 1 to record your time In or Out
5. Press 3 to enter a Department change
6. Enter the cost center of the department
7. Press the # key
8. After pressing the # key, listen for a special tone. The tone verifies your entry. If you do not press the # key, the recording of your time will not be saved.
9. Hang up
10. This same procedure is used to record your time In and Out

IMPORTANT PHONE NUMBERS

- Central Staffing Office (staffing issues) 443-481-1760
- Hospital Operator 443-481-1000
- Administrative Coordinator (admin issues after hours) 443-481-5509

AAMC CAMPUS MAP



- New Tower, New Emergency Department Under Construction
- Garage C- Main Hospital
- Garage B- Wayson and Donner Pavilions
- Garage D- Sajak Pavilion
- Garage E- Health Sciences Pavilion
- Future Garage

AGENCY NURSE PRACTICE

- An evaluation must be completed at the end of the first shift.
- Agency nurses receive a skills checklist at the start of the first shift. Not all skills can be observed on initial orientation and agency personnel may be limited in patient care until skills are validated. Upon completion, return skills checklist to the Central Staffing Office.
- Orientation will consist of computer training and observation of unit-specific skills.
- Each unit has identified skills that cannot be performed by agency staff. These should be documented on the evaluation sheet.
- All Agency RN's will be required to use Time Call (instructions on page 3).

MISSION, VISION, VALUES, & PHILOSOPHY

[Click the policy to review: ADM1.1.01 Vision, Mission, Values & Philosophy](#)

JOB DESCRIPTION & EXPECTATIONS

[Click the policy to review: HR8.8.02 Process for orientation of agency and contractual staff](#)

Job Description Review:

POSITION TITLE: AGENCY/CONTRACT NURSE

FLSA STATUS: NONEXEMPT

DEPARTMENT TITLE: GENERIC

JOB GRADE: 00

SUPERVISOR'S TITLE: NURSE MANAGER/DIRECTOR

POSITION: 504

POSITION OBJECTIVE

Contributes to the provision of high-quality, cost-effective health care as a provider of direct and indirect patient care and by effective collaboration with other members of the health care team. Functions as a competent member of the health care team.

Within the scope of this job the individual will be exposed to blood-borne pathogens and hazardous materials. The individual will be required to utilize personal protective equipment in accordance with universal precautions.

KNOWLEDGE/EXPERIENCE

Current licensure as a registered nurse by the Maryland Board of Nursing.

WORKING CONDITIONS/PHYSICAL REQUIREMENTS

Medium work: Exerting up to 50 pounds of force occasionally, and/or up to 20 pounds of force frequently, and/or up to 20 pounds of force constantly to move objects. The above is intended to describe the general content of and requirements for the performance of this job. It is not to be construed as an exhaustive statement of duties, responsibilities or requirements. (Date reviewed: 01/06/04)

BEHAVIORAL COMPETENCIES

(Performance Key: 3 = Excellent, 2 = Good, 1 = Fair)

___ 1. Communication

The ability to present ideas and information in a timely, concise, effective and interpersonally appropriate manner through both written and oral forms. This competency is further demonstrated by the ability to receive and effectively process information through appropriate listening skills.

___ 2. Commitment to Change

The demonstrated commitment to contribute to and support effective change in order to enhance organizational performance. This competency is demonstrated by continuously identifying and acting on opportunities to improve AAHS processes and services

___ 3. Continuous Self-Improvement

The demonstrated commitment to identify opportunities, invest time, and participate in activities resulting in a personal and professional development.

___ 4. Customer Relations

The demonstrated ability to develop and cultivate mutually beneficial relationships with both internal and external customers. Customer relations behavior is demonstrated by continually striving to meet or exceed customer expectations, enhancing trust and respect for others.

___ 5. Problem Solving/Decision Making

The demonstrated ability to identify issues and opportunities, collect appropriate information, effectively process information and make timely and effective decisions to improve outcomes.

___ 6. Role Model

The demonstrated ability to be trusting, trustworthy and respectful of myself and others by insuring confidentiality and appreciation for others' time, resources and respect for the dignity of each person.

___ 7. Teamwork

The demonstrated ability to establish and maintain effective relationships with others. Teamwork is characterized by working toward a shared purpose or goals or through cooperating, collaborating and partnering with others.

___ 8. Accountability

The demonstrated ability to take responsibility and ownership for the outcome of all actions and decisions in fulfilling job requirements with special emphasis on customer satisfaction

PROFESSIONAL / TECHNICAL COMPETENCIES / ESSENTIAL

(Performance Key: 3 = Excellent, 2 = Good, 1 = Fair)

Clinical Decision Making/Judgment

- ___ 1. Demonstrates clinical nursing knowledge and skill in the specialization of the unit.
- ___ 2. Demonstrates the ability to apply the nursing process effectively in the care of culturally diverse patients and families.
- ___ 3. Demonstrates the ability to utilize all applicable laws, policies, standards, guidelines and evidence-based practice in the provision of patient/family care.
- ___ 4. Organizes and reprioritizes patient care activities based on subtle and overt and/or environmental changes.
- ___ 5. Consistently and thoroughly assesses patients to collect data and identify learning needs according to established standards and policies.
- ___ 6. Utilizes a systematic, continuous and complete analysis of assessment data to develop individualized problem lists for assigned patients.
- ___ 7. Develops and individualizes a plan of care for each patient in accordance with established standards, appropriate prioritization of problems/needs, and mutually agreed upon goals.
- ___ 8. Efficiently implements the patient's plan of care in accordance with applicable standards, policies, procedures and guidelines.
- ___ 9. Demonstrates proficiency in medication administration, pain management and other unit or initiative specific skills.
- ___ 10. Continuously evaluates the effectiveness of the plan(s) of care, making revisions and recommendations based on analysis of patient responses to interventions.

Nurse-Patient Family Relationships

- ___ 1. Demonstrates the ability to assess the patient's/family's learning needs, readiness to learn, learning style, and presence of barriers to learning. Demonstrates the ability to develop, implement and evaluate teaching plans for patient populations in unit specialty in accordance with applicable standards.

- ___ 2. Demonstrates the ability to apply knowledge of growth and development across the life span to the care of patients.
- ___ 3. Provides direct patient care to patients and families in a culturally, developmentally and ethically appropriate manner.
- ___ 4. Plans of care address the physical, psychosocial, spiritual and learning needs of the patient/family.

COMPETENCY

Agency nurses working at Anne Arundel Medical Center must have demonstrated and documented competency before they are able to care for patients with the following health care needs:

Agency RNs can NOT perform blood bank specimen labeling

Critical Care Unit

- Epidural/Intrathecal Catheters
- Ventriculostomy
- Neuromuscular Blocking Agents
- Peripheral Nerve Stimulator
- Transcutaneous or Transvenous Pacemakers
- PA Catheters
- Femostops
- IABP Therapy
- Esophagogastric Tamponade Tube
- Peritoneal Dialysis
- Moderate Sedation
- Management of Ventilated Patient
- Intraabdominal Pressure Monitoring

Oncology Unit

- Chemotherapy infusion
- Epidural/Intrathecal Catheters

Progressive Care Unit

- Vascular patient population
- Peritoneal Dialysis

Mother/Baby Unit

- Infant Security
- Neonatal Infant Pain Scale

Pediatric Unit

- Pediatric – Blood Administration
- Infant Infusion Pump
- IVIG Administration

CONFIDENTIALITY & PATIENT RIGHTS

Click the policy to review: **HR 8.2.05 - Confidentiality**

Click the policy to review: **ERR3.1.03 - Principles of patients` rights and responsibilities**

FACTS ABOUT THE SPEAK UP PROGRAM

- ✦ In March 2002, a national program was launched to urge patients to take a role in preventing health care errors by becoming active, involved, and informed participants on the health care team.
- ✦ Teach your patients to "SPEAK UP"
 - Speak up if you have questions or concerns.
 - Pay attention to the care you are receiving.
 - Educate yourself about dx, meds, treatment & plan.
 - Ask family or friend to be your advocate.
 - Know your meds – what and why.
 - Use a health care facility that is evaluated against current patient safety standards.
 - Participate in all decisions about your treatment.
- ✦ All inpatients will receive a "Speak Up" brochure.
- ✦ Patients can report concerns via the hotline, Web site, or by writing in the brochure. If a patient gives you a concern in writing, send it via interoffice mail to "Speak Up".
- ✦ Staff should try to address any patient concerns as soon as possible with the patient, manager, physician, or patient advocate

ENVIRONMENT OF CARE / SAFETY MANAGEMENT

Fire or Smoke in your area (Code Red)

1. Locate the fire extinguishers and red fire alarm pull boxes on your unit. In case of fire or smoke in your area, do not shout "FIRE!"; stay calm.
2. **R.A.C.E.:**
 - a. **REMOVE** - Get everyone away from immediate danger.
 - b. **ALARM** - Activate the alarm by pulling lever on nearest red alarm box.
Or using nearest phone:
 1. Dial 1111
 2. Dial 6911
 3. Dial 911 (Pathways and other Off-Site facilities). Upon answer, explain there is a Code Red and give location.
 - c. **CONFINE** - Close doors and windows to keep fire and smoke from spreading.
 - d. **EXTINGUISH** - Attempt to extinguish the fire if it's small and confined.
3. Use the fire extinguisher properly (**PASS**).
 - a. **PULL** the pin.
 - b. **AIM** the extinguisher low, point the nozzle at the base of the fire.
 - c. **SQUEEZE** handle to release extinguishing agent.
 - d. **SWEEP** back and forth as you walk backward away from the area.

**Uniform Emergency Code System
Will Go Into Effect May 1st 2004**

The New Codes Are

Code Red:	Mr Firestone
Code Pink:	Child Abduction
Code Blue:	Cardiac Arrest
Code Gold:	Bomb Threat
Code Orange:	Hazardous Material Spill
Code Yellow:	Emergency or Disaster

This is a Maryland State Uniform Emergency Code System adopted by the Department of Health and Mental Hygiene. This regulation was established as the result of a bill passed in 2001 by the State Legislature and is applicable to all Maryland hospitals. These new codes will be used in all applicable AAMC policies and procedures as of May 1, 2004.

ELECTRICAL EQUIPMENT SAFETY

1. Check connections and cords for the following:
 - a. Be alert for damaged cords, plugs, and outlets.
 - b. Avoid using extension cords.
 - c. Keep cords out of the way of traffic.
2. Use Equipment Safety:
 - a. Read and follow all instructions posted on equipment.
 - b. Don't put anything wet on electrical equipment.
 - c. Turn equipment off before unplugging.
 - d. Always unplug by pulling the plug, not the cord.
 - e. Don't use any equipment that sparks or gives the slightest shock.
 - f. Never try to repair equipment - contact Biomedical or Engineering.
3. Electrical equipment brought in by patients, i.e. hair dryers, razors, etc.
 - a. Any equipment brought in from home by patients must be assessed by the Engineering department for safety prior to patient using item.

Blood Borne Pathogens and Personal Protective Equipment

1. Exposure to blood borne pathogens can occur through: contact with broken, chapped, or cut skin; needle stick injuries; and contact with mucous membranes.
2. The medical center maintains a Universal Precautions policy.
3. Personal protective equipment helps you practice universal precautions and is one of your best defenses against exposure to infectious materials. When you use the appropriate personal protective equipment, and use it correctly, you can significantly reduce your risk of infection.
4. When using personal protective equipment, be sure it:
 - a. Fits properly each time you use it.
 - b. Provides you with the protection you need. It should not allow blood or other potentially infectious materials to pass through or reach your clothes, skin, eyes, mouth, or other mucous membranes.
5. Anne Arundel Medical Center provides the following personal protective equipment for your safety. For the location of this equipment or if you have any questions, please see your area manager.
 - a. Gloves - powered/powder-free/latex-free
 - b. Face masks
 - c. Particular respirator face masks (to be used with respiratory isolation)
 - d. Face shields
 - e. Goggles
 - f. Impervious gowns
 - g. Shoe covers
 - h. Surgical caps
 - i. ABG needle resheathers
 - j. Protective IV angiocaths

- k. Safety BGM lancets
- l. Sheathed syringes
- m. Protected butterfly needles
- n. Protected vacutainer barrels
- o. Plastic blood collection tubes
- p. Sharps containers in various sizes
- q. Needleless IV system

Material Safety Data Sheets (MSDS)

1. MSDS sheets describe the hazards of the chemicals that an employee uses on the job.
2. If a MSDS sheet is required, ask a department supervisor for the copy of the MSDS you want.
3. If more information is needed, check with the manager on duty.

Hazardous Material/Spill Response Plan

1. Contact the hospital's Spill Team (Code Orange) by call 6911 for Medical Park if:
 - a. you are unfamiliar with clean-up procedure.
 - b. spilled material is listed on the Spill Response Policy 101-35A Code Orange.
 - c. chemical spill is over one gallon.
 - d. chemical is highly toxic/volatile.
2. Spills are contained by using the "Think **C.L.E.A.N.** Plan"
 - a. **C**ontain the spill.
 - b. **L**eave the area.
 - c. **E**mergency: eye wash, shower, medical care.
 - d. **A**ccess spill procedure.
 - e. **N**otify Security at 6911.
3. Chemical Spills - All chemical spills are contained according to OSHA guidelines following procedures as outlined on the MSDS sheet.
4. Biohazard Spills
 - a. Use personal protective clothing and equipment.
 - b. Contain spill and prevent splashes by covering with paper towel or chux.
 - c. Pour generous amounts of disinfectant onto the contaminated surface.
 - d. Allow disinfectant to sit on spill for at least 10 minutes.
 - e. Broken glassware should be removed carefully with disinfectant soaked gauze and placed into an impervious sharps container.
 - f. Carefully wipe up and dispose of contaminated material into marked Biohazard waste container. Rinse area with soap and water. Dry with mop or paper towel.

Smoking Policy

It is the intent of AAMC to provide a safe, healthy environment for patients, visitors, employees, volunteers and medical staff. Our goal is to have a smoke-free hospital campus and therefore the use of lighted tobacco products (smoking) or electronic smoking devices (E Cigarette) is prohibited on all AAMC properties located at the Medical Park campus, including the Acute Care Pavilion, the Clatanoff, Edwards, Donner, Wayson and Sajak Pavilions and all parking garages, lots, and grounds within the defined area associated with these buildings.

Bomb Threat

When a call is received in a work area, have a co-worker notify the following center that a bomb threat is in progress:

1. Security Center 6911.
2. Pathways and other off site facilities 911.

Using the Bomb Threat Checklist found with the Bomb Threat Policy 101-35, get as much information about the caller as possible. Until a co-worker is able to locate this checklist for you, ask the following questions:

- a. Time bomb is set to explode.
- b. Where located.
- c. What kind of bomb.
- d. Why is he/she doing this.

Note the following details: sex, accent, speech impediment, age, background noises, unusual phrases.

Internal Disaster Evacuation Plan

1. Horizontal Evacuation - Horizontal evacuation is the lateral movement of all patients utilizing wheelchairs, stretchers, blanket drags, or other conveyances, to the nearest and safest protected area.
2. Vertical Evacuation - In the absence of corridor separations, downward movement to a safe area is necessary. One floor below the fire is usually safe, but two are recommended.
3. Methods of Evacuation
 - a. For non-ambulant patients, use stretchers, blankets if possible, beds if practical, and wheelchairs if possible.
 - b. All ambulatory patients form a chain and are led to the nearest exits.
 - c. An individual is assigned at exit door to maintain order and give directions.
 - d. All patients should be wrapped in blankets.
 - e. Carry patients as a last resort, if no other way is available, in order to escape dangerous areas. However, in carrying patients, consider: The weight and condition of a patient the adaptability of the rescuer.

External Disaster Plan

To respond to mass casualties as a result of any manmade or natural disaster in the community which will exceed the normal capacities of the Emergency Department. The plan is intended to provide emergency medical services with a minimum amount of interruption to the routing patient services of the medical center. Upon hearing "Disaster Plan now in effect" over the overhead paging system:

1. Report to your department if not already there and remain there unless assigned by the department manager to do otherwise.
2. Restrict use of the telephone and elevators unless absolutely necessary.
3. All questions from the media should be directed to Public Relations at ext. 4700.
4. If the external disaster involves chemicals and/or hazardous materials, the plan will be initiated by announcing: CODE YELLOW.
5. If the external disaster involves radiological materials, the plan will be initiated by announcing: CODE YELLOW.

Safe Body Mechanics

1. Bend at your hips and knees, not at the waist.
2. Keep loads close to your body. If you lift 50 pounds with your arms away from your body, the force of the load on your back reaches 500 pounds.
3. During the lift, contract your stomach muscles to protect your back. Use the force of your legs to do the work - not your back and arms.
4. Avoid twisting motions. They misalign your back and increase risk of injury. Instead, take small steps and pivot.
5. Avoid overreaching, whether up, down, or across. Use a step stool when reaching something high.
6. Don't lift objects above shoulder height or below waist.
7. Always keep your working surface slightly higher than waist level to avoid back strain.
8. Push whenever possible instead of pulling.
9. When you have to stand for long periods, minimize back strain by placing one foot on a stool or another similar object. Change positions frequently.
10. Never lift a load that is too heavy for you

Occupational Exposure to Blood Borne Pathogens

1. Reportable Exposures
 - a. All needle sticks and skin penetrations from sharp instruments.
 - b. Splashes involving contact of body secretions with mucosal surfaces.
 - c. Skin contact with body secretions.
 - d. Accidental ingestion of body secretions.

2. Reporting Procedure - Immediate reporting is essential, since treatment regimens, when indicated, must begin within one to two hours.
3. Report to:
 - a. Notify the supervisor on duty **AND**
 - b. Call the Employee Health Office at ext. 1965 (M - F 7:30 a.m. - 4:00 p.m.) if open **AND**
 - c. Call the company you work for **AND**
 - d. Go to the Emergency Department within the hour to have the exposure evaluated.

ANNE ARUNDEL MEDICAL CENTER EMERGENCY OPERATIONS PLAN 101-18W

I. General Policy Statement

Anne Arundel Medical Center actively maintains a high state of readiness in order to respond to a variety of disasters or emergencies in our community. The Hospital Incident Command System (HICS) is designed to give detailed and integrated emergency management guidance to the Medical Center employees and medical staff. The HICS command structure also integrates AAMC with the National Incident Management System (NIMS) and the community command structure, such as EMS and LEPC.

The Emergency Operations Plan addresses four categories of emergency incidents:

Code Yellow:	Emergency or Disaster
Code Red:	Fire (Mr. Firestone)
Code Gold:	Bomb Threat
Code Orange:	Hazardous Material Spill

II. General Information About HICS

- A. The details of the Emergency Operations Plan use the HICS as emergency management system in response to trauma/accident, hazardous materials accident and radiation accident.
- B. HICS is an emergency management system made up of positions on an organizational chart, which may be needed to address an emergency incident.
- C. The HICS organization chart shows a chain of command, which incorporates four sections under the overall leadership of the Incident Commander (IC). Each of the four sections: Logistics, Planning, Finance, and Operations have a chief appointed by the IC responsible for their section. The chiefs in turn designate directors and unit leaders to sub-functions with supervisors and other staff filling critical roles. The structure limits the span of control in an attempt to distribute the work. It also provides for a system of documenting and reporting all emergency response activities. (See attached organizational chart.)
- D. Each of the positions has a specific mission to address an emergency situation and has an individualized checklist (Job Action Sheet - JAS) designed to direct the assigned individual in duties of each particular role. (See attachment.)
- E. Forms are also included to enhance this HICS system and promote accurate documentation and accountability so an incident can be reconstructed for lessons learned. (See attachment.)

- F. The HICS plan is flexible – only those positions or functions, which are needed, should be activated.
- G. The positions on the HICS plan may be fully activated for a larger, extended disaster such as a hurricane or mass trauma. However, full activation may take hours or even days. The majority of disasters or emergencies at AAMC as trauma accidents will require the activation of far fewer positions.
- H. More than one position may be assigned to an individual. Situations of a critical nature may require an individual to perform multiple tasks until additional support can be obtained. This is made possible with the use of the position checklists (Job Action Sheets). For example, the night Hospital Operations Coordinator (HOC) initially becomes the Incident Commander and the labor pool unit leader. Tasks, which are determined as high priority, will be assigned by the Incident Commander as support personnel become available.
- I. The activation of positions on the HICS chart will be different based on the needs of the emergency incident. (See attachments for position activation for trauma/accident, hazardous materials, and radiation.)

Note: Each emergency has its own set of priorities and circumstances but with pre-written checklists almost anyone can assume a role after a few minutes of reading.
- J. This plan can be activated in a “stand-by” mode which allows alerted staff to be ready in the event a situation occurs. The Incident Commander, Public Information Officer, Safety & Security Officer, Liaison Officer, Logistics Officer, Planning Chief, Financial Chief, and Operations Chief will be alerted to a possible Emergency Incident. Positions will be activated as the situation arises. Examples would be a storm alert or a terrorist alert.
- K. Utilize all available internal and external communication back-up plan such as Nextel phones; 2-way radios and the HAM radio system.
- L. The staff will be directed to use standard and consistent terminology including the use of plain English during emergencies.

III. Incident Evaluation Procedure

When Administrator on Call (AOC) or the Hospital Operations Coordinator (HOC) is alerted to a possible emergency incident situation, he or she will often want to consult with other Tier One members of the Incident Management team before deciding on the appropriate level of response.

The following procedures will provide the format for a rapid situational assessment based on the best information available and the judgment of the principal responders.

- Administrator On-Call, executive leadership or Hospital Operations Coordinator notified of possible Incident.
- REDALERT activated to notify Tier 1 alert recipients by one of the above parties.
 - To activate – dial 443-481-1069
 - Enter your numeric user ID when prompted
 - Enter 1# to activate a new alert
 - Enter the alert ID - 1414 #

Activating this alert will send a message to all Tier 1 recipients to join a conference call. If you are the initiator of this alert, you should log into the conference bridge as “Moderator”.

To initiate or join a conference call:

- Dial 443-481-3188
- When prompted enter the conference ID 1414#
- You will be prompted to press 1# to join or 2# to moderate
 - If you are moderator the pass code is 1414#
 - Other participants will hear a warble tone as members join or depart.

The following alert message will be sent to all Tier 1 recipients via email, page, automated phone message to mobile phones, & office and home phones if needed:

This is notification of pending command center activation. You are asked to join an emergency conference call at this time.

Conference Bridge Telephone number 443-481-3188 Conference ID and password 1414#

ATTN: SUPPORT PERSONNEL

If you are information systems or telecommunications support staff - do not join conference call - stand by for additional information regarding command center operations.

IV. Activation of the Emergency Operations Plan

Incident Commander or Administrator on Call (AOC) will activate the Hospital Incident Command System (HICS):

1. Incident Commander or Administrator on Call (AOC) will notify Communications that the Emergency Incident – Code Yellow is in effect and the RED ALERT notification system will be activated.
2. Communications will announce over the public address system three (3) times, “The Emergency Operations Plan – CODE YELLOW is now in effect.”
3. Communications will repeat step two twice, every five minutes and once every 15 minutes following the first announcement.
4. All HICS activated positions will report to the Incident Command Center for briefing and to pick up section materials. Each person will then establish Section Command Centers and assign duties as designated. The IC or designee will activate the Emergency Operations Plan per type of emergency incident (i.e. Trauma/ Accident, Hazardous Materials, Chemical/Biological, Radiation, Utilities failure).
5. The following six steps should be carried out for each incident by the Incident Commander, supported by the General Staff:
 1. Understand the emergency management organization policy and procedures
 2. Assess incident situation
 3. Establish incident objectives
 4. Select appropriate strategy to achieve objectives
 5. Perform tactical direction, assign resources, and monitor results
 6. Provide follow-up, change strategy or tactics as necessary
6. In the event that the Command Center in the Clatanoff Pavilion 1st Floor is not available due to damage or lack of utility services, the Command Center will be set up in the Administrative Offices on the first floor of

the ACP (North). As much equipment as needed will be transferred to the ACP from the storage closets in the Clatanoff.

V. General Staff Response

A. All staff will immediately report to their department manager/supervisor upon hearing, "The Emergency Operations Plan (Code Yellow) is now in effect" called over the PA System.

(NOTE: All staff requested to come from their homes will report to Labor Pool prior to reporting to their Department.)

B. HICS Section Chiefs (Logistics, Planning, Finance, and Operations)

2. Section Chiefs must report to IC to pick up packets and proceed to designated section site.
3. Section chiefs must assure the activities of their respective sections (Job activities) can be carried out 24 hours per day.

C. All directors or designees will report to HR Labor Pool department status and number of staff that are available to HR Pool.

D. Medical Staff

2. Hospitalist Service

- a. Hospitalists will immediately report to the Emergency Department to assess needs with the ED Physician Incident Commander and to coordinate the hospitalist team response as required.

3. Medical Staff-at-Large

- b. Communications will activate Tier I of the Medical Staff Disaster List
- c. The ED Physician Incident Commander will notify Communications as to the appropriate additional Medical Staff specialties to notify.
- d. Once the Command Center is established the Medical Care Director will coordinate with the ED Physician Incident Commander to assess ongoing Medical Staff needs.
- e. All appropriate medical staff in Tier I and as identified by the ED Physician Incident Commander or the Medical Care Director will be called by communications. Medical staff will report availability, estimated time of arrival, and contact information by phone to Communications. Responses will be reported by Communications to the Medical Care Director.

4. Temporary Privileges in the Event of a Disaster- Temporary privileges may be granted to provide additional medical services if a community or regional disaster requires a volume of clinical services beyond the capacity of the medical staff.

- a. For the well-being of the patients and community served by the Medical Center, all categories of staff members may render services within the scope of their professional licenses in bona fide emergency situations. Cases where emergency privileges have been exercised shall be reviewed by the Medical Board Executive Committee.

b. Emergency Verification of Credentials and Temporary privileges in the Event of a Disaster

In the event of a community or regional medical disaster, the Emergency Incident Commander for the Medical Center will initiate the AAMC Emergency Management Plan (EC 4.10) Disaster Response Protocol. The Vice President for Medical Affairs, or the person acting in that capacity, will assess the availability and capacity of

Medical Staff members to provide appropriate care for all patients under treatment by the Medical Center in accordance with the protocol.

If additional physicians or allied health practitioners are needed beyond the resources of the Medical Staff, the Vice President for Medical Affairs, or the person acting in that capacity, will be authorized to grant temporary privileges to volunteer physicians and allied health professionals on a case by case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners for the duration of the disaster. **Under the direction of the Vice President for Medical Affairs, or the person acting in that capacity, the performance and conduct of all volunteer practitioners who are assigned disaster responsibilities are to be managed through direct observation, mentoring, and/or clinical record review by appropriate AAMC personnel.**

Care, treatment, and service provided by non-staff physicians responding to AAMC during a disaster shall be managed by the HICS Medical Director with an AAMC physician of the same specialty if possible.

Non-staff physicians responding to AAMC during a disaster shall wear a badge with a unique identifier in conjunction with the physician's own Medical Staff badge from his/her primary hospital.

Required emergency credentials

1. Verification if feasible through current state medical license as presented by the volunteer, preferably with photo ID; or any other emergency method by which the person's license can be rapidly confirmed and
 2. A valid government-issued identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - A current picture hospital ID card that clearly identifies professional designation
 - A current license to practice
 - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
 - Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRB, ESAR-VHP, or other recognized state or federal organizations or group.
- c. Temporary privileges granted in a disaster situation will be consistent with the training and experience of the individual practitioner.
- d. The medical staff begins as a high priority the primary source verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control as per article 5.4-3 Temporary Privileges for Continuity of Care and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
- e. In the extraordinary circumstances that primary source verification cannot be completed in 72 hours for volunteer practitioners who have provided care, treatment and services under the disaster privileges it will be done as soon as possible. In this circumstance, there will be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and an attempt to rectify the situation as soon as possible.
- f. The organization makes a decision (based on information obtained regarding the professional practice of the

volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

E. Special Nursing Areas

1. Nursing Educators will report to discharge area for assignment.
2. IV Therapist
 - a. One therapist will immediately report to the Emergency Department
 - b. All others will remain in inpatient areas.
3. Care Management
 - a. Senior care manager will report to discharge area to coordinate activities.
 - b. Care managers, discharge planners, and UR nurses will report to inpatient areas to facilitate discharges.

F. Medical Records

- One medical records clerk will report to Emergency Room immediately to facilitate patient tracking.

G. Clinical Coordinator Center

- One staff member will immediately report to HR Pool.

H. Radiation Oncology Center (Donner Pavilion)

- a. Director or designee will report availability of staff to HR Labor Pool.
- b. The Radiation Techs shall be prepared to work with the Radiology Director to coordinate equipment, personnel, and supplies.

I. Pathways

- a. Director or designee will report availability of staff to HR Pool.
- b. Staff will be prepared to use the Pathways Gym for minor treatment site in case of mass casualties or evacuation point.

VI. Safety and Security

Safety and Security policies and procedures during an Emergency Management incident or exercise are included in the Medical Center's Security Management Plan (EC.2.10) EOC Policy EOC 4.2.01.

VII. Utilities Management

Utilities Management policies and procedures during an Emergency Management incident or exercise are included in the Medical Center's Utilities Management Plan (EC.7.10) EOC Policy EOC4.7.01

VIII. Transfer Procedures and Alternative Sites

A. Incoming Patients

- a. After evaluation and stabilization by an Emergency Department physician, the following types of patients will generally be transferred to other facilities for definitive treatment. Appropriate consents to transfer for patient will be secured in keeping with AAMC transfer policy. The nurse assigned transfer responsibilities shall coordinate these activities under the direction of the Medical Coordinator/designee. The means of transportation will occur by local EMS ambulance, private ambulance service as arranged through Syscom.

- b. Patients stabilized and cleared by ED physician will be held in the Short Stay area.

B. Existing Inpatients

- a. If the nature of the emergency (e.g. loss of normal electric power) could effect the on-going care and treatment of existing inpatients, the medical staff in the areas effected must determine if conditions warrant the transfer of particularly vulnerable (obstetrics, oncology, NICU, cardiac) patients or entire patient populations to alternate sites.
- b. If patient evacuation is deemed necessary, all efforts should be made to ensure that the family unit remains intact during evacuation.

C. Suggested facilities which may be able to accept patients in transfer:

- a. Children, i.e. NICU/Pediatric or with Multiple system trauma – Johns Hopkins (Baltimore), Children’s Hospital National Medical Center (Washington, D.C.), or University of Maryland Medical System – Shock Trauma (Baltimore)
- b. Adults with multiple systems trauma – MIEMSS/Shock Trauma (Baltimore) or MedStar Washington Hospital center (Washington, D.C.)
- c. Severely burned children or adults – Bayview Medical Center or Washington Hospital Center
- d. Active duty military personnel – military hospitals
- e. Dependents of military personnel – military hospitals
- f. Psychiatric patients – Psychiatric facilities available

IX. Patients stabilized and cleared by ED physician will be held in the Short Stay area.

X. Suggested facilities which may be able to accept patients in transfer:

- 1. Children with multiple system trauma – Johns Hopkins (Baltimore), Children’s Hospital National Medical Center (Washington, D.C.), or University of Maryland Medical System (shock/trauma).
- 2. Adults with multiple systems trauma – MIEMSS/Shock Trauma (Baltimore) or MedStar Washington Hospital Center (Washington, D.C.)
- 3. Severely burned children or adults – Bayview Medical Center or Washington Hospital Center
- 4. Active duty military personnel – military hospitals
- 5. Dependents of military personnel – military hospitals
- 6. Psychiatric patients – Psychiatric facilities available
- 7. Open Heart patients – Washington Hospital Center, UMMS, JHH, Union Memorial, Sinai, and St. Joseph’s Hospital.

XI. Evacuation Alternative Sites

- a. In the event a total hospital evacuation needed to occur, this would be coordinated with the Maryland Emergency Medical System and the state and local health departments. (Evacuation Policy 101-18T and 101-18S)
- b. In the event of rapid mass casualties, the gym at Pathways may be used for minor triage or a staging point for evacuation and transfer.

XII. **Deactivating the Emergency Operations Plan “All Clear”**

“All Clear” emergency incident status will be determined by the IC in consultation with the Operations Chief and VPMA. The Communications Center will announce to the Medical Center campus three times over the PA system, “All Clear – The Emergency Operations Plan (Code Yellow) is no longer in effect.” The Red Alert Notification System will also alert personnel of deactivation.

XIII. Training and Orientation of AAMC Personnel

- A. Department directors, managers, and supervisors will review the Emergency Operations Plan appropriate for the department in the departmental orientation. (See Policy 101-18C.)
- B. Under the HICS Command structure, Section Chiefs, Unit Leaders, and Directors, will be responsible for training their subordinate staff members in six critical areas of Emergency Management: communications; resources and assets; safety and security; staff responsibilities; utilities; and clinical activities as applicable to their duties as described in the HICS job action sheets. This training will be included in regular departmental training sessions, off-site specialized training, and during scheduled emergency exercises and actual emergency incidents.
- C. Key members of the Incident Command organization will receive command level training on the National Incident Management system (NIMS) via FEMA sponsored and recommended training courses. Key personnel will attend local, regional, and national seminars, conferences, educational meetings, and event planning debriefing sessions related to hospital and community emergency management.

XIV. Incident (Exercise) Planning, Observation, and Evaluation

- A. AAMC will conduct at least two Emergency Incident Exercises each calendar year. One of the exercises will be a community-wide event in cooperation with other local governmental, police, fire and rescue, public health, and health care organization. The Hazard Vulnerability Analysis (HVA) will be used to determine the most likely events and emergency scenario and these events will be given priority in exercise planning. One exercise per year will be escalated to evaluate how effectively the Medical Center performs when we cannot be supported by the local community.
- B. For each planned exercise an exercise monitor will be assigned. This individual will be a person who has experience and training in incident management and exercise planning. This individual will be responsible for documenting planned exercises and actual emergencies using attachment 5.
- C. Each emergency incident or exercise will be critiqued using attachment 6. Critiques will be attended by key incident command center personnel who participated in the incident or exercise including physicians and support staff.
- D. The multidisciplinary Emergency Management Committee will analyze incident and exercise critiques and coordinate follow-up actions. This committee will be responsible for evaluating strengths and weaknesses and making improvements to policies and procedures. The effectiveness of these changes will be evaluated in subsequent incidents or exercises.
- E. The Environment of Care Committee will review the actions of the Emergency Management Committee.

XV. Emergency Incident Command Review

- A. The IC will convene a Post-Incident Conference with the section chief leaders and other appropriate personnel to review and critique the emergency incident. The critique will focus on achieving the four purposes of the HICS Plan: Logistics, Planning, Finance, and Operations. Corrective actions will be assigned to specific individuals and follow up will be done by the Emergency Management Committee.
- B. The IC will send the Post-Incident Report to the organization’s Environment of Care Committee and the Emergency Management Committee.

PATIENT SAFETY

[Click the policy to review:](#)

GNP14.6.04 - Double identifiers of patient information

GNP14.6.01 - Universal protocol for preventing wrong site, wrong protocol, wrong person surgery

MED16.1.25 - Medication reconciliation

NAP12.1.15 - Report communications

BEHAVIORAL RESTRAINTS/SECLUSION

[Click the policy to review:](#)

GNP14.6.17 - Restraints/Seclusion

SAFE PATIENT HANDLING AND LIFTING

[Click the policy to review:](#)

GNP14.6.16 - Safe patient handling and lifting

FALL PREVENTION

[Click the policy to review:](#)

NAP12.1.21 - Falls: risk assessment and management of patient who has fallen

Who is at Risk for Falling? (Note: This list is not all inclusive but gives examples of the types of patients who could be at risk for falling. The RN should communicate to support staff those patients who are at risk for falls.)

- ❑ Patient has history of more than one fall within the 6 months before admission
- ❑ Patient has experienced a fall during hospitalizations
- ❑ Patients with changes in mental status (ETOH abuse or neuro disorder)
- ❑ Patients with hypotension and/or bradycardia
- ❑ Patients with large blood loss (GI bleeds or post surgery patients)
- ❑ Patients with recent changes in mobility (weakness, stroke pt's, orthopedic surgeries)
- ❑ Patients with low blood sugars
- ❑ Patients with breathing difficulties who are SOB with minimal exertion
- ❑ Patients who have frequency or incontinence
- ❑ Patients who have received PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES.

Fall Precautions

- ❑ Call light within reach and patient instructed on how to call for assistance
- ❑ Bed in low position and wheels locked
- ❑ Orient patient/family to surroundings
- ❑ Respond to call lights quickly
- ❑ Ensure patients have non-slip footwear on prior to ambulating
- ❑ Adequate lighting especially at night
- ❑ Two top side rails up while in bed, or all side rails up when on stretcher
- ❑ Secure bed, bedside commode and wheelchair in locked position. Ensure that the bedside table, urinal, commode, phone or other items are in reach
- ❑ Make sure glasses and hearing aids are working and are on patient. If they are not on patient, make sure they are within reach
- ❑ Clean up spills and ensure dry floor before ambulating
- ❑ Encourage activity as ordered, if patient uses walker or cane at home make sure available to help patient ambulate
- ❑ Upon admission patient/family will receive education on reducing their risk of falling, to include but not limited to Patient/Family Fall Brochure and fall prevention reminders. With change in fall status, additional education will be provided to patient/family
- ❑ Verify bed alarms are on

Reference:

AAMC policy NAP12.1.21- Falls: risk assessment and management of patients who have fallen 11/1/2006, Fall and Fall precautions resource list revised 5/07

CULTURAL SENSITIVITY

The goal of the health care system is to provide optimal care for all patients. We must keep in mind that culture and ethnicity are strong determinants in an individual's interpretation or perception of health and illness. Religion, ethnicity, and culture interweave into the fabric of each response of a particular individual to treatment and healing.

ANA Position Statement

- Knowledge of cultural diversity is vital at all levels of nursing
- Cultural groups often utilize traditional health care providers, identified and respected within the group.
- Concepts of illness, wellness, and treatment modalities evolve from a cultural perspective or world view and are part of the total cultural belief system.
- Recognizing cultural diversity, integrating cultural knowledge, and acting, when possible, in a culturally appropriate manner enables nurses to be more effective in initiating nursing assessments and serving as client advocates.

Barriers to Cultural Competence

Equal Treatment Model

All people are treated the same. This is what my parents told me as I was growing up. Melting Pot syndrome- put everyone in same pot together. This could lead to failure to recognize ethnic differences and needs of various patients.

Cultural Dissonance

When the needs of ethnic minority group in the hospital are not recognized this could lead to cultural dissonance. This is when 2 distinctively different cultures are match up to each other. In Nurse/Patient relationship, patient is often labeled as "non-compliant" because the patient's individual or cultural needs are not fully explored.

Ethnocentrism

Belief that one's own culture is better than others. This is often unconscious but pervasive and imposed on the care of the patient. Nurses often believe that their ways (Traditional western views) of health care practices are the best, most moral, and correct.

AGE-SPECIFIC CARE

Each age group has different communication, comfort, and safety needs. How these needs are met depends, in part, on the age of the patient and your understanding of their needs. Please use the following information as a guide for age-specific care. See figure on following page.

	Communication	Comfort	Safety
Infant	<ul style="list-style-type: none"> • Introduce self to caregiver and explain procedures • Smile and speak slowly, calmly to infant • Use soft sounds, such as music, to comfort • Try to initiate eye contact, but do not force. 	<ul style="list-style-type: none"> • Keep warm & dry, avoid bright lights • Allow for usual feeding schedule • Allow caregiver nearby • Allow patient to keep comfort objects • Meet physical needs promptly 	<ul style="list-style-type: none"> • Pt may feel safer when cuddled • Provide non-flammable toys and safe environment • Avoid choking hazards • Transport using size-appropriate means
Toddler	<ul style="list-style-type: none"> • Introduce self to pt and caregiver, involve caregiver in plan • Expect self-centered thinking from child • Do not rush patient. May need time to think about what has been asked of him/her • Use simple words to explain things 	<ul style="list-style-type: none"> • Provide warmth • Allow pt to keep favorite comfort objects • Establish routine of care and keep continuity • Consolidate care to provide rest • Encourage use of playroom 	<ul style="list-style-type: none"> • Do not leave unsupervised. Pt often does not recognize danger. • Keep side rails up • Provide non-flammable toys • Avoid choking hazards • Limit separation from caregiver
Pre-school	<ul style="list-style-type: none"> • Introduce self to patient and caregiver • Get down to eye level to talk to child • Do not rush patient • Offer choices when possible • Allow pt to touch equipment • Include parents in explanations • Use familiar characters to assist in communication. • Expect regressive behaviors 	<ul style="list-style-type: none"> • Allow pt to talk and verbalize fears • Do not separate from comfort objects • If frightened, may accept explanations/exams given on "teddy" or favorite toy • Praise attempts to cooperate 	<ul style="list-style-type: none"> • Limit separation from caregiver. • Usually able to obey simple commands and recognize danger • Set limits. Often cannot understand why something is acceptable vs. unacceptable. • Provide close supervision • Provide safe environment • Watch for hazards
School-Aged	<ul style="list-style-type: none"> • Introduce yourself • Provide explanations appropriate to age. • Talk to child directly • Allow time for repeated questions • Allow to explore equipment before use • Involve in planning and decisions 	<ul style="list-style-type: none"> • Allow security objects. • Be subtle in encouraging child to take comfort object with him • May need parent • Use calm, unhurried approach • Allow child some input on decisions • Reassure that it is okay to cry 	<ul style="list-style-type: none"> • Curious • Able to accept limits • Review rules and parameters of safety • Provide safe environment • May transport in wheelchair
Adolescents	<ul style="list-style-type: none"> • Introduce yourself • Use adult vocabulary. Do not "talk down" to • Very curious- take time for explanations and questions • Needs privacy • Provide choices. 	<ul style="list-style-type: none"> • Maintain privacy. May be very modest • Allow patient to choose whether or not caretaker is present • Take time for explanations 	<ul style="list-style-type: none"> • Can recognize danger • Inform pt of hospital/department rules • Transport as an adult • Provide safe environment
Young Adult/Early Middle Age	<ul style="list-style-type: none"> • Introduce yourself • Call pt by title and last name • Do not use endearment terms, such as "honey" • Explain procedures using details • Allow time for questions • Be respectful 	<ul style="list-style-type: none"> • Maintain adult privileges- decision making, privacy, routine of personal habits • Offer assistance with personal care • Inform of available amenities/ services • Inform of hospital/department policies (ex. smoking, visitors) 	<ul style="list-style-type: none"> • Keep needed items within reach- including walking and hearing aids • Fall precautions, if appropriate
Late Middle Age/ Late Adult	<ul style="list-style-type: none"> • Same as "Young Adult/Early Middle Age" • Ensure assistive devices are in working order • Speak slowly, clearly, looking at patient. Do not shout at the hearing impaired patient. • Put objects where patient can see them • Keep room well lit, use night- lighting 	<ul style="list-style-type: none"> • Same as "Young Adult/Early Middle Age" • Do not rush pt • Ask family to bring in familiar items from home • Tell confused pt who you are, where they are, and what time of day it is every time you meet them. • May need repeated offers of assistance for personal care needs • Keep pt warm • Follow home routine as closely as possible 	<ul style="list-style-type: none"> • Fall precautions, if appropriate • Keep needed items within reach, including walking aids • Weak or confused pts may need special safety measures • Do not rush pt. Reaction time is slower • Help pt to and from bathroom if necessary

CORPORATE COMPLIANCE

What is Compliance?

- "The willingness to follow or consent to another's wishes" - Webster
- Not a new concept
- Who do we comply with at AAHS?
 - Federal Government
 - State Government
 - Other Regulatory Agencies

Your Role in Compliance

- Identify
 - Know what a compliance issue looks and feels like
- Summarize
 - Know the facts
 - Be able to summarize them for a better review
- Report
 - Know who to contact to discuss the issue so it may be resolved

Identify

- Issues of non-compliance
 - Breach of Confidentiality and/or Security
 - Fraudulent or Abusive Billing Practices
 - Conflicts of Interest
 - Kickbacks/Bribes
 - Employee Theft or Embezzlement

Summarize

- Get the Facts
 - Who, What, When, Where, How??
 - Why are you concerned?
 - Violation of law or regulation
 - Violation of AAHS policy
 - "It just doesn't feel right"
 - Has the issue been brought up before?

Report

- Chain of Command Reporting
 - Prefer that you discuss with your supervisor or manager first
- Compliance and Ethics Hotline
 - 443-481-1338 24 hour voicemail
 - 443-481-1313 fax
 - compliance@aaahs.org
 - US Postal Mail/Interoffice Mail

Reports can be made anonymously!

INFANT SECURITY

AAMC delivers more than 5,000 newborns per year. We are the second largest in the state.

Abductor profile:

- Almost always female, usually early 20's
- Typically overweight
- Gainfully employed
- Recent pregnancy loss not revealed to partner
- Fakes one or more pregnancies
- Relies on manipulation and lying as coping mechanisms
- Nesting behavior consistent with expectant parent (announces the pregnancy)
- Carefully plans the abduction, visits site several times before the event
- Asks detailed questions about procedures and layout
- Obtains uniform, lab coat or other staff attire
- Waits for an opportunity, then takes action. Visible in hallway for as little as four seconds
- May be known to parents
- Race/skin color of abductor almost always matches the infants
- Abductor of older child is often an estranged parent or family members

Safety Measures

- All staff must be aware of the risk
- All staff must be familiar with prevention measures
- All staff must be alert to visitor behaviors
- Women's & Children's staff receive additional training

Staff Education

- All hospital personnel are required to wear color photo ID badge
- Women's & Children's hospital and medical staff wear color coded (red stripe) "Authorized Baby Care Giver"

Transportation

- Mother always escorted by a Women's & Children's RN or Tech when discharged
- Infants are transported:
 - by bassinet
 - carried by mother while she is riding in a wheelchair/stretcher
 - in car seat carrier
 - NEVER carried in arms outside of patient's room
- Children are transported by:
 - wheelchair or stretcher
 - Jeep or Wagon

Prevention

- Educate families and staff
- Know abductor profile
- Know acceptable modes of transportation
- Identify unusual behaviors
- Know your role in a Code Pink
- Control access to restricted areas
- ASK QUESTIONS

Unusual Behavior

- Repeated visits just to “see or hold” infants
- Detailed questioning about procedures or layout
- Taking uniforms or identification
- Physically carrying an infant in the hallway
- Leaving the building with an infant on foot
- Carrying large packages off the maternity unit
- False fire alarm or code, creates opportunity for abduction

Code Pink

- Suspected or actual infant/child abduction
- Clatanoff Pavilion is secured – access into/out of building is restricted
- Security Personnel and County Police provide direction
- All staff in the Clatanoff Pavilion are to remain on site until cleared by county police
- Staff in hospital are expected to stop and question all individuals with infants, children and bags

Control Access to Restricted Areas

- Do not allow unauthorized personnel to ride restricted elevators or enter restricted doors when you pass through
- Escort people to their destination

Ask Questions

- “Pardon me, I’m _____ from the _____ Department. We are very concerned about patient security at AAMC, do you have a badge? May I ask what the purpose of your visit is? It is our policy that everyone must have proper identification. Please come with me to the Security Office”.
- “Excuse me, I’m _____ from the _____ Department. We are very concerned about Patient Security at AAMC. Do you have a Visitor Pass? Who are you visiting, please? Please walk with me to Security to get the proper identification”.

INFECTION CONTROL

Health care-associated infections affect 2 million patients in the US each year and are responsible for 80,000 deaths per year. Transmission of health care-associated pathogens most often occurs via the contaminated hands of health care workers. Nurses, doctors and other health care workers can get thousands of bacteria on their hands through contact with their patients and the patient care environment.

CDC Guidelines Hand Hygiene Guidelines

The Centers for Disease Control and Prevention (CDC) and other healthcare-related organizations believe that cleaning your hands before and after having contact with patients is one of the most important measures for preventing the spread of bacteria in healthcare settings.

Wash hands with soap and water if:

- your hands are visibly soiled (dirty)
- hands are visibly contaminated with blood or body fluids
- before eating
- after using the rest room

Washing Your Hands Effectively

When washing hands with plain or antimicrobial soap:

- wet hands first with water (avoid HOT water)
- apply 3 to 5 ml of soap to hands
- rub hands together for at least 15 seconds
- cover all surfaces of the hands and fingers
- rinse hands with water and dry thoroughly
- dry with a paper towel

When should you use an alcohol-based handrub?

If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based handrub for routinely cleaning your hands:

- before having direct contact with patients
- after having direct contact with a patient's skin
- after touching equipment or furniture near the patient
- after removing gloves

Using Alcohol-based Handrub Effectively

- Apply 1.5 to 3 ml of an alcohol gel or rinse to the palm of one hand and rub hands together
- Cover all surfaces of your hands and fingers
- Include areas around/under fingernails
- Continue rubbing hands together until alcohol dries
- If you have applied a sufficient amount of alcohol hand rub, it should take at least 10 -15 seconds of rubbing before your hands feel dry.

Artificial Nails Policy

- Nails need to be intact and short, no more than ¼" in length
- Polished nails are acceptable only if nail polish is clear and intact (no chips!)
- Artificial nails are not allowed for those administering patient care or patient-related care

ISOLATION GUIDELINES AND STANDARD PRECAUTIONS

Isolation Type	Examples of Organisms/Diseases in this Isolation category	Personal Protective Equipment (PPE) for ALL HCWs, visitors, and family members	Housekeeping Requirements
Contact Isolation B = Basic	<ul style="list-style-type: none"> • MRSA, VRE, ESBL, Multidrug-resistant organisms (MDRO) • Uncontrollable draining wounds • RSV –Respiratory syncytial virus (+Droplet) • Shingles (+Airborne only if disseminated zoster) • Impetigo/ Scabies/ Head Lice 	<ul style="list-style-type: none"> • Gloves • Gowns for contact with patient and direct patient environment 	Basic Isolation Cleaning B: <ul style="list-style-type: none"> • Quaternary ammonium disinfectant 1 bucket, 1 mop for single room • Change privacy curtains after each isolation patient. • Single use cloths with disinfectant to all surfaces, including equipment in room; spot clean walls/ ceiling
Contact Isolation A = Advanced	<ul style="list-style-type: none"> • Multidrug-resistant (MDR) <i>Acinetobacter sp.</i>; other significantly resistant organisms <p>(Infection Control will assign "A" as needed)</p>	<ul style="list-style-type: none"> • Gloves • Gowns use EVERY time in isolation area/room • Mask with face shield as needed (respiratory secretions, splashes, trache patient, etc.) 	Advanced Isolation Cleaning A: <ul style="list-style-type: none"> • Basic Isolation Clean (see above) Plus • Wash all walls and spray ceiling with disinfectant.
Contact Isolation G = Complex	<ul style="list-style-type: none"> • <i>Clostridium difficile</i> (Cdiff) and other spore producing pathogens • Rotavirus, Norovirus 	<ul style="list-style-type: none"> • Gloves • Gowns for contact with patient and direct patient environment 	Complex Isolation Cleaning G: <ul style="list-style-type: none"> • Basic Isolation Clean Except • Use 1:10 diluted BLEACH instead of the usual disinfectant.
Droplet Isolation B	<ul style="list-style-type: none"> • Seasonal influenza • RSV (+Contact B) • Pertussis (whooping cough) • Suspected or confirmed bacterial meningitis (d/c after 24 hours of antibiotic treatment) 	<ul style="list-style-type: none"> • HCWs and visitors: Mask with face shield • Patient: surgical mask used only while transporting patient 	Basic Isolation Cleaning B: (see above)
Airborne Isolation B	<ul style="list-style-type: none"> • Suspected or confirmed pulmonary <i>M. tuberculosis</i> • Chickenpox (+Contact B) • Disseminated Shingles/zoster (+Contact B) • Measles (rubeola) 	<ul style="list-style-type: none"> • Healthcare workers (HCWs): N95 respirator- choose size and brand you have been fit-tested to wear • Visitors: surgical mask • Patient: surgical mask used only while transporting patient 	Basic Isolation Cleaning B: (see above)
Standard Precautions	<ul style="list-style-type: none"> • ALL patients require Standard Precautions. <p>(Examples of these infections/ conditions that do not require transmission-based isolation include: HIV, AIDS, Malaria, Hepatitis B&C, viral meningitis, etc.)</p>	<ul style="list-style-type: none"> • No isolation sign required. • PPE (gloves, gown, mask) is used as needed to prevent contact with blood and body fluids • No transmission-based isolation needed 	Standard room clean: <ul style="list-style-type: none"> • Quaternary ammonium disinfectant bucket/mop changed per routine + when visibly soiled • Change privacy curtains per schedule + when visibly soiled; change after every CCU pt • Single use cloths with disinfectant to all surfaces, including equipment in room; spot clean walls/ ceiling.

For more details regarding transmission-based isolation, see Infection Control policies on the intranet. Infection Control Issues? Please call ext. 1591/1592. Housekeeping Issues? Please call ext. 5350.

Environmental Services/ Housekeeping will remove the horizontal isolation sign from the door after discharge or transfer, clean the sign and return it to the nurses' station.

INCIDENT REPORTING / 4PTS HOTLINE

All reportable incidents should be reported to the 4PTS hotline (x4787). Examples include but are not limited to:

- Patient falls
- Medication errors or near misses
- Specimen labeling errors
- Missed order for treatment, medication, etc
- Narcotic discrepancy
- Removal of a patient's ID bracelet
- Significant delays in treatments or disposition

Click policy to review:

ADM1.1.62 - AAMC Incident reports policy

MEDICATION ADMINISTRATION

Click policy to review:

MED16.1.02 - Medication administration

Objectives

1. Awareness of Sound-Alike-Look-Alike (SALA) policy & chart on AAMC Intranet
2. Review Key Medication Order Policies
3. Note recent changes in Medication Administration Policy
4. Review Medication Error Reporting
5. Review Verbal Orders

SOUND-ALIKE-LOOK-ALIKE (SALA) MEDICATIONS

JCAHO National patient Safety Goal #3 Requires AAMC to develop and maintain a list of medications that can be confused and potentially leading to errors. Our list is developed from both JCAHO's suggestions AND medication error reports from 4PTS calls. In addition, the corresponding actions taken by AAMC to prevent these errors are listed.

The detailed AAMC list of SALA medications is available as an attachment to the policy on the Intranet.

Medication Order Policy Highlights

JCAHO-required Intranet policies to guide use and interpretation for:

- Standing Orders–Basic components of a med order
- PRN Orders–Need indication for “as needed”
- Hold Orders–Either hold indefinitely OR hold for a clinical parameter
- Automatic Stop Orders– Orders are stopped automatically post-op, on transfer, narcotics @ 4 days, and ketorolac(toradol) @ 5 days
- Resume Orders–“Blanket”resume orders are not allowed (e.g. resume all pre-op meds).
 - Each medication must be written out completely.
- Titrate Orders–Must have clinical parameters to titrate dose to
 - Narcotic titration also requires initial dose, increment of titration, interval of titration, and maximum allowable dose.
- Taper Orders–Must have goal indicated; either off or down to a certain dose

Range Orders

Range orders are permitted when deemed essential to the care of the patient by the MD–

- Both “time”and “dose”ranges are allowed, however time ranges are redundant and should be discouraged

Interpretation of range orders is outlined as follows:–

- The 1st dose must be administered using the lowest dose and the longest interval in the specified range(s). For example:
 1. Dose 2-4 mg would be given as 2 mg initially
 2. Time 3–4 hours would be given at 4 hours

IF the initial, or subsequent, dose is inadequate the time the peak effect is anticipated:

One additional dose may be given as follows:

- The additional dose cannot exceed the difference between the 1st dose given and the largest dose in the interval. AND
- The time before giving another dose begins at the administration of the additional dose
- For example: “Morphine 1-2 mg IV q 3 hours PRN pain” would be given as 1 mg for the first dose. If the patient still rates pain unacceptable within 30 minutes of the first dose, an additional dose of 1 mg may be given. The next dose may be given 3 hours after the additional dose. Since 1 mg was shown to be ineffective initially, the next dose could be 2 mg.

Multiple Narcotic Orders

- In place to prevent excessive multiple narcotic administration which may lead to an adverse drug reaction
- States that only one short-acting narcotic may be used at a time.
 - MD orders must give specific directions to the nurse as to when to choose one drug over another.
 - Examples of acceptable orders:
 - Morphine 2 mg q 3 hours PRN pain, may give percocet-5 2 tabs po q 4 hours PRN pain when taking PO Morphine 2 mg q 3 hours for severe pain, Percocet -5 1 tab q 4 hours for moderate pain)
 - A narcotic option may not be given until the end of the time span for the last short-acting narcotic given (e.g. in the examples above, the patient cannot get Percocet until 3 hours following the last morphine dose)
- Short-acting narcotics may be given for breakthrough pain when patient is on a long-acting narcotic
 - Multiple short-acting meds may be ordered with a long acting narcotic if done according to the previous guideline
- Long-acting narcotics should be limited to only one medication which should be adjusted by the MD for optimal pain control. Multiple long-acting narcotics may only be used on patients who are admitted already on multiple long-acting narcotics.

Medication Administration Policy - MED 16.1.01

Recent Updates:

- Added language about labeling medication containers (Joint Commission National Patient Safety Goal):
 - Meds prepared or transferred to a container, other than the manufacturer's, and not administered immediately should be labeled with:
 - Medication
 - Strength
 - Amount
 - Expiration if not used within 24 hours or if stability expires before 24 hours
- Vials should be managed as follows:
 - Single use (no preservatives) should be discarded immediately after use
 - Multi-dose vials (with preservatives) should be dated & initialed when opened; any vials found dated ≥ 28 days or not dated/initialed should be discarded
 - 72% nursing stations had undated or expired vials last inspection
- Remove "sharps container" as an option where drugs can be wasted
 - Refer also to MED16.1.17 -Narcotic Storage, Security, Documentation and Waste
 - Fentanyl patches must be "wasted" in Pyxis, folded in half, and flushed down the toilet–Only 40% of patches appear to be wasted properly Medication Error (& Near Miss) Reporting
- Definitions:
 - Within policy ADM1.1.62 -Incident Reports :
 - Incident: Any variance from procedure, property damage or loss, or unexpected occurrence experienced by patients, such as fall or injuries or any injury to visitors on Medical Center premises.
 - Near Miss -Any process variation that did not affect the outcome, but for which a recurrence carries a

significant chance of a serious adverse event and/or outcome.

- Reporting
 - All incidents are reported by calling the 4-PTS hotline (ext. 4787).
 - The incident is reported at the first knowledge that a variance has occurred, whether it is associated with a negative outcome or not. This includes variances that are noticed before actual delivery to the patient (near-misses).

PAIN MANAGEMENT

In an effort to increase safety of opioid analgesia, AAMC does not usually allow more than one long acting or more than one short acting opioid to be ordered/active at one time unless there are clear instructions as to which medication to administer under which circumstances.

Acceptable examples:

Morphine 2mg IV q2hrs prn pain while NPO
 Percocet 5mg 1-2 tabs po q4hrs prn pain when tolerating PO

Morphine 2mg IV q2hrs prn severe pain
 Percocet 5mg 1-2 tabs po q4hrs prn moderate pain

Percocet 10/325 1-2 tabs po q4hrs prn pain
 Dilaudid 6mg po q3hrs prn pain if Percocet ineffective and discontinue Percocet thereafter.

Unacceptable examples

Morphine 2mg IV q2hrs for pain
 Dilaudid 2-4mg po q3hrs for pain
 Percocet 5mg 1-2 tabs po q4hrs prn pain

If a patient is admitted with an analgesic regimen that already consists of more than one long-acting or more than one short acting opioid, it is allowable to continue the patient on their pre-existing regimen.

Reassessment & Documentation of Pain

- When a 'prn' analgesic is administered, you are required to reassess and document your reassessment within 1 hour.

- Consideration of the onset, duration and peak effectiveness should be considered when timing your reassessment of pain.
- Make every effort to reassess & document pain w/in 30 minutes for IV analgesics and w/in 60 minutes for PO analgesics.
- The documentation of the reassessment of pain is audited every month and reported to the unit directors!

Dilaudid

- The administration of IVP and IM Dilaudid here at AAMC are only approved for staff in the ED, OR, PACU, CCU and Interventional Radiology.
- Dilaudid PCA can only be ordered by those physicians who have completed the Dilaudid prescribing competency through the Medical Staff Office. This can be verified via the pharmacy or via Meditech. All of the PharmD's are competenced to prescribe Dilaudid. If a non-competenced physician wishes to have a patient on a Dilaudid PCA, obtain a PharmD consult for Dilaudid PCA management.

PCA by Proxy

- PCA by Proxy means that someone *other than* the patient pushes the bolus button.
- AAMC does NOT allow PCA by Proxy per our PCA Policy. Please educate family members, friends and significant others about the increased risk of respiratory depression when anyone but the patient pushes the bolus button.
- AAMC does not allow nurse proxy dosing either. If the patient is unable to initiate a bolus dose on their own, they are not an appropriate candidate for PCA management!

Patient / Family / SO Education

- Pain management education must be documented in the Interdisciplinary Patient Education Record (IPER).
- The following documentation is REQUIRED for every patient:
 - The "risks for pain" – this is now a look up option in the IPER in the pain management section
 - Pain scale
 - Pain management plan

ABUSE AND DOMESTIC VIOLENCE (DV)

Domestic Violence (DV) is a pattern of behavior used by one person in a relationship to gain power and control over another, usually an intimate partner. It can include physical, psychological, emotional, verbal, sexual, and/or economic abuse.

Referrals to the AAMC Abuse & DV Program

- Page A/DV through the Hospital Operator 443-481-1000, after paging A/DV send a Clin Con;
- For noncritical issues contact A/DV @ 443-481-1209.

Domestic Violence (Adult Partner Abuse)

- 30% of female homicides are committed by intimate partners
- DV is the leading cause of death of both pregnant women and women who are one year post delivery or pregnancy termination
- 25-45% of battered women were battered while pregnant
- Battered women account for 25% of women who attempt suicide
- **Reporting Laws:** In MD, there is no mandatory reporting unless assault is with a deadly weapon (i.e. gun, knife) or moving vessel (i.e. car, boat).

Child Abuse

- Abuse of a minor child (under 18 years)
- Mandated report to Department of Social Services Child Protective Services (CPS)
- Abuse may be physical or neglect
- A person does not have to be "certain" of abuse in order to report; it is the responsibility of CPS to investigate
- **Reporting Laws:** mandatory report to Department of Social Services, Child Protective Services

Vulnerable Adult/Elder Abuse

- Older adults may be subjected to a pattern of abusive behavior
- Abuse may be committed by a family member (such as an adult child or grandchild) or by someone with whom they have an intimate relationship, such as a spouse or life partner.
- In some cases, the family member or intimate partner may also be the caregiver.
- Vulnerable adults (such as physically or mentally disabled individuals) may be at risk for abuse.
- **Reporting Laws:** Mandatory report to Department of Social Services, Adult Protective Services

Why doesn't the victim leave? Fear, economic dependency, no one to help, shame, language and/or cultural barriers, poor self confidence

Why does the victim stay? Commitment, no place to go, children, religious beliefs, medical problems, immigration status

What to say: "What you are experiencing is abuse," "It is not your fault," "Help is available."

Indicators of Abuse

- Injury pattern is inconsistent with mechanism or explanation
- Contusions, abrasions, minor lacerations, fractures, sprains
- Injuries to head, face, arms, neck, multiple injury sites, repeated chronic injuries, injuries in various stages of healing
- During pregnancy – breasts, abdomen, genital area
- Shyness, fright, embarrassment, evasiveness, passivity, jumpiness
- Limited access to finances
- Restricted ability to communicate by phone
- Chronic pain, chronic headache / migraine
- Depression, anxiety, sleep disturbances, vague complaints, headaches, choking sensation, hyperventilation, G.I. symptoms, panic attacks
- Substance abuse
- Feelings of isolation, inability to cope, suicide attempts or gestures, Post Traumatic Stress Syndrome
- Limited access to routine or emergency medical care
- Non compliance with treatment regimens, missed appointments
- Lack of independent transportation
- Psychogenic pain
- Post Traumatic Stress Disorder
- GI / abdominal complaints
- Dizziness

EMERGENCY RESPONSE, CODE BLUE & RAPID RESPONSE

	Code Blue	Rapid Response
Criteria for Activation	<p style="color: #0070C0;">Immediate response – goal to defibrillate as needed within 2 minutes of call for:</p> <ul style="list-style-type: none"> • Respiratory or cardiac arrest 	<p style="color: #C00000;">Responds within 10 minutes to adults for these reasons:</p> <ul style="list-style-type: none"> • Any worrisome signs or symptoms • ACUTE change in heart rate (<40 or >130 beats/min) • ACUTE change in systolic BP (<90 mmHg) • ACUTE change in respiratory rate (<8 or >28 breaths/min) • ACUTE change in oxygen saturation (<90% despite O2) • ACUTE change in LOC • ACUTE Bleeding • ACUTE Neurological Change/ Stroke (assess patient using Cincinnati Scale + Visual Fields – may call Intensivist and/ or Hospitalist to come see patient for possible Stroke Team activation; RRT RN will perform NIH Stroke Scale assessment if Ischemic Stroke is suspected) • Dysrhythmias • Rapid Deterioration • Seizures
Primary Responders	<ul style="list-style-type: none"> • Physician: intensivist, ED physician, Pediatric Hospitalist, Neonatologist, NNP • Critical Care RN, ED RN • Respiratory Therapist • Administrative Coordinator • Primary RN/LPN/CTC/PC • Unit based tech / escort 	<ul style="list-style-type: none"> • CCU's Care Team Coordinator (CTC) • Respiratory Therapist

Both Code Blue and Rapid Response require MD/ RN signature and an evaluation of the event on the back of the yellow Resuscitation Form. This copy goes to Critical Care Committee for monthly review.

CODE CARTS

Defibrillator/ pacer check is performed and documented daily. Code cart checklist is checked daily.

All outer locks on the adult code carts, broselow carts and NICU carts should be the same color. A cart that has different colored locks on the outside or has a lock missing or broken may not contain all the needed supplies.

Click policy to review:

GNP14.6.15 - Code Blue

GNP14.6.14 - Rapid Response Team for Adults

ADVANCE DIRECTIVES

Click policy to review:

ERR3.1.02 - Advance directives

PEAK CENSUS

Click policy to review:

ER NAP12.1.12 - Peak census

***You have reached the end
of the agency nurse orientation packet.
Please complete the orientation checklist
and return to appropriate personnel.***