Meadows Health has compiled a self-reading training program to help new hires understand important basic policies/principles of healthcare. We welcome you to Key Elements training. Please carefully review the module as you will be required to acknowledge receipt and review of the program. If you have any questions regarding the content, management would be happy to answer your questions during our General Orientation Session.

Our mission is to Provide
Quality Healthcare

Our vision is to be a
Center of Excellence

The Goal of this manual is to provide an annual review of information for MRMC staff and volunteers to satisfy requirements of hospital, local, state, and federal regulatory agencies.
TABLE OF CONTENTS

HOSPITAL ACCREDITATION 6

2018 NATIONAL PATIENT SAFETY GOALS 7

Domestic Violence and/or Abuse/Neglect/Exploitation of Children or Adults 9

COMPLIANCE & ETHICS 10

TRANSLATION SERVICES 12

CYRACOM 13

CULTURE 15

DIVERSITY & CULTURE 16

Dying With Dignity 18

ADVANCED DIRECTIVES 19

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) 20

TOBACCO FREE CAMPUS POLICY 21

SAFETY MANAGEMENT PLAN 22

INCARCERATED PATIENTS 22

Hazardous Materials and Waste Management Plan 23

FIRE PLAN 24

EVACUATION ROUTE 26

MRMC Disaster Plan 27

EMERGENCY OPERATIONS/DISASTER PLAN: DECONTAMINATION PLAN 28

Bomb Threat 32

Infant Abduction 33

Workplace Violence 33
Emergency Codes
Medical Equipment Plan
ELECTRICAL SAFETY
Environment of Care
CONFIDENTIALITY
Signs and Symptoms of Addictive Disorder in Practitioners or Co-Workers
Disruptive Conduct/Workplace Violence
INFECTION CONTROL
Blood-borne Pathogen Exposure Control Plan
INFORMATION SYSTEMS
RISK MANAGEMENT
Employee Work Related Incidents
CONCERNS PROCEDURE
PATIENT RIGHTS & RESPONSIBILITIES
PATIENT COMPLAINTS
PATIENT GRIEVANCES
VISITATION POLICY
Performance Improvement
PATIENT SAFETY REPORTING
PATIENT SAFETY / FALL RISKS / ENTRAPMENT
RESTRAINS
TEAMWORK
CONTROLLED SUBSTANCE IN THE WORKPLACE
OCCUPATIONAL EMPLOYEE HEALTH
Sharps Injuries and Body Fluid Exposures
DNV GL's pioneering NIAHO® program integrates ISO 9001 with the Medicare Conditions of Participation.

It's time for a change.

We have dedicated ourselves to helping you empower quality and patient safety through a more efficient and outcomes-based accreditation program; restoring efficiency and value to hospital accreditation. Imagine accreditation surveys becoming something you look forward to not something you fear.

We received CMS Deeming Authority in 2008, and since then have accredited nearly 500 hospitals of all sizes and in every region of the United States. We are the first and only accreditation program to integrate the CMS Conditions of Participation with the ISO 9001 Quality Management Program. Our collaborative survey teams visit your hospital annually, not every three years, making each visit far less stressful and more of a routine check up on your success, not an epic investigation of your faults.

Our Philosophy

WHAT: Accreditation can -- and should -- enable a broader culture change toward high performance and continual improvement.

HOW: By combining the 'mandatory' CMS evaluation with a proven world class quality management system into one seamless program.

WHY: Because that's why you got into healthcare; to focus on people and their health, not checklists and rules from outsiders.

Contact us for information about Hospital Accreditation for your organization.

Thus, DNV accreditation adheres to the NIAHO® standards which require hospitals to be accountable to ensure that quality management processes are planned, managed, measured, documented and improved. DNVHC is working to change the "culture of accreditation" by creating partnerships with their accredited hospitals to collaboratively work together to focus on continual improvement, apply innovative methods for compliance and patient safety, and ensure the quality of care provided to their patients. At the same time, DNVHC holds the hospitals accountable to ensure they are compliant with their standards that also meet the CMS CoPs.

Meadows Health continues to adhere to the Safety Goals published by the Joint Commission.
The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

**Identify patients correctly**
- NPSG.01.01.01: Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
- NPSG.01.03.01: Make sure that the correct patient gets the correct blood when they get a blood transfusion.

**Improve staff communication**
- NPSG.02.03.01: Get important test results to the right staff person on time.

**Use medicines safely**
- NPSG.03.04.01: Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
- NPSG.03.05.01: Take extra care with patients who take medicines to thin their blood.
- NPSG.03.06.01: Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

**Use alarms safely**
- NPSG.06.01.01: Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

**Prevent infection**
- NPSG.07.01.01: Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
- NPSG.07.03.01: Use proven guidelines to prevent infections that are difficult to treat.
- NPSG.07.04.01: Use proven guidelines to prevent infection of the blood from central lines.
- NPSG.07.05.01: Use proven guidelines to prevent infection after surgery.
- NPSG.07.06.01: Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

**Identify patient safety risks**
- NPSG.15.01.01: Find out which patients are most likely to try to commit suicide.

**Prevent mistakes in surgery**
- UP.01.01.01: Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body.
- UP.01.02.01: Mark the correct place on the patient’s body where the surgery is to be done.
- UP.01.03.01: Pause before the surgery to make sure that a mistake is not being made.

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This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.
Policy
It shall be the policy of Meadows Regional Medical Center to identify and report cases of alleged or suspected domestic violence or abuse/neglect/exploitation of children or adults as required by state law.

What is it?
● Domestic Violence is evidence or the threat of violence within families, past or present, or persons living together in the same household.

● Abuse is intentional maltreatment of an individual, which may cause either physical or psychological injury. It can be physical, mental or sexual of an adult or child.

● Neglect is not taking care of a person’s basic needs by withholding or inadequately providing food, water, clothing, medical care, good hygiene or putting an individual in an unsafe or unsupervised position.

● Financial Exploitation involves unauthorized use of an elderly person’s funds or property, either by a caregiver or an outside scam artist.

Signs & Symptoms of Abuse/Neglect
● Physical: bruising, abrasions, lacerations, bite marks, unexplained/inconsistent injuries and/or fractures and burns, strangulation marks, missing or loose teeth, withdrawn or fearful.

● Sexual: Along with physical indicators, may include: STD’s, pregnancy <16 years old, trauma to genitalia, recurrent urinary tract infections (UTI) or pelvic inflammatory disease (PID), difficulty/pain in walking, torn, stained clothing, history of loss of consciousness of memory, withdrawn.

● Neglect: malnourished, poor hygiene, poor skin condition, developmentally delayed, chronic health problems without appropriate care and follow-up.

● Domestic: In addition to physical and sexual indicators includes: penetrating injuries, gunshot wounds, concussions, miscarriage/pregnancy complications, anxiety, depression, anger, suicidal/ideation, vague responses, crying and self blaming, history of child abuse.

All non-clinical personnel should be alert to what they see or hear, which would lead one to suspect abuse, or neglect, or exploitation. This should immediately be reported to the employee’s immediate supervisor. The supervisor will take action to make sure this is investigated further. (Refer to MRMC policies on domestic abuse and abuse/neglect for additional information regarding signs/symptoms and reporting.)

All clinical staff will be responsible for notifying the charge nurse and/or nursing supervisor as deemed appropriate and will notify the proper law authority. All employees of Meadows Regional Medical Center have a legal, moral and policy obligation to report any abuse, neglect, or exploitation.
Message from the President and Chief Executive Officer and Chairmen of the Board

Meadows Health’s mission is to deliver high-quality, patient-focused healthcare. It is essential that we provide these services ethically and in compliance with applicable laws and regulations in every respect. Integrity in the care delivery to our patients and in the way we conduct business every day is an imperative in today’s healthcare environment. More importantly, it is simply the right thing to do for our patients and for everyone we touch through our services.

Our Compliance & Ethics: Code of Conduct firmly establishes our unwavering commitment to promote ethical and legal business practices as well as our intent to timely and fully respond when areas of non-compliance are identified. The Code of Conduct will be assigned to you for your review as a new employee through the Healthstream Education System. The Code of Conduct sets the basic standards of conduct we must follow as we fulfill our primary purpose of caring for our patients. It applies to every Meadows Health employee, Medical Staff member, contractor, vendor, volunteer, and Board Member. The Code of Conduct also contains resources to assist you in answering questions about appropriate behaviors in the workplace.

Of course, no document can address every situation which may be encountered. In some instances, common sense, morals, conscience and good judgment must be your guiding forces. If you are unclear about something or believe the Code has been violated, you should immediately contact your direct supervisor, the Chief Compliance Officer, a member of Administration or Human Resources. You can also call the Compliance Hotline at 1-866-326-6759 or visit our website at www.meadowsregional.ethicspoint.com. Your concern will be thoroughly and confidentially reviewed, and actions will be taken to correct any identified unethical or illegal behavior or behavior that is inconsistent with the Code of Conduct contained herein. You have our personal assurance and commitment there will be no retribution for raising concerns or reporting possible improper conduct.

We thank you for your commitment and dedication in caring for our patients and to the betterment of our health system. It is incumbent upon each one of us to ensure that we remain compliant and consistent with current healthcare regulations as well as the values that define our organization. Consequently, we ask that you help ensure the consistent application of our organization’s shared values and standards set forth in our policy.

J. Alan Kent
President & CEO

Ronnie L. Stewart
Chairman, MRMC
The Corporate Compliance Program is designed to help all of us make good decisions. It also helps to ensure that our values are reflected in everything we do. These principles apply to all of our employees and anyone who acts on behalf of Meadows Regional Medical Center.

Employee Responsibility:
Our work policies are designed to help you fulfill the requirements of providing healthcare services and to help you do your job. However, you are responsible for the results of the decisions you make. We ask that you raise questions about any part of your job when you feel our work policies are not in line with our Mission. Employees have an obligation to communicate with management with items of concern. You can communicate directly with your manager, Director, Vice-President or feel free to call the Chief Compliance Officer, Sandra Kate Ellington M-F 8AM-5PM at 912-538-5898 or you have access 24/7 to our Compliance Hotline & Website:

CONFIDENTIAL COMPLIANCE HOTLINE: 1-866-326-6759 or
Visit our website at www.meadowsregional.ethicspoint.com
COMMUNICATION WITH PATIENTS WITH LIMITED ENGLISH PROFICIENCY ("LEP") VISION AND/OR HEARING IMPAIRMENT

DEFINITIONS:
Limited English Proficient (LEP) - Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

PROCEDURE:
Circumstances Requiring Interpreter Services
Interpreters and/or auxiliary aids services should be provided in all circumstances where necessary for effective communication in connection with treatment rendered by the Hospital to a patient and/or in order for the patient to receive the full benefit of the hospital services. Examples of circumstances in which interpreters should generally be used include, but are not limited to, the following:

- Determination of patient’s medical history or description of condition.
- Discussion of patient’s rights, informed consent, or permission for treatment.
- Determination and explanation of patient’s diagnosis or prognosis, and current condition.
- Explanation of procedures, tests, treatment, treatment options, or surgery.
- Explanation of advanced directives or power of attorney.
- Explanation of medications prescribed including dosage as well as how and when medication is to be taken and any possible side effects.
- Discharge planning and discharge instructions.
- Explanation of follow-up treatments, therapies, test results, or recovery expectations.
- Resolving billing or insurance issues that may arise.

Assessment and Primary Language Identification:
Upon registration, the primary language of every patient shall be ascertained and recorded. Staff should determine whether a patient is Limited English Proficient (LEP) or hearing/speech impaired and if so, the primary language spoken by that patient. Determine if special communication assistance is needed. This information will be documented in the patient’s medical record.
Documentation of Language Assistance:
Staff members (Nursing) should also record each LEP/Hearing Impaired patient’s primary language in the patient’s medical record.

Beyond this initial assessment, staff should record in the patient’s chart any ongoing provision of interpreter services and/or auxiliary aids. This includes:

   A. time of interpreter requests, arrivals and departures;
   B. full name of the interpreter used;
   C. whether interpreting was done via phone or in person; d) any auxiliary aids provided.

Informing Patients of their Rights:
The staff will inform the patient of his/her right to have language interpretation and auxiliary aids available to them, and explain that there is no charge for their use.

If it is determined that communication assistance is necessary, the staff member shall inquire as to what language the patient best communicates, or prefers. For patients utilizing sign language, it is important to ascertain the type of sign language the patient uses.

This information is documented in the medical record.

Obtaining an Interpreter:
Check the hospital’s volunteer interpreter’s roster to identify an appropriate interpreter. In the event that hospital personnel are not available to assist, the hospital will utilize 24 hour telephonic Language Services (Tele-Interpreters), and local resources who speak a foreign language or can assist with the deaf or visually impaired. Check the policy for list of approved interpreters.

Cyracom—Provides toll-free access to foreign-language telephone interpreters covering 150 languages.

Using Family or friends as interpreters:
   a) MRMC employees shall not require or encourage the use of a patient’s family member, especially children as an interpreter of healthcare information for the following reasons:
      Family or friends’ emotional involvement with the patient can jeopardize interpretation of critical medical information. Such persons may not be versed in the medical terminology required for communication between patient and health professionals. Such use may compromise confidentiality.

   b) Using the patient’s family or friends as a substitute may be justified only after all other options have been exhausted and/or at the direct request of the patient and only after it is clearly explained to the patient/family that a trained interpreter is available at no cost to them. This request will be documented in the patient’s medical record.
Using Other Personnel as Interpreters:
MRMC discourages the use of other employees, who do not have training as interpreters, to engage in interpreting.

Bilingual Staff:
Bilingual clinical staff may provide care in languages in which they are proficient as determined by the procedure for testing the proficiency of interpreters.

Hearing Impaired Patients:
   a.) For patients utilizing sign language, it is important to ascertain the type of sign language with which the patient is familiar.
   b.) Check the hospital’s external resource list for sign language interpreters.
   c.) A video interpreting service is available 24 hours a day, 7 days a week through Cyracom for use for patients requiring sign language interpretation. There is a computer designated for this service in L&D, ER, and on the Med/Surg/Telemetry Unit.

Auxiliary aids:
The following aids are available to assist patients: Contact the Patient Care Services Office to obtain:
   ● Closed caption devices for television sets- Contact the Engineering Department
   ● Telephone handset amplifier
   ● Braille phone/Hearing aid compatible
   ● Various Communication Boards that display English, Spanish, and pictures.

Written Translation:
Hospital will translate in writing critical documents into languages other than English as appropriate. Documents that are not translated in writing may be translated orally by an interpreter when necessary.

Questions and Complaints:
The Patient Relations Coordinator shall provide any person who wishes to file a complaint regarding such matters with a copy of the patient grievance procedure at MRMC.

EQUIPMENT AVAILABLE (Contact Patient Care Services)
   ● Sip and Puff for Quad patients
   ● Braille Telephone
   ● Speaker Phones
   ● Close Caption for Televisions- contact Engineering Department
What is Culture?
That component of our lives including: physical attributes, diet, worldview, language, philosophy or religion.

The melting pot of America works both for and against acculturation. As new immigrants bump elbows with the “American Way”, they find themselves challenged to “fit in”. However, they could also band together with folks from their homelands and maintain the customs and lifestyle they used to have. These subcultures that maintain cultural differences challenge healthcare providers.

Ethnocentrism
When we view ourselves as the correct culture or ‘right’ way of seeing the world and see others’ behavior or beliefs as weird or bizarre, we prejudice our ability to give appropriate care to our patients of other cultures. This can result in:
- Misdiagnoses
- Failure to treat appropriately
- A feeling of frustration & isolation for patients & families

Cultural Competency
Knowledge and understanding of cultural practices in the geographical area, which includes:
- Language
- Family Roles
- Health Behaviors
- Nutrition
- Childbearing Practices
- Death
- Spirituality

Understanding these areas of a person’s lifestyle can enable us to be better caregivers and improve the wellness of those who come to us for healing.
What Can You Do?

Listen with sympathy and understanding. Be open-minded and respectful towards beliefs, values and practices.

Encourage an open dialogue between patients, family members and the health care team.

Awareness of language and communication issues can help bridge the patient's and healthcare provider’s views on health. Ask questions of patients and family members.

Recognize the role that others play in a patient’s care and involve them as much as possible.

Negotiate agreement. It is important to understand the patient’s views on illness and disease so that treatment fits in their cultural framework. Incorporate the patient’s views whenever possible.

Keep In Mind...

- As health care professionals, we are trained on how to deal with “disease”. It is important to remember that people experience “illness” (the human experience of disease). Disease and illness should not be viewed as excluding each other; they are both important aspects of “sickness”.
- We are all “ethnic”. It is important to avoid the trap of only looking at “them”.
- All clinical encounters are cross-cultural encounters of at least 6 different cultures that need to be acknowledged: a) the patient’s own culture; b) community culture; c) provider’s own culture; d) provider’s subspecialty culture (surgeons, internists, pediatricians, Ob-gyn); and f) the institution’s culture; etc.
- In dealing with diversity, it is important to acknowledge that one should deal with and accept differences (no values attached). It is important to differentiate between what is different from what is detrimental to health.
- The main issues delivering culturally competent care and understanding, good listening skills, and the ability to negotiate between different explanatory models of illness and disease. For example, the cause of an illness may be environmental, bacterial, or viral. However, the patient may believe the cause of his or
her illness to be “the evil eye” or “curses”. Cultural conflicts often involve communication, food preferences, family relationships, and beliefs about the cause of the illness.
Meadows Health is committed to treating those patients who are suffering an incurable and irreversible condition where death is pending, with dignity. This means providing comfort and care through the provision of pain management and the treatment of primary and secondary symptoms that will respond to treatment, as desired, by the patient and/or family. This includes assessing and assisting the patients and the family in coping with the grieving process.

**To One In Sorrow**

Let me come in where you are weeping, friend,
And let me take your hand.
I, who have known a sorrow such as yours, can understand.
Let me come in -- I would be very still beside you in your grief;
I would not bid you cease your weeping, friend,
Tears bring relief. Let me come in -- and hold your hand,
For I have known a sorrow such as yours,
And understand.

-Grace Noll Crowell

Grief is defined as sadness felt after a loss; for example; a death of a close relative. Just as people feel grief in many different ways, they handle it differently, too. For some, reaching out for support from others may bring comfort. Others may isolate themselves or bury themselves in work to take their minds off of their loss. For some, it may help to talk with others. Others may feel that it is much too hard to find the words to express such deep and personal emotion. There are others that look deep inside themselves and rely on their culture and spirituality to help them through the process. As culture influences all aspects of life, it can play a very large role in how one deals with illness, end-of-life, and the grieving process. In assisting the patients and family in coping with the grieving process, we must be sensitive to each patient and the way in which they have chosen to deal with their loss. At Meadows Regional, this sensitive care is provided through an interdisciplinary approach, using the gifts that all members of the health care team can offer to provide the best possible experience for the patient and family.
Since 1991, Georgia has offered a way for adults to make decisions in advance about the type of treatment they would choose in the event that they become terminally ill. The passage of the Patient Self-Determination Act allows persons of sound mind to sign “Advance Directive”, directions for family members and medical providers about their choice of future medical care.

As of July 1, 2007, the GA legislature passed the Georgia Advance Directive for Health Care. This document replaces the Living Will and Durable Power of Attorney for Health Care although, these two documents, done prior to July 1, 2007, will be honored.

The new document has four parts:

Part one – allows you to choose an agent to speak for you if you are unable to speak for yourself. You should discuss your wishes with your agent.

Part two – allows you to state your treatment preferences if you were to have a terminal illness or are in a state of permanent unconsciousness.

Part three – allows you to nominate a person to be your guardian should one ever be needed.

Part four – requires your signature and those of your witnesses.

Persons of sound mind may also sign Do Not Resuscitate orders. These orders simply instruct health care providers on whether you wish to be resuscitated in the event that such CPR would be futile or its effects would be short-lived.
EMTALA was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Its original intent and goals are consistent with the mission of ACEP and the public trust held by emergency physicians.

- Referred to as the "anti-dumping" law, it was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer.
- EMTALA requires Medicare-participating hospitals with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, national origin, race, creed or color.

What are the provisions of EMTALA?

Hospitals have three main obligations under EMTALA:

1. Any individual who comes and requests must receive a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and treatment.

2. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.

3. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

- A hospital must report to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.

What are the penalties for violating EMTALA?

Both CMS and the OIG have administrative enforcement powers with regard to EMTALA violations. There is a 2-year statute of limitations for civil enforcement of any violation. Penalties may include:

- Termination of the hospital or physician's Medicare provider agreement.
- Hospital fines up to $50,000 per violation ($25,000 for a hospital with fewer than 100 beds).
- Physician fines $50,000 per violation, including on-call physicians.
- The hospital may be sued for personal injury in civil court under a "private cause of action"
- A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover damages.

Reference:
Meadows Health prohibits the use of any tobacco products, either smoking or smokeless, in any MRMC owned or leased space including buildings or grounds and affiliated premises (i.e., Business Services, Annex Building, Wellness Center, and others) as designated by the Chief Executive Officer, in consultation and cooperation with the medical staff and the Board of Trustees.

This policy applies to all employees, contractors; volunteers; medical staff; patients and visitors in or on a Meadows Health premises, clinic vehicles and other sites or property owned by the hospital.

Effective January 1, 2005 MRMC is a Tobacco-Free Facility

Ready to break from the PACK?

Quitting is tough, but help is available. Here is a good place to start.

- Make a plan and get help sticking to it. Join a support group, tell family and friends and let them help you quit.
- Talk with your primary doctor about methods of smoking cessation. He or she may be able to prescribe medications to help you quit.
- When you feel withdrawal symptoms coming on, do something to relax, such as taking a hot bath.
- A daily exercise routine is also necessary to maintain health and suppress cravings.
- Avoid situations where you'll be tempted to smoke, i.e. bars.
Policy:
Meadows Regional Medical Center has an active Safety Management Plan, which serves to provide a safe environment for patients, visitors, and staff. Safety / Security policies and plans are developed to protect people, as well as, property.

Purpose / Objective:
Providing a safe environment for the provision of patient care is essential as part of the hospital’s mission. The purpose and objectives of the Safety Management Program are:
- Establishing, supporting, and maintaining a program that is based on monitoring and evaluation of organizational experience, applicable law and regulation, and accepted practice.
- Providing a program to reduce risks to employees, patients, physicians, contractors / vendors, and visitors while inside the hospital and on the property by providing a physical environment free of hazards.

Who do I call....
- Environmental Issue (Water on the floor/slip hazard, etc) – Contact your Supervisor or Environmental services
- Equipment Issue – Engineering and your Supervisor
- Patient Care Concern – Your Supervisor, House Supervisor, Director, VP of Nursing
- Employee Accident (Workers’ Compensation) – Your Supervisor, House Supervisor, Director, Infection Control Nurse or Human Resources
- Visitor Accident – Your Supervisor, House Supervisor, Director & Human Resources
- Workplace Violence/Manpower Issue – Security (Dial 5911 and ask for security to be paged) and your most available Supervisor.

INCARCERATED PATIENTS

The Primary Caregiver of the unit housing the incarcerated patient is responsible for assuring that each police officer/guard receives orientation/education to emergency disaster codes used at Meadows Regional Medical Center. Information concerning appropriate interaction with incarcerated patients, response to unexpected or unusual clinical and safety events or incidents, the hospital channels of clinical, security, and administrative communications, as well as clinical versus administrative use of restraints will be provided to each forensic staff member. Forensic staff officer/guard will be asked to read the information in the packet and sign to validate this process. Documentation of such education and orientation will be placed in the patient’s medical record.
The Hazardous Materials and Waste Management Plan is a means for you to get information about hazardous chemicals in your workplace. It’s for your protection. These policies, inventories, and MSDS’s are in each department and available at all times.

Each department at MRMC has developed an inventory of substances that are considered hazardous by OSHA guidelines. These are updated annually or more often if the inventory changes.

Information regarding chemical hazards can be obtained 3 ways:

1. **Labels**
   - All hazardous chemicals must be labeled with the identity of the substance, name, and address of the manufacturer, and any warning either by picture or words.

2. **Safety Data Sheets (SDS)**
   - SDS’s give detailed information of a chemical
   - Includes identity of a chemical, emergency phone number, hazardous ingredients, exposure limits, physical, fire and explosion data, health hazards, reactivity data, spill/leak procedures, protective equipment, and special precautions.
   - Access to SDS online information is available on desktops in each department. User Name is MRMC1. Password is also MRMC1.

3. **Information and Training**
   - Your department has information about what is required. Please refer to MRMC’s safety program and other emergency / safety information located on the MRMC shared drive.

As a MRMC employee, I am competent in the following areas of the Hazardous Communication Program:

- Understand physical and health hazards of the products in work area
- Understand labeling, storage, disposal, and use of products in work area
- Understand methods that may be used to detect the presence of release of a hazardous product in my work area
- Understand appropriate work procedures to protect self from exposure to a hazardous product in my work area
- Understand emergency procedures to protect self from exposure to a hazardous product in my work area
- Understand location and use of personal protective equipment to protect self from exposure to a hazardous product in my work area
- Know location of Hazardous Communication Manual and SDS files within my work area
The purpose of the Fire Plan is to provide a Fire Safety Program, which will reduce risks to employees, patients, physicians, and visitors at MRMC. The fire plan provides the basis for the facility Fire Safety Program and applies to all employees of MRMC, Clinics, and all properties owned by the hospital. Please review your “red” safety manual for complete details.

Dial “5911” to report a fire.

If a fire occurs in your area, follow the RACE formula for your area to implement the “Code Red” procedures.

Your responsibilities during a fire are:
- Know the fire plan
- Know the location of the fire extinguishers and fire pull station
- Clear all corridors and exits from obstruction
- Prepare to evacuate patients if instructed by the Fire Marshall
- Do not use elevators during a fire

Extinguishing a Fire

Remember P.A.S.S.
- PULL the pin
- AIM nozzle at base of fire
- SQUEEZE the handle
- SWEEP nozzle side to side
● Elevators – Never use the elevators during a fire except at the direction of the Fire Department.

● Bedding or Mattress Fire – Consider this a large fire. Remove everyone from the room and close the door to contain the smoke. Douse the fire with water from a faucet; use a fire extinguisher or cover the fire with a wet towel or blanket. Do not remove the mattress from the room; it may re-ignite or even explode. Engineering will remove the mattress from the room directly to the outside of the building. All mattresses that have been exposed to fire damage, regardless of how small, must be removed from the building.

● Oxygen Involved Fire – Cut off supply of oxygen at individual unit. If tank is in the area of the fire, turn the off valve to position “OFF” and remove tank from area. If necessary, the oxygen to an area can be cut off at the zone valve upon approval of the Nursing Supervisor or Charge Nurse in that area. Oxygen may be shut off by the Nursing Supervisor, Charge Nurse, Safety Officer, or Firemen for the safety of patients, staff, and visitors.

● Fire Extinguishers – never put an extinguisher that has been used back in its storage space. Call the Engineering Department for immediate replacement.

● Hallway Carts – Carts on wheels can remain in the hallways only if they are in use. “In use” is defined as used within 30 minutes. It is the responsibility of the staff in the department to move carts out of the hallways if an evacuation is necessary.

● Sprinkler Systems – The fire alarm system is connected to water flow alarms of sprinkler systems. Areas should maintain 18 inches or more of open space below a sprinkler deflector to the top of storage.

● Evacuation – The order to evacuate is given by the Chief Executive Officer, the Safety Officer, Nursing Supervisor, or the Fire Department. The Facility Evacuation Plan, located in the Emergency Operations Plan, is followed in the event that this order is given. Whenever possible evacuate in a horizontal direction – try to go to a safe area on the same floor. Evacuation will be made at least beyond a fire barrier door. All exit and evacuation routes are listed in the Evacuation plan; however, individual areas throughout the facility will have the routes posted. All employees must know the nearest available route and alternative routes in the event of an emergency.
# MEADOWS HEALTH EVACUATION ROUTE

## FIRST FLOOR

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>PRIMARY EXIT ROUTE</th>
<th>ALTERNATE EXIT ROUTE</th>
<th>CONSOLIDATION POINT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>Admin Exit</td>
<td>QM Exit</td>
<td>Admin Parking Lot</td>
</tr>
<tr>
<td>Auxiliary</td>
<td>Front Lobby</td>
<td>Administration Exit</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Biomed</td>
<td>Loading Dock Exit</td>
<td>QM Exit</td>
<td>Loading Dock Lot</td>
</tr>
<tr>
<td>Cancer Center</td>
<td>QM Exit</td>
<td>Admin Exit</td>
<td>Admin Parking Lot</td>
</tr>
<tr>
<td>Cath Lab</td>
<td>Cath Lab Exit</td>
<td>Patient Discharge Exit</td>
<td>Patient Discharge Area</td>
</tr>
<tr>
<td>Central Sterile</td>
<td>Surgery Exit</td>
<td>Employee Entrance</td>
<td>Physicians' Parking Lot</td>
</tr>
<tr>
<td>Dietary</td>
<td>Loading Dock Exit</td>
<td>Front Lobby</td>
<td>Loading Dock Lot</td>
</tr>
<tr>
<td>Education</td>
<td>Admin Exit</td>
<td>Front Lobby</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Ambulance Entrance</td>
<td>ED Entrance</td>
<td>Ambulance Entrance</td>
</tr>
<tr>
<td>Engineering</td>
<td>Loading Dock Exit</td>
<td>QM Exit</td>
<td>Loading Dock Lot</td>
</tr>
<tr>
<td>Environmental Services</td>
<td>Loading Dock Exit</td>
<td>QM Exit</td>
<td>Loading Dock Lot</td>
</tr>
<tr>
<td>Health Information Mgt</td>
<td>Pt Discharge</td>
<td>Ambulance Entrance</td>
<td>Pt Discharge Area</td>
</tr>
<tr>
<td>Infection Control</td>
<td>Admin Exit</td>
<td>Front Lobby</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Information Services</td>
<td>QM Exit</td>
<td>Loading Dock</td>
<td>Admin Parking Lot</td>
</tr>
<tr>
<td>Infusion Department</td>
<td>ED Entrance</td>
<td>Ambulance Entrance</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Employee Entrance</td>
<td>Front Lobby</td>
<td>Physicians' Parking Lot</td>
</tr>
<tr>
<td>Materials Management</td>
<td>Loading Dock Exit</td>
<td>Employee Entrance</td>
<td>Loading Dock Lot</td>
</tr>
<tr>
<td>Medical Staff Services</td>
<td>QM Exit</td>
<td>Admin Exit</td>
<td>Admin Parking Lot</td>
</tr>
<tr>
<td>Nursing Supervisor</td>
<td>Front Lobby</td>
<td>East Stairwell</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Observation Unit</td>
<td>OB Exit North</td>
<td>Surgery exit North</td>
<td>Physicians Parking Lot</td>
</tr>
<tr>
<td>Obstetrics/Nursery</td>
<td>OB Entrance</td>
<td>OB North Exit</td>
<td>OB Parking Lot</td>
</tr>
<tr>
<td>Patient Care Services</td>
<td>QM Exit</td>
<td>Admin Exit</td>
<td>Admin Parking Lot</td>
</tr>
<tr>
<td>Quality Management</td>
<td>QM Exit</td>
<td>Admin Exit</td>
<td>Admin Parking Lot</td>
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<tr>
<td>Radiology</td>
<td>Radiology Exit by Cath Lab</td>
<td>ED Entrance</td>
<td>OB Parking Lot</td>
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<tr>
<td>Registration</td>
<td>South Exit</td>
<td>Front Lobby</td>
<td>Front Parking Lot</td>
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<tr>
<td>Security</td>
<td>Ambulance Entrance</td>
<td>ED Entrance</td>
<td>Ambulance Area</td>
</tr>
<tr>
<td>Surgery</td>
<td>Surgery North Exit</td>
<td>OB Entrance</td>
<td>Physicians' Parking Lot</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Admin Exit</td>
<td>QM Exit</td>
<td>Front Parking Lot</td>
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</table>

## SECOND FLOOR

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>PRIMARY EXIT ROUTE</th>
<th>ALTERNATE EXIT ROUTE</th>
<th>CONSOLIDATION POINT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiopulmonary</td>
<td>West Stairwell</td>
<td>Central Stairwell</td>
<td>Patient Discharge Exit</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>West Stairwell</td>
<td>Central Stairwell</td>
<td>Patient Discharge Exit</td>
</tr>
<tr>
<td>Medical/Surgical – East</td>
<td>East Stairwell</td>
<td>Central Stairwell</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Medical/Surgical - North</td>
<td>North Stairwell</td>
<td>Central Stairwell</td>
<td>Physicians' Parking Lot</td>
</tr>
<tr>
<td>Progressive Care Unit</td>
<td>South Stairwell</td>
<td>Central Stairwell</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>East Stairwell</td>
<td>Central Stairwell</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Central Stairwell</td>
<td>East Stairwell</td>
<td>Front Parking Lot</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Central Stairwell</td>
<td>East Stairwell</td>
<td>Front Parking Lot</td>
</tr>
</tbody>
</table>
Policy Excerpt:

I. MITIGATION

Mitigation activities are designed to lessen the severity and impact of a potential emergency or disaster. An emergency or disaster is considered to be any type of situation within the hospital or community resulting in injuries or illnesses which exceed the hospital's ability to render routine care to the victims involved. A situation will be termed a disaster if more than several physicians and paramedical personnel are needed to be called to supplement personnel on duty.

A. Hazard Vulnerability Analysis

A Hazard Vulnerability Analysis is conducted annually by the Safety Officer in cooperation with Emergency Management Officer, Region Emergency Coalition, local EMS and FEMA agencies, to determine the potential emergencies that could affect the hospital's services in the event of a disaster. Based on the analysis, the following priorities have been identified and addressed in the following plans:

1. Tornado/Hurricane/Severe Thunderstorm – Severe Weather Plan
2. Chemical or Radiation Accident - Decontamination Plan
3. Bomb Threat - Bomb Threat Plan
4. Infectious Patients - Influx of Infectious Patients Plan
5. Accident with Mass Casualties – Emergency Operations/Disaster Plan

II. Plans have been developed for external and internal disasters, including Emergency Operations Plan, Evacuation, Bomb Threat, Chemical or Radiation Contamination, and Severe Weather Plan. Specific procedures for each response are outlined in sections of this Emergency Operations Plan.
All personnel are expected to assist in a disaster. This may include the need for certain individuals to report to work in order to care for patients while others in the community leave the area in search of better or safer conditions. MRMC’s safety officer and administrative staff will monitor the safety of those reporting under these conditions.

Please make yourself familiar with the Emergency Operations Plan and your role before, during, and after a disaster.

EMERGENCY OPERATIONS/DISASTER PLAN: DECONTAMINATION PLAN

A. Introduction
Healthcare facilities must be able to care for victims of disaster situations that are immediately evident and not immediately evident. Transport and handling of hazardous chemicals increases the likelihood of an accident involving a hazardous chemical spill. If a radiation accident occurs, the staff must be prepared to handle the victims to properly treat victim injuries and to prevent exposure to the staff.

B. Chemical Contamination
In the ideal situation victims will already be properly decontaminated before they are brought to the Emergency Department and they will pose very little if any risk to staff or the facility. However, there are situations where a contaminated victim arrives at the Emergency Department before the decontamination process has been initiated or completed. This plan provides guidelines for the decontamination and care of the chemical accident victim.

C. Radiation Contamination
In any radiation contamination accident the first priority is to distance the victim from the source of contamination. The two major principles for the care of individuals in radiation accidents are: (1) preventing further exposure and (2) providing appropriate treatment as rapidly as possible. Many of the injuries associated with radiation contamination result from thermal exposure to the body. In many instances stabilization of a patient at the nearest healthcare facility and transfer to another facility capable of providing more extensive care for such injuries may be recommended.

D. Notification
1. In the event that the PBX Operator receives a call that a hazardous chemical accident or radiation accident has occurred, the call will be forwarded to the Emergency Department. The PBS Operator will immediately notify the Chief Executive Officer/designee and Nursing Administration that such a call has been received.

2. In the event that the Emergency Department receives a call or is notified by Toombs County Emergency Management that a chemical accident or radiation accident has occurred, the person receiving the call will notify the Chief Executive Officer/designee and Nursing Administration that an accident has occurred.

3. The Chief Executive Officer/designee will decide if a "Code Orange" will be initiated. If a "Code Orange" is called the facilities Phase Recall System will be initiated as described in the Emergency Operations Plan.

4. The following persons will also be notified, as appropriate to the spill:
   a. Hospital Safety Officer (chemical and radiation)
   b. Radiation Safety Officer (radiation)
   c. Medical Director of Radiology (radiation)

E. Pre-Hospital Triage Information
   The person in the Emergency Department receiving the call that a chemical accident or radiation accident has occurred shall obtain the following information from the caller:
   1. The number of victims involved in the accident;
   2. The medical status of each victim;
   3. The source of contamination/contaminant, if known;
   4. The estimated time of the first victims' arrival to the Emergency Department;
   5. If on-site decontamination has been performed or if the patient is being transported due to their critical status without decontamination; and, if on-site medical treatment has been initiated and if so what care has been rendered.

F. Decontamination Area
   1. The area designated for decontamination of chemically or radioactive contaminated victims will be at the EMS entrance to the Emergency Department. Incoming ambulance personnel will be instructed to remain with the patient inside their vehicle until they are notified that Emergency Department personnel are ready to begin the decontamination process.
   2. The decontamination area will be cordoned off and setup by Engineering personnel. Wash and rinse areas will be arranged so as to allow water to run/drain into the sewer system for chemical contamination or appropriate hazardous waste storage containers for radiation exposure.
   3. Decontaminated victims will enter the Emergency Department via the EMS entrance. Victims will be assigned to the appropriate Rooms. "Clean" hospital personnel, equipment, and all other Emergency Department patients will enter the department via the Ambulance entrance. Victims who have been decontaminated, treated, and are ready to be discharged will exit the department via the Ambulance entrance.

G. Preparation of the Decontamination Team
   1. Decontamination team members will remove all personal clothing items such as belts, wool clothing, jewelry, contact lens, etc, which cannot easily be decontaminated.
2. Decontamination team members will dress out in disposable gowns, plastic goggles and plain latex gloves to protect the staff.

3. For decontamination of a radiation accident victim, the decontamination team must wear dosimetry badges. The Radiation Officer/Director of Radiology/designee will monitor dosimetry badges during the decontamination. If members have high exposure, they will be replaced with other trained staff.

4. If large amounts of crumbling asbestos or hazardous dust are present, a paper surgical mask will be worn by members of the team.

5. If very concentrated acids, caustics or with sustained amounts of oily or lipid - soluble liquids (e.g. pesticides), disposable coveralls and un-milled gloves will be worn by members of the team.

6. The Decontamination Team will consist of:
   a. Emergency Department Staff
   b. Engineering Personnel
   c. Safety Officer/Designee
   d. Radiation Safety Officer
   e. Selected trained staff

H. Decontamination of the Chemical Accident or Radiation Accident Victim

1. Upon arrival at the decontamination area a medical status report of each victim will be given to the Emergency Department physician by EMS personnel:
   a. If the contaminated victim’s condition is stable, decontamination will proceed in the decontamination area.
   b. If the contaminated victim's condition is unstable emergency care will be initiated and decontamination will proceed once the victim is stabilized.

2. Remove the contaminated victim's clothing and place in 55 gallon drums.

3. Decontamination will be accomplished by a thorough wash-down of the of the victims skin with large amounts of soap and water.
   a. For contamination of open wounds gentle scrubbing or irrigation of the wound with copious amounts of water will be done.
   b. Victims whose eyes are contaminated will have their eyes flushed with sterile saline for 15 - 30 minutes.
   c. Contaminated facial and nose hair and ear canals must be gently irrigated with normal saline, and frequently suctioned.
   d. Additional decontamination will be completed based on MSDS and poison control guidelines.
   e. If the contamination is for a radiation accident, the water must be collected in appropriate hazardous material storage containers.
   f. For radiation accidents, radiation dosimetry readings will be obtained after every wash-down with gamma meters.

4. Upon completion of the decontamination process victims are admitted to the Emergency Department.

5. In the event that the influx of patients is such that normal operations in the Emergency Department are interrupted, the Emergency Department Nurse Manager/designee and the
I. Decontamination of Hospital Staff
   Emergency Department staff and decontamination team attending to victims who were not decontaminated must consider themselves to be potentially contaminated. Decontamination procedure will be the same as for the contaminated accident victim.

J. Clean-Up
   Clean-up of the decontamination area will begin as soon as all victims and personnel have exited the area.
   1. Equipment used in the decontamination area will be washed and hosed down in the area, rinsed in clean area and allowed to air dry.
   2. Supplies (disposable) that have entered the decontamination area are to be considered contaminated and disposed of as hazardous waste.
   3. The ground surface area that compresses the decontamination area will be flushed with the large amounts of water to remove any remaining chemical residue and to ensure further dilution of contaminants within the sewage system.
   4. Water from radiation decontamination wash/rinse process will be drained into designated 55 gallon drums and disposed of as hazardous waste.
   5. For radiation accidents, the decontamination area and area in the Emergency Department where decontaminated victims were treated will be cleared by the Radiation Safety Officer/designee before normal traffic flow is resumed

K. Departmental Responsibility
   1. Engineering
      a. Engineering personnel will report to the designated decontamination area, cordon off the area and set up for the decontamination process.
      b. Engineering and/or Security will clear the area of all non-essential personnel and control staff and visitor traffic in the area.
      c. Engineering and/or Security will post at the Emergency entrance driveway to control and re-route traffic in this area as necessary.
      d. Engineering personnel will bring the designated 55 gallon drums to the decontamination area for the receipt of contaminated clothing and other belongings of victims and staff.

   2. Emergency Department Nursing Staff
      a. Emergency Department personnel will initiate the departmental plan for decontamination and care of the chemical or radiation accident victim.
      b. Personnel assigned to the Decontamination Team will wear appropriate attire.
      c. Personnel not assigned to the Decontamination Team will prepare to receive decontamination victims in the Emergency Department.
      d. The Emergency Department Nurse Manager/designee will contact the Regional Poison Control Center, or will use Micromedex Poisondex System or MSDS for current treatment/patient care information and to determine any hazards of secondary contamination. Section N contains a listing of chemicals that present high and low risk for secondary contamination.
e. Nursing Service personnel responding to the "Code Orange" will assume duties as assigned by the Emergency Department Nurse Manager/designee.

3. **Emergency Department Physicians**  
The Emergency Department Physician will not enter the decontamination area unless needed to attend a critically ill or injured patient. If needed, the physician will follow the same protocols for gowning and observe the same safety measures as other members of the decontamination team.

4. **Admitting/Data Processing**  
Personnel from Admitting/Data Processing will assume the same duties as those specified in the facilities Disaster Plan or "Code Blue" situations.

5. **Engineering Department**  
Engineering personnel shall ensure that all contaminated articles are bagged, labeled and disposed of in accordance with the facilities Hazardous Waste Management Plan.

L. **Safety Officer's Responsibility**  
1. The facility’s Safety Officer/designee will report to the Emergency Department.  
2. Assume responsibility for ensuring that the decontamination area has been set up and that staff members are following procedure for handling the decontamination process.  
3. Assure that contaminated articles are properly disposed of and that clean-up procedures are initiated as soon as the decontamination area is secured.

M. **Radiation Safety Officer's Responsibility**  
1. The facility's Radiation Safety Officer/designee will report to the Emergency Department.  
2. The Radiation Safety Officer/designee will assume responsibility for ensuring that the decontamination area has been appropriately set-up and that staff members are following appropriate procedure for handling the decontamination process.  
3. The Radiation Safety Officer/designee will ensure that hazardous waste from the decontamination process and other contaminated articles are disposed of appropriately and that clean-up procedures are initiated as soon as the decontamination area is secured.  
4. The Radiation Safety Officer will be responsible for ensuring that all contaminated areas have been "Cleared" with documented dosimetry readings within a normal range.

**Bomb Threat**

In the event of a bomb threat:
- Note the time of the call. The phone call may be the only contact with the caller and the only opportunity to obtain information. Attempt to keep the person talking. The more the caller communicates, the more information will be obtained. Document everything the caller states.
- Prolong the conversation as long as possible and listen for background noises and the caller’s voice.
- Ask? The time of the explosion.  
- Ask? The location of the bomb.  
- Ask? Why the bomb was placed.  
- Do not hang up the telephone. The line can possibly be traced.  
- Do not reveal information to guests, patients, or coworkers.  
- Using a different phone, notify the supervisor and security immediately.
Infant Abduction

The staff member discovering the occurrence will immediately dial 5911 and notify the operator to page “Code Pink.”

- Security personnel will coordinate a search of the entire facility
- Secure the exits
- Politely ask visitors and staff who are carrying bulky items to stop, so that those items may be searched.

Workplace Violence

The safety and security of Meadows Regional Medical Center, Inc.’s (MRMC) employees, customers, vendors, contractors and the general public are of vital importance. Therefore, acts or threats of violence made by an employee or guest will not be tolerated.

Healthcare workers face an increased chance of experiencing aggression in the workplace from patients and/or guests. Risk factors are elevated in hospital settings due to pain, devastating prognoses unfamiliar surroundings, mind and mood altering medications and drugs, and disease progression can also cause agitation and violent behaviors. The Environment of Care Committee is committed to preventing violence in the workplace and has will develop and maintain a program to perform hospital analysis, hazard prevention & control, safety training, recordkeeping, and periodic program evaluation.

All Team Members, management and employees, are responsible for reporting events or concerns to the Safety Officer & using de-escalation methods or "run, hide, fight" methods, when appropriate.
Workplace Violence Patient, Visitor or Other Person Aggression Procedure:

All Team Members, management and employees, are responsible for taking action and reporting acts of aggression or violence from a patient, visitor or other to an employee of our organization.

MRMC will not tolerate any of the following acts or threats of violence:

- Made by a patient, visitor or other person to Team Member threatening their life, health, well-being, family or property.
- Including, but not limited to, intimidation, harassment or coercion.
- That endangers the safety of our Team Member, other patient, vendors, contractors or the general public.
- Made directly or indirectly by words, gestures or symbols.
- Any use or possession of weapons, defined at the hospital's discretion, on premises or equipment.

Team Members who observe suspicious workplace behavior, threats or acts of violence, aggressive behavior, offensive acts or threatening comments, and the like, are required to immediately report such conduct to security personnel or any member of management.

Emergency Codes

To Report an Emergency Dial 5911

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL CLEAR</td>
<td>After normal operations have been restored the “All Clear” will be paged overhead three (3) times.</td>
</tr>
<tr>
<td>AMBER</td>
<td>Pediatric Abduction</td>
</tr>
<tr>
<td>BLACK</td>
<td>Bomb Threat</td>
</tr>
<tr>
<td>BLUE</td>
<td>Adult Cardiac Arrest</td>
</tr>
<tr>
<td>BLUE PEDIATRICS</td>
<td>Cardiac Arrest Pediatrics</td>
</tr>
<tr>
<td>GREEN</td>
<td>Neonatal Resuscitation</td>
</tr>
<tr>
<td>GREY</td>
<td>Security / Manpower</td>
</tr>
<tr>
<td>PINK</td>
<td>Infant Abduction</td>
</tr>
<tr>
<td>RED</td>
<td>Fire</td>
</tr>
<tr>
<td>Silver</td>
<td>Secure in Place (Shooter/Person with Weapon)</td>
</tr>
</tbody>
</table>
It is every employee’s responsibility to become familiar with all hospital-wide and department safety policies. Please review your “red” safety manual for complete details specific to your department.

Medical Equipment Plan

Having a medical equipment plan is essential in providing safe patient care as part of the hospital’s mission. Implementation of and adherence to this plan will help ensure a safe environment for both patients and employees who use or come in contact with any fixed or portable diagnostic, therapeutic, or monitoring equipment as well as all other fixed or portable electrical equipment.

All medical equipment will be assigned a category in the computer based on equipment function, risks, maintenance requirements, and equipment incident history. A current, accurate, unique inventory of all medical equipment will be maintained and will include all hospital owned equipment, contract, leased equipment, and physician-owned equipment. The Biomedical Engineer (or department designee) will be responsible for maintaining all hospital owned equipment and for oversight of maintenance of all contracts, leased and physician-owned equipment. Preventive maintenance will be performed on all medical equipment which complies with written equipment testing procedures and standards for all pieces of equipment, and which provides for testing of all equipment prior to use and at least annual retesting with proper and complete documentation.

Documentation of all equipment problems and failures, including user errors, that have or may have an adverse effect on patient safety and/or the quality of care by means of the Occurrence Reporting System and referring all such relevant information to the Safety Officer and Risk Manager for reporting to the Environment of Care...
Committee. User errors will be reported by Biomed based on departmental policies. A user error is determined if equipment fails while being operated and, after a functional test, is found to be functioning correctly.

**Tag-Out Procedure**
Establishes a control for the removal from service and the return to service of equipment, piping, circuits, and systems. This ensures safety of personnel working on or around such equipment.

**Responsibility of ALL Personnel:**
- Observe equipment or systems for the presence of “DANGER” tags and adhere to the requirements of this procedure.
- NO equipment or system is to be in operation if tagged with a “DANGER” tag.
- NO attempts to restart or re-energize machines of equipment that are tagged.
- When a “DANGER” tag is attached to machinery, equipment or a system, it is not to be removed and the machinery, equipment or system cannot be operated.
- All equipment that falls, is dropped, or has other cause for possible damage must be removed from service immediately and sent to Engineering for check out and/or repair.
It is the policy of this facility to reduce to a minimum the potential for injury to patients, visitors, and employees due to electric shock.

**Electrical Shock Prevention**
- All new equipment purchases by the hospital will be inspected for electrical hazards.
- All existing electrical equipment shall be tested for electrical safety.
- All hospital electrical receptacles shall be annually inspected for correct polarity, quality of grounding, and mechanical security.

**Electrical Safety Preparation**
- Personal equipment by patients, visitors, or employees is prohibited unless engineering has inspected such equipment.
- The use of extension cords will be limited to emergency situations and must be inspected by engineering.
- Only hospital-approved electrical equipment may be used in the hospital.
The management of utilities is an integral part of the hospital’s overall Environment of Care Program and is essential in providing quality and safe patient care as the hospital’s mission. The purpose and objectives of the Utility Systems Management Program are:

- Establishing, supporting, and maintaining a Utility Systems Management Program
- To manage the system in a manner that will provide the greatest measure of safety to patients and employees in order to reduce the risk of personal harm.

**This program applies to the following systems:**

- Electrical Power
- Medical Gases
- Vacuum
- Steam heat, ventilation, A/C
- Plumbing
- Alarm Systems
- Natural Gas
- Communications (nurse/emergency call, audible page, telephones, computers, etc.)

**Utility Management Program includes:**

- Promoting a safe, controlled, comfortable environment of care
- Reducing the potential for hospital acquired illnesses
- Assessing and minimizing risks of utility failures
- Ensuring operational reliability
- Establishing criteria for identifying, evaluating, and taking inventory
- Maintenance strategies
- Intervals and inspection/testing/maintaining critical components
- Report and investigate utility problems, failures, or user errors
- Emergency procedures
CONFIDENTIALITY

It is the policy of MRMC that all information related to the patient and patient record be kept in strictest confidence. Patients or patient information should not be discussed in any public areas such as the elevator, cafeteria, or hallway. Quality medical care is related to the patient’s freedom to disclose detailed personal information and the healthcare professionals pledge to protect it.

HIPAA Terminology:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains provisions to protect the confidentiality and security of personally identifiable information that arises in the course of providing health care. In order to understand how HIPAA affects healthcare, there are a few important terms that are defined by the law. A covered entity is the organization that has to comply with HIPAA. The HIPAA Privacy Rule governs Protected Health Information (PHI) which is defined as information that can be linked to a particular person (i.e., is person-identifiable) that arises in the course of providing a health care service. Confidentiality protections cover not just patient’s health-related information, such as the reason they are being treated, but also information such as address, age, Social Security number, and phone number.

- Patient Information should be available only to persons who have a need to know in order to care for the patient.
- If you receive any requests for patient information in person or by telephone from anyone not directly involved with the patient’s care, refer them to medical records.
- Unauthorized computer access to a patient’s record for any information unless you have authorized access is a breach of confidentiality.
- Any breach of confidentiality is considered a serious violation and disciplinary action may include, but is not limited to reprimand, suspension, and termination.
- Pictures may not be taken without the expressed written consent of all persons involved.
- MRMC respects the patient’s right, recognizing that each patient is an individual with unique health care needs. It is the hospital’s obligation and privilege to assist the patient in exercising their rights, and to inform them of any responsibilities they may have in exercising those rights.
- Employees are required to follow our HIPAA (Health Insurance Portability and Accountability Act) policy requirements as they relate to standards of privacy and information systems.
- Unauthorized access of any patient record or sharing of information from such record constitutes a breach of the confidentiality of the record, which may lead to sanction including, but not limited to, termination of employment.
- Employees should report breaches of confidentiality to their Department Directors.

Refer to MRMC policies/procedures for more information on HIPAA Privacy Responsibilities
It is the policy of Meadows Regional Medical Center to provide a mechanism for the possible identification and referral for treatment of a member of the Medical Staff or Allied Health Staff who is, or may be impaired.

**Impaired Practitioner** – One who is potentially unable to render patient care or practice in their specialty with reasonable skill and safety to patients because of impaired judgment due to physical or mental illness, including deterioration through the aging process, loss of motor skill, psychological dysfunction, or use or abuse of drugs or chemicals, including alcohol.

Signs of suspected impairment include, but are not limited to the following:

- Irritability, depression, mood swings
- Difficult to contact, won’t answer phone or return calls
- Missed appointments, unexplained absences
- Complaints by patients and staff
- Neglect of patients, incomplete charting, or neglect of other medical staff duties
- Inappropriate treatment or dangerous orders
- Excessive prescription writing; unusually high doses or wastage noted in drug logs
- Irresponsibility; poor memory; poor concentration
- Intoxication or odor of alcohol on breath while on duty
- Bloodshot or bleary eyes
- Trembling, slurred speech

*If any individual working in the Hospital has a reasonable suspicion that a practitioner appointed to the Medical Staff is impaired, steps should be taken to report concerns to the concerned individual’s immediate supervisor. The supervisor will then refer to the MRMC’s policy on Impaired Physician to confidentially report the issue.*
It is the policy of Meadows Regional Medical Center that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, the Board requires that all individuals, employees, physicians, and other independent practitioners conduct themselves in a professional and cooperative manner while in the Hospital or while involved in Hospital business.

If an employee fails to conduct him or herself in this manner, the matter shall be addressed in accordance with Human Resources policies. If a non-employed physician or other independent practitioner fails to conduct him or herself appropriately, the matter shall be addressed in accordance with MRMC’s policy regarding disruptive medical staff members. It is the intention of this Hospital that this policy be enforced in a firm, fair, and equitable manner.

The Board of Trustees through its assigned agents, officers, or medical staff leaders will deal with disruptive behavior by physicians and other independent practitioners. Egregious incidents such as sexual harassment, assault, felony convictions, fraudulent acts, stealing, throwing equipment(records, or inappropriate physical behavior may result in immediate termination of employment or medical staff membership.

Any physician, employee, patient, or visitor may report potentially disruptive conduct. The individual reporting such conduct need not be a party to the conduct but may be an observer of such conduct.

Disruptive Conduct may be reported as per hospital policy/protocol using the disruptive practitioner form found on the MRMC Intranet under Medical Staff Services.

The report shall be submitted to the Chief of Staff, relevant Department Chair, or a facility administrator and then forwarded to other appropriate individuals. Once received, the Department Chair in consultation with the Chief of Staff will investigate a report.
There are three goals to hospital infection control and prevention:

- Protect the patient
- Protect the healthcare workers, visitors, and others in the healthcare environment
- Accomplish the two previous goals in a cost effective manner whenever possible

Some of the benefits of infection control are:

- Decreased length of hospital stay
- Decreased costs for the hospital and patient
- Decreased liability, mortality and morbidity
- Decreased re-admissions, employee illness and risk of antibiotic resistant germs

Hand hygiene is one of the most significant infection control practices that will reduce the transmission of pathogenic organisms in a healthcare environment.

**Proper Hand washing Technique**

- Scrub both sides of the hands with soap and running water for 15-20 seconds
- To keep your hands clean, turn off the faucet with a paper towel
- Wash after using the toilet facilities
- Before and after patient contact if visibly soiled
- Before and after eating
- Suspected or confirmed C-Diff patient
- After wearing latex gloves

Use an alcohol based waterless product in cases other than those listed above.

**How to use an alcohol-based hand rub**

- Apply 1.5 to 3 ml (about the size of quarter) of an alcohol gel or rinse to the palm of one hand, and rub hands together.
- Cover all surfaces of the hands and fingers, including areas around/under fingernails.
- Continue rubbing hands together until alcohol dries (about 15-20 seconds).
- Make sure the hands are completely dry prior to putting on gloves.
- Wash hands with soap and water when you feel a build-up of emollients on your hands.
A blood borne pathogen exposure control plan is a document required by the Occupational Safety and Health Administration to provide guidelines for healthcare facilities to reduce significant risk of infection of employees exposed to infected body fluids or tissue from infected persons or animals. The rule addresses definitions, work practices, procedures, equipment and policies related to staff training, information dissemination, preventative and post-incident medical interventions. It also identifies healthcare workers at varying degrees of risk to insure that they receive appropriate training, protective equipment, vaccination, and that existing Body Substance Isolation standards are utilized to reduce the risk of infection by blood borne pathogens.

**Employee / Volunteer Responsibilities**

- You are responsible for reading the blood borne pathogen exposure control plan located on each unit / department
- You are responsible for wearing the appropriate Personal Protective Equipment (PPE) when you have any anticipation of contact with blood or body fluids
- You are responsible for reporting work related injury or exposure to your manager
- If you are exposed to blood or body fluids, seek treatment immediately
- Hepatitis B Vaccine is offered to any employee with a likelihood of occupational exposure to blood or body fluids
- Needle boxes must be changed when they are 2/3 full

**Other Important Infection Control Procedures:**

- Wear gloves and other PPE to protect you from contact, splashes or exposure to any blood or body substances
- Place soiled linen in the proper bag. Never put linen on chairs or on the floor. Carry all soiled linen away from your body
- Handle clean linen with clean hands; do not carry next to your uniform or lay linen on soiled surfaces. Keep clean linen covered
- Only bloody or potentially infectious items should be placed in the Infectious Waste (red) bags.
- Dispose of sharps directly into sharps containers. Never recap sharps
- Keep food preparation areas clean. Store staff foods/drink in a separate refrigerator from patient nourishments.
- Patients and their families should be educated about infection control. Emphasize hand washing and barrier precautions.
CONTACT PRECAUTIONS
(in addition to Standard Precautions)

VISITORS: Report to nurse before entering.

Gloves
Don gloves upon entry into the room or cubicle. Wear gloves whenever touching the patient’s intact skin or surfaces and articles in close proximity to the patient. Remove gloves before leaving patient room.

Hand Hygiene
Hand Hygiene according to Standard Precautions.

Gowns
Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient-care environment.

Patient Transport
Limit transport of patients to medically necessary purposes. Ensure that infected or colonized areas of the patient’s body are contained and covered. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport destination.

Patient-Care Equipment
Use disposable noncritical patient-care equipment or implement patient-dedicated use of such equipment.
**VISITORS:** Report to nurse before entering.

Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets generated by a patient who is coughing, sneezing or talking.

**Personal Protective Equipment (PPE)**
*Don mask* upon entry into the patient room or cubicle.

**Hand Hygiene**
*Hand Hygiene* according to Standard Precautions.

**Patient Placement**
*Private room*, if possible. Cohort or maintain spatial separation of 3 feet from other patients or visitors if private room is not available.

**Patient Transport**
*Limit transport* to medically necessary purposes.

If transport or movement in any healthcare setting is necessary, instruct patient to *wear a mask* and follow Respiratory Hygiene/Cough Etiquette.

No mask is required for persons transporting patients on Droplet Precautions.
**VISITORS:** Report to nurse before entering.

Use Airborne Precautions as recommended for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route.

**Patient Placement**
- **Place** in an **AILR (Airborne Infection Isolation Room).**
- **Monitor air pressure** daily with visual indicators.
- **Keep door closed** when not required for entry and exit.

In ambulatory settings instruct patients with a known or suspected airborne infection to wear a surgical mask and observe Respiratory Hygiene/Cough Etiquette. Once in an AILR, the mask may be removed.

**Patient Transport**
- **Limit transport** to **medically necessary purposes.**

If transport outside an AILR is necessary, instruct patients to **wear a surgical mask,** and observe Respiratory Hygiene/Cough Etiquette.

**Hand Hygiene**
- **Hand Hygiene** according to Standard Precautions.

**Personal Protective Equipment (PPE)**
- Wear a fit-tested, NIOSH-approved N95 or higher level respirator for respiratory protection when entering the room of a patient when listed diseases are suspected or confirmed.
Information users are individuals who have been granted explicit authorization to access, modify, delete, and/or utilize protected health information. Users will use the protected health information only for the purposes specifically approved by their job description. Users will also comply with all security measures as defined by MRMC’s Security Officer and/or IS Director. Users will additionally refrain from disclosing any protected health information in their possession (unless authorized). Users will also report to the Security Officer and/or IS Director all situations where they believe information security vulnerability or violation may exist. All users, including management, will receive periodic security awareness training and security updates.

**Use of Systems**
Management reserves the right to revoke the privileges of any user at any time. Conduct that interferes with the normal and proper operation of information systems, which adversely affects the ability of others to use these information systems, or which is harmful or offensive to others will not be permitted.

**Privacy**
Unless contractual agreements dictate otherwise, data sent over the organization’s computer and communications systems are the property of the organization. To properly protect and manage this property, management reserves the right to examine all data stored in or transmitted by these systems. Users should have no expectation of privacy associated with the information they store in or sent through the systems.

**Passwords**
Passwords will never be shared or revealed to anyone else besides the authorized user. All passwords will be promptly changed if they are suspected of being disclosed, or are known to have been disclosed to unauthorized parties. Users will not write their passwords down unless they have effectively concealed or physically secured such password. Passwords should never be disclosed, especially via email or over the phone. To do so exposes the authorized user to responsibility for actions that the other party takes with the password.

Users are responsible for all activity performed with their personal user-IDs. User-IDs will not be utilized by anyone but the individuals to whom they have been issued. Users will not allow others to perform any activity with their user-Ids. Similarly, users are forbidden from performing any activity with IDs belonging to other users.

*Please refer to MRMC’s Information Services Security Policy for more information regarding information systems.*
RISK MANAGEMENT

Risk Management is the process of identifying and treating any risk, which may result in a lawsuit. The goal of Risk Management is to protect the patient, staff or volunteer and/or the institution both physically and financially. You have a responsibility to report any incident, which may have caused or can potentially cause harm to a patient or visitor.

MRMC is now utilizing online occurrence reporting. There are three ways to access this form.

1. Through the Google Intranet Site
2. Through MIDAS + Launch Screen
3. Through Remote Data Entry in the Midas + icon

(Please contact Jill Williams at extension 5584 or via email at jewilliams@meadowsregional.org with questions regarding accessing this online form)

Occurrence Reporting:

● Occurrence- potentially significant incident or event which is inconsistent with the normal or expected operation of the hospital.

Patient Occurrence:

● The nursing or patient care area usually documents a patient occurrence. Only document what you see and any preventive measures. Do not document in the record that an occurrence report was completed.

Visitor Occurrence:

● Get the name, address and phone number.
● Notify your supervisor.
● Offer to take the visitor to the Emergency Department. If they choose to go, escort them and explain what you saw to the staff.
● Complete an occurrence report utilizing the online occurrence reporting system.

Employee Work Related Incidents (Accident, Injury, Illness or Near Miss) :

● Employee work related incidents are reported through Human Resources by completion of the HR Workers Comp Reporting Packet.
● Employees are required to notify their supervisor, immediately.
● Certain types of accidents (contaminated needle sticks or body fluid exposure) require URGENT notification and additional steps.
● See Work Related Incidents...Page ___ and contact Human Resources 912-277-2170 with questions.

What should be reported?

● Environmental problems
● Patient / visitor falls
● Equipment failure
● Lost and damaged articles
● Report to risk management in writing, using an occurrence report form within 24 hours of an occurrence.
Meadows Regional Medical Center believes that one of our most important goals is to provide a safe workplace. From time to time, we realize that accidents may take place. Our organization is self-insured for work related injuries and participates in the Georgia Self-Insurers Guaranty Trust. With that in mind, it is every team member’s responsibility to report accidents, injuries, work caused illness or near misses, immediately to their supervisor.

- Notify your supervisor an incident took place, immediately. Supervisors may be a lead tech, charge nurse, supervisor, house supervisor or director. Any one of these individuals can assist you.
- There are two types of accidents: 1) slips, falls, strains, bumps, bruises, breaks, contusions, lacerations or burns; 2) Special URGENT accidents defined as contaminated needle sticks or body fluid exposure. These require immediate action to test the source patient. You should report to your supervisor AND call the House Supervisor for guidance.
- Report the incident to HR by completion of our HR Workers Comp Reporting Packet. All Human Resources forms are located on the MRMC Connect Intranet site. Select Employee HR Tools from the Directory Listing; Go to Employee Forms & Benefits and select the Packet appropriate for your site location Example: HR1-Workers Comp Reporting Packet – Vidalia GA (would be appropriate if you work in Vidalia)
- When in doubt, see your supervisor or contact Human Resources 912-277-2170.
WORK RELATED INJURIES & ACCIDENTS

REPORTING REQUIREMENTS - PAGE 2

STEP 1: Report Injury
STEP 2: Complete the HR Workers Comp Reporting Packet
STEP 3: Get Packet by going to the MRMC Connect
Site and select Employee HR Tools

STEP 4: Go to Employee Forms and Benefits
STEP 5: Select the packet for your location and print
Our organization believes that team members should feel comfortable in having open discussion with their respective supervisor regarding employee concerns. We encourage you to speak with your direct supervisor and attempt to resolve any issues that might arise.

Please be advised that if you are unable to resolve the issue or you do not feel it is appropriate to approach your direct supervisor, there are other options:
Patients have the right to:

- Expect a response to any reasonable request.
- Considerate and respectful care.
- End-of-life comfort and dignity.
- Effective pain management and to be informed about pain and pain relief measures.
- Acknowledgment of psychosocial and spiritual concerns regarding death and dying.
- Refuse treatment (to the extent permitted by law).
- Receive information about treatment and illness.
- The name of their primary doctor and others involved in their care.
- Sufficient information needed to make an informed consent.
- Voice concerns and be informed of the mechanism for the review and resolution of concerns regarding quality of care.
- There are 4 different methods to place a complaint to DNV GL Healthcare:
  - Toll Free: 866-496-9647
  - Mailing Address: 400 Techno Center Dr.
    Suite 100
    Milford, OH 45150
    Attn: Complaints
  - Website: www.dnvglhealthcare.com
    "Hospital Complaint" link on right side
  - Email: hospitalcomplaint@dnvgl.com
- Complain to CMS if the hospital cannot resolve their issue by contacting the state agency at 404-657-5726 or Office of Regulatory Services Healthcare Section, 2 Peachtree St., NE, 33rd Floor, Atlanta, GA 30303 or the Joint Commission’s Office of Quality at 1-800-994-6610 or emailing complaint@www.jointcommission.org.
- Participate in the consideration of ethical issues.
- Privacy and confidential treatment. Some ways to protect patient privacy are to close patient doors, knock before entering a patient room, and use curtains to shield patients during treatment.
- Access personal medical record.
- Leave the hospital, even against the advice of the physician.
- Adequate discharge instructions.
- Their bill and to receive an itemized list of charges.

Patients have a responsibility to:

- Provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to their health. They must report unexpected changes in their condition to the responsible practitioner. They must report whether they clearly understand a contemplated course of action, and what is expected of them.
- Follow the treatment plans recommended by their physician and other healthcare workers.
- Follow hospital rules and regulations affecting their care and conduct.
- Consider the rights of other patients and hospital personnel, and for assisting in control of noise and the number of visitors. They must respect the property of other persons and of the hospital.
- Ask/discuss what to expect regarding pain and pain management. Patients should ask for pain relief when pain first begins and should help staff members with assessing their pain and pain relief.

Note: PATIENT also refers to the patient’s legal representative/durable power of attorney for healthcare.
Meadows Health believes that it has a responsibility to assure that all complaints regarding hospital services are investigated and addressed in a timely manner. Patients and/or patient’s families are assured that generating a complaint/ grievance in no way compromises care neither rendered nor limits access to care at our hospital at any time.

**What is a patient complaint?**
A patient complaint is an allegation or source of an allegation or source of dissatisfaction expressed verbally by a patient; family member, guardian, or representative about care and/or services provided by MRMC’s staff and/or health care providers, and resolution is provided on the spot by staff present.

**What is a patient grievance?**
A patient grievance is a formal or informal written or verbal complaint that is made to the hospital by the patient or the patient’s representative, when a patient issue cannot be resolved promptly by hospital staff directly involved in the situation. If a complaint cannot be resolved promptly by staff present or is referred to hospital management it is considered a grievance.

Also, whenever the patient or the patient’s representative request their complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital, then the complaint is a grievance and enters the grievance process.

At the time of admission “The Patient Information Guide” and the list of Patient Rights and Responsibilities are available to the patient and their family. The guide is located in the patient’s room. The guide informs the patient of their right to share comments about their care. Patients are encouraged to express their concerns to those directly involved in their care, or to those individuals directly involved in the particular situation first where the complaint is reviewed and usually resolved with no intervention by any other party. If, however, the complaint cannot be resolved by those directly involved, the patient admission guide informs the patient that he/she may contact the Department Director, Nursing Supervisor, or Patient Relations Coordinator to file a complaint/grievance then proceed to higher channels. Patient satisfaction surveys are also used by the facility to inquire about healthcare and service received during the hospital stay.
All patient grievances written or verbal (including telephone grievances), regardless of the point of origin, are recorded on a Patient Complaint/Grievance Form (#1518) by the person receiving the grievance then forwarded immediately to the Patient Relations Coordinator and the appropriate department. The patient is then immediately contacted, if possible, to acknowledge the receipt of the grievance. The Patient Relations Coordinator will then review each grievance and ensure the appropriate department initiates the investigation. She will ensure written response to the patient is within seven business days.

**The patient may submit a written grievance to:**
- Chief Executive Officer
- Meadows Regional Medical Center
- P.O. Box 1048
- Vidalia, GA 30474

The patient is also informed that he/she may lodge a grievance with the Georgia Department of Human Resources, Office of Regulatory Services, regardless of whether he/she has first used the hospital’s grievance process. Address and phone number will be given to the patient upon request.

Patient grievance investigation files are confidential, and the files and the information they contain are available only to those persons appropriately involved in the investigation and/or resolution of a grievance. The grievance is analyzed and investigated and appropriate action taken which may include but not be limited to review of departmental operating systems, employee counseling, education, etc. Grievances will be directed to the department that handles the subject of the complaint (ie. Quality of care issues or premature discharge concerns will be managed through the hospital’s Utilization Management, Performance Improvement Process, and/or Medical Staff Peer Review. Any patient alleging substandard care and/or inaccurate diagnosis, which could result in a potential claim, will be reported to Risk Management.) Results of trends from grievance investigations will be incorporated into the hospital’s Performance Improvement activities as indicated by the Quality Council.
VISITATION POLICY

It is the policy of Meadows Regional Medical Center to allow equal visitation rights for hospitalized patients to provide emotional support to the patient during their hospital stay. Regulation of visitors is dependent on the patient acuity, infection control, procedures that are performed, the desire of the patient to have visitors, and the hospitals justified clinical restrictions.

The hospital will allow a family member, friend, or other individuals of the patient’s choice to be present with the patient for emotional support during the course of stay unless it infringes on others rights, safety, or is medically or therapeutically contraindicated. This individual may or may not be the patient’s surrogate decision-maker or legally authorized representative.

PURPOSE:
1. To allow a family member, friend, or other individuals of the patient’s choice to be present with them during their hospital stay to provide emotional support and alleviate anxiety.
2. To allow visitors to visit the patient in order to support patient care.
3. To control the spread of infection.
4. To maintain the rights of all patients to privacy.

A patient may verbally designate a Support Person to exercise the patient’s visitation rights on his or her behalf, should the patient be unable to do so. A support person is a family member, friend, or other individual who is at the hospital to support the patient during the course of the patient’s stay at the hospital and may exercise the patient’s visitation rights on the patient’s behalf if the patient is unable to do so. Such an individual may, but not need be, an individual legally responsible for making medical decisions on the patient’s behalf.
Performance Improvement Model

A process that helps you see what can be improved and how.

MRMC’s PI Model: P D M A I

- P  Plan
- D  Design
- M  Measure
- A  Aggregate/Analyze
- I  Improve

Failure Mode and Effect Analysis (FMEA)

FMEA is a systemic method for identifying and preventing product and process problems before they occur. FMEA is aimed at prevention of failure.

- F  Failure
- M  Mode
- E  Effect
- A  Analysis

Utilizing inter-disciplinary interviews, determining the true cause of an event. Usually the “root cause” of an error is process related and not people related.
An unexpected death or occurrence that results in permanent loss of a limb or function, suicide, infant abduction or discharge to the wrong family, rape, hemolytic transfusion reactions, and surgery on the wrong patient or body part. Sentinel events should be reported immediately to the nursing supervisor/department director and an occurrence form needs to be completed. Sentinel event alerts are listed on the Joint Commission web site, www.jointcommission.org.

An unexpected occurrence in which there was no adverse outcome to the patient, but had the potential to cause harm. An example could be a wrong dose of medication drawn up but not given to the patient or given with no harm to the patient.

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

- Death
- Permanent harm
- Severe temporary harm

An adverse event is a patient safety event that resulted in harm to a patient.

A NO HARM event is a patient safety event that reaches the patient but does not cause harm.

A CLOSE CALL (also referred to as “near miss” or “good catch”) is a patient safety event that did not reach the patient.

A hazardous (or “unsafe”) condition(s) is a circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event.
Any patient can have an accident, but some are more likely to fall than others.

Risk Factors for Patient Falls may include the following:

- Age
- Mental Status
- Elimination Needs
- History of Falls
- Mobility
- Communication Deficits
- Visual Impairments
- Medication

Some measures will help to provide a safe environment for these patients.

- Placing a yellow prompter outside of the patient’s room for identification purposes
- Placing a yellow armband on the arm of the patient
- Documenting information on the care plan of the patient and reporting this information to oncoming nursing staff
- Indicating fall risk on the whiteboard in the patient’s room
- Applying yellow gripper socks
- Completing routine checks on the patient with the offer of bathroom assistance and water at least every two hours
- Clearing room of unsafe furniture
- Keeping the bed in the low position.
- Keeping the bed brakes locked.
- Assuring that the bed alarm is utilized and appropriate setting is documented for high risk patients
- Leaving the bathroom light on at night or times of low light.
- Assuring that the patient can reach the Nurse Call button.
- Placing patient articles (i.e. water, telephone, urinal, assistive devices, etc.) in easy reach.
- Leaving patient room door open.
- Clean up spills immediately
RESTRAINTS

The staff of Meadows Regional Medical Center recognizes that the patient has the right to expect continuity of care throughout the facility. The use of restraints is discouraged and restraints are utilized only as a last resort after assessment of the patient when it is necessary to protect the patient from harm to self or to others or to prevent significant, continued disruption of the therapeutic environment.

Restraints are used only when non-physical interventions are ineffective or not viable and there is imminent risk of the patient harming himself/staff/others. Restraint use is based on the assessed needs of the patient in the immediate care environment and not the interaction of the patient with the staff and other patients. Use of restraints is NOT based on prior history of substance use or history of dangerous behavior. Restraints are NOT used as a means of punishment, staff convenience, or as a substitute for supervision of the patient.

Definitions:
Restraint: Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition. (Examples include: vest restraint, wrist and ankle restraint, including physical force when indicated for behavioral health purposes.) This is done with or without the patient’s permission. Physical force may be human/mechanical device/or a combination of the two.

- Medical Restraints: Application of restraints when the primary reason for use directly supports medical healing. Example: A patient diagnosed with Alzheimer’s repeatedly attempts to remove an IV.
- Behavioral Restraints (Violent or Destructive Behavior): Application of physical force to a patient (by human, mechanical devices, or both) in an emergency situation when there is imminent risk of the patient physically harming him/her or others, or staff due to an emotional or behavioral disorder. Example: An inebriated patient presents in the emergency department displaying combative behavior.

Alternatives to restraints must be attempted and documented as failed prior to the initiation of restraints. Examples of alternatives include:
- Ask family to stay with the patient
- Move to room closer to nurse
- Leave door open
- Change in surroundings
- Provide reality orientation/diversion activity

Refer to Policy Stat for all policies and procedures. The Restraints Policy can be found under patient care services policies and procedures.
Teamwork: Customer Relationships
- Recognize your customers; our patients, physicians, volunteers, family members, co-workers, and vendors
- Anticipate needs by asking customers, “How can I help?”
- Communicate delays rather than waiting for patients/family to ask
- When customers ask for directions, personally escort whenever possible
- Be sensitive to customer’s physical, social, and cultural needs
- If unable to resolve customer’s issues, refer to appropriate supervisor

Teamwork: Accountability and Commitment to Co-Workers
- Be on time to your workstation and meetings
- Assist co-workers in completing assignments when help is needed
- Refrain from unnecessary call-ins. Your co-workers deserve and expect your attendance when assigned to a shift.

Teamwork: Sense of Ownership
- Take care of your facility; do your part to maintain an exceptional workplace where you are proud to bring your loved one for care.
- Keep your work area and surrounding environment clean and safe; pick up litter and return equipment to its proper place
- On and off the job, this is YOUR hospital, project a positive image

Teamwork: General Considerations
- Completing your job affects patient care and others completing their job
- Be committed to form a partnership with your co-workers
- Display supportive, professional behaviors; demonstrate a willingness to achieve the overall goals of your unit, department, and hospital.
- Communicate necessary information in a timely manner
- Welcome new employees – make them feel part of the team
- Share your knowledge and skills with new co-workers
- Be supportive, be encouraging, and compliment each other
- Remember the Golden Rule:
CONTROLLED SUBSTANCE IN THE WORKPLACE

1. The unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the workplace.

2. It is forbidden to use or possess alcohol or illegal drugs at anytime during the workday or anywhere on Meadows Regional Medical Center premises. Persons using MRMC as a student or contract worker are also forbidden to engage in the sale, or other transaction involving illegal drugs on the premises. All persons must not be under the influence of alcohol or drugs while at MRMC. Disciplinary action appropriate to the violation will be handled on a case-by-case basis. This action may include termination of the relationship with the individual.

3. Any questions related to this policy should be directed to Human Resources.

Situations may arise in which the prescribed treatment or care for a patient may be in conflict with the ethical or cultural values or religious beliefs of a staff member. In such situations, it is the responsibility of the employee to immediately notify his/her supervisor or department manager of his/her concerns and to request that he/she be excused from participating in a particular aspect of treatment or care of the patient. Specific aspects of care that could cause potential conflict include, but are not limited to, the following:

- Blood/blood component administration
- Termination of viable pregnancy
- Reproductive sterilization procedures
- Initiation and/or cessation of life support
- Organ harvesting procedures

The employee must present the request in writing and must include the specific aspects of care from which he/she is requesting to be excused and the reasons for making the request.

The supervisor or department manager will then make a decision on the request. The requesting employee is responsible for providing appropriate patient care until alternate arrangements can be made. Refusal to provide care will result in disciplinary action up to and including termination. In no circumstances will a request be granted if it is felt that so doing would negatively affect the care of the patient. In no circumstances will the care or treatment of the patient be compromised.

*Please refer to MRMC’s Administrative Policy: Ethical Issue Resolution for more information regarding staff rights.*
The Employee Health Program provides appropriate health services to this facility's associates in order to ensure and protect their health and the health of their contacts.

The Employee Health Program services include the following:

1. Certain immunizations:
   a. Influenza immunization
   b. Hepatitis B immunization, if indicated and desired

2. Certain treatments:
   a. Anti-viral therapy for exposures to:
      1) HIV
      2) Hepatitis B
   b. Anti-bacterial therapy for exposures to:
      1) Meningococcal disease
      2) Syphilis
      3) Tuberculosis
      4) Other infectious diseases, as indicated

3. Annually, employees are required to submit to health evaluations. Evaluations will include, but are not limited to, the submission to Tuberculosis Test.

Refer to Employee Health Policies and Procedures for more services provided by MRMC’s Employee Health Department.
Sharps Injuries and Body Fluid Exposures

Immediate Care following a Contaminated Sharps Injury or Body Fluid Exposure:

1. Don’t Panic!
2. Immediately wash the exposure site with soap and water.
   - Do NOT use strong solutions (bleach, iodine) to exposed areas.
3. Let area bleed freely for a few seconds – do NOT squeeze or rub injury site.
4. Exposure to EYES:
   - Irrigate gently and thoroughly with water or normal saline (30 seconds). While irrigating pull the eye lid up and down.
   - If you wear contact lenses, keep them in while you irrigate the eye. Then you may remove the contacts.
5. Exposure to MOUTH:
   - Spit the blood or body fluid out.
   - Rinse the mouth several times with water, spitting out after each rinse.
6. Notify the Charge Nurse in the department where the exposure occurred immediately.
7. Charge nurse will immediately notify the Nursing Supervisor @ ext. #6900 and ensure immediate care was followed appropriately.

Keep in mind, time is of importance!
(2-3 hour Window)
Clock starts at time of exposure and ends once medications are taken (if required).
VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant):
What you need to know

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May. Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:
- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year thousands of people in the United States die from flu, and many more are hospitalized.

Flu vaccine can:
- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. They cannot cause the flu.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn’t exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:
- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- If you have any severe, life-threatening allergies.

If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.

- If you ever had Guillain-Barré Syndrome (also called GBS).

Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.

- If you are not feeling well.

It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.
4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:
- soreness, redness, or swelling where the shot was given
- hoarseness
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:
- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 in 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting a flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:
- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

5 What if there is a serious reaction?

What should I look for?
- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?
- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967. VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?
- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC’s website at www.cdc.gov/vaccines

Vaccine Information Statement
Inactivated Influenza Vaccine

Office Use Only

08/07/2015
42 U.S.C. § 300aa-26
INFLUENZA (FLU) Flu and You

Influenza (Flu)

What is the flu?
The flu is an illness caused by flu viruses. The flu may make people cough and have a sore throat and fever. They may also have a runny or stuffy nose, feel tired, have body aches, or show other signs they are not well. The flu happens every year and is more common in the fall and winter in the U.S. People of all ages can get the flu, from babies and young adults, to the elderly.

Flu in People

Do people in the U.S. get the flu?
Yes. Flu viruses spread worldwide. Flu tends to occur mostly in the fall and winter months in the United States. Many people get the flu each year. The flu is also found in other parts of the world. But the time of year when flu is most common can vary from one area to another.

How does the flu spread?
People who have the flu can spread the virus by coughing or sneezing. Droplets released when a sick person coughs, sneezes, or talks can land in the mouths or noses of people who are nearby. The droplets can also be inhaled into the lungs.

People may also catch the flu by touching their mouth or nose after touching something with the virus on it, such as doorknobs, tables, or an infected person's dirty hand.

Spread of the virus:

CDC U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
How do you know if you have the flu?

Signs of the flu can include:

- Fever
- Cough
- Sore throat
- Runny or stuffy nose
- Feeling weak or more tired than usual
- Headache
- Chills
- Body aches

Two less common signs of the flu include:

- Vomiting
- Diarrhea

Not everyone who is sick with flu will have all the signs of the flu at the same time. Some people with the flu don’t have a fever. Most people who get the flu get better without seeing a doctor or taking medicine.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
INFLUENZA (FLU) Flu and You

How sick do people get with the flu?

Some people get very sick and others do not. Most people who get sick get better without seeing a doctor or taking medicine. However, some people can get very sick from the flu and can die. Many of the people who get very sick are older than 65 years or have a medical condition such as: diabetes, heart disease, asthma, or kidney disease, or are pregnant. Children younger than 5 years of age are also at greater risk.

How long can a person with the flu spread the virus to other people?

Most people may be able to spread the flu from 1 day before showing symptoms to 5 to 7 days after symptoms begin. Severely ill persons or young children may be able to spread the flu longer.

Prevention & Treatment

What can I do to protect myself from getting sick?

CDC recommends these steps to fight the flu:

- Vaccination
- Stay away from people who are sick.
- Wash your hands often with soap and warm water. If soap and water are not available, use an alcohol-based hand rub.
- Use medication the way your doctor recommends it.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
INFLUENZA (FLU)  Flu and You

Everyday health habits to protect your health and the health of others:

- Cover your nose and mouth with a tissue or your arm when you cough or sneeze. Throw the tissue in the trash after you use it.
- Wash your hands often with soap and water. If soap and water are not available, use an alcohol-based hand rub.
- Do not touch your eyes, nose or mouth because germs can spread this way.
- If you are sick with flu-like symptoms, stay home for at least 24 hours after your fever is gone.

*Your fever should be gone without using fever-reducing medicine. Staying at home means that you should not leave your house except to get medical care. Stay away from others as much as possible so you don’t make them sick.

During flu season, be prepared in case you get sick and need to stay home for a few days. Keep some over-the-counter medicines, alcohol-based hand rubs, tissues, and anything else you need so that you do not have to go out while you are sick. If you are really sick or have other medical conditions or concerns, call your doctor. Your doctor will let you know if you need a flu test, flu treatment, or other care.

If I have a family member at home who is sick with the flu, should I go to work?

People who are not sick but have a sick family member at home with the flu can go to work as usual. Take simple steps such as washing your hands often with soap and warm water. If you cannot find soap and water, use an alcohol-based hand rub. Take these steps to prevent getting the flu from a sick family member.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
INFLUENZA (FLU) Flu and You

What is the best way to wash my hands to avoid germs?

Washing your hands often will help protect you from germs. When you wash your hands:

- Use soap and warm water.
- Wash for 15 to 20 seconds.

When soap and water are not available, use an alcohol-based hand rub. If using a hand rub, rub your hands with the sanitizer until they are dry.

If you or someone you know gets sick and shows any of the following warning signs, get EMERGENCY medical care:

In children:

- Fast breathing or trouble breathing
- Bluish or gray skin color
- Not drinking enough fluids
- Serious or constant vomiting
- Not waking up or not interacting
- Being so irritable that the child does not want to be held
- Flu-like symptoms improve but then return with fever and worse cough

In infants:

You should also look for these warning signs: being unable to eat, having no tears when crying, and having far fewer wet diapers than normal.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
INFLUENZA (FLU) Flu and You

In adults:

- Hard time breathing or shortness of breath
- Pain or pressure in the chest or stomach
- Sudden dizziness
- Confusion
- Serious or constant vomiting
- Flu-like symptoms improve but then return with fever and worse cough

Are there medicines to treat the flu?

Yes. Prescription medicines called antiviral drugs can treat the flu. If you are sick, these drugs can make you feel better faster and make the flu feel milder. Most people who get sick get better without the need for these medicines. But, if you need help getting well, your doctor may decide to give you antiviral drugs.

For more information call CDC info at 1-800-CDC-INFO (232-4636) or go to www.cdc.gov/flu.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
KNOW THE SIGNS OF A HEART ATTACK

Common Heart Attack Warning Signs

1. Pain or discomfort in chest
2. Lightheadedness, nausea, or vomiting
3. Jaw, neck or back pain
4. Discomfort or pain in arm or shoulder
5. Shortness of breath
BODY MECHANICS

Observe the principles of good body mechanics:
- Maintain good posture in all activities
- Pushing and pulling are preferable over lifting
- Push rather than pull

When lifting:
- Keep load close to your body and bend your knees
- Tighten your abdominal muscles when you lift
- Use arms and legs, rather than your back muscles to lift
- Maintain the natural curves of your spine
- Avoid twisting as you lift
- Get help if the load is too large or too heavy

When reaching
- Reach only as high as is comfortable
- Don’t stretch.
- Use a stool or ladder if necessary
- Don’t climb on furniture or boxes

When bending
- To bend safely, kneel down on one knee; bend at your hips.

When sitting
- Sit in a chair that allows both feet to be flat on the floor, maintain good posture, and if possible, use a lumbar support for your lower back.

When standing for long periods
- Balance your spine by placing one foot on a low stool
- Keep your knees slightly bent
- Keep your pelvis tilted forward
- Avoid slouching
Lifting Safety: Tips to Help Prevent Back Injuries

Have you checked the object before you try to lift it?
- Test every load before you lift by pushing the object lightly with your hands or feet to see how easily it moves. This tells you about how heavy it is.
- Remember, a small size does not always mean a light load.

Is the load you want to lift packed correctly?
- Make sure the weight is balanced and packed so it won't move around.
- Loose pieces inside a box can cause accidents if the box becomes unbalanced.

Is it easy to grip this load?
- Be sure you have a tight grip on the object before you lift it.
- Handles applied to the object may help you lift it safely.

Is it easy to reach this load?
- To avoid hurting your back, use a ladder when you're lifting something over your head.
- Get as close as you can to the load. Slide the load towards you if you can.
- Don't arch your back--avoid reaching out for an object.
- Do the work with your legs and your arms--not your back.

What's the best way to pick up an object?
- Use slow and smooth movements. Hurried, jerky movements can strain the muscles in your back.
- Keep your body facing the object while you lift it. Twisting while lifting can hurt your back.
- Keep the load close to your body. Having to reach out to lift and carry an object may hurt your back.
- "Lifting with your legs" should be done only when you can straddle the load. To lift with your legs, bend your knees, not your back, to pick up the load. Keep your back straight.
- Try to carry the load in the space between your shoulder and your waist. This puts less strain on your back muscles.

How can I avoid back injuries?
- Warm up. Stretch your legs and your back before lifting anything.
- Pace yourself. Take many small breaks between lifts if you are lifting a number of things.
- Don't overdo it--don't try to lift something too heavy for you. If you have to strain to carry the load, it's too heavy.
● Make sure you have enough room to lift safely. Clear a space around the object before lifting it.
● Look around before you lift, and look around as you carry. Make sure you can see where you are walking. Know where you are going to put down the load.
● Avoid walking on slippery, uneven surfaces while carrying something.
● Don't rely on a back belt to protect you. It hasn't been proven that back belts can protect you from back injury.
Selected personnel at Meadows Regional Medical Center may have duties that require them to work in the vicinity of radiation, radioactive materials, or taking care of patients that have undergone a radionuclide procedure. Our goal is to provide the appropriate training to enable all employees to perform duties without fear or risk of harm from various types of “radiation” found in the workplace.

- Located in the radiology department and operating room within the hospital, x-ray machines (Diagnostic or CT) and radioisotopes used in nuclear medicine produce ionizing radiation. In hospitals, these machines ONLY pose a risk of radiation exposure when they are being used to take an x-ray. If your job requires that you are around these machines during operation, the radiology technologist will give you notice when to leave the room, or they will provide proper shielding, such as a lead apron.

- In nuclear medicine, the potential of radiation exposure DOES NOT COME FROM MACHINES, but from RADIO NUCLIDES used for scanning different body systems. These radio nuclides or radioisotopes remain in a special area in nuclear medicine department until they are dispensed to the patient. Once the radionuclide enters the patient’s body, the patient becomes radioactive. The level of radioactive dose the patient receives is variable and should pose no or minimal threat to others in the hospital or the general public.

- In magnetic resonance imaging (MRI), a large magnet and radio waves are used to provide a noninvasive way to look at organs and structures inside the body. The MRI unit maintains its power strength and will always pull any magnetic object. The MRI magnet is ALWAYS ON. Metals that can be pulled towards the magnet may produce heat, may cause burns and can endanger a person. This heat is produced by the magnetic fields generated when the MRI scanner is running. This can create a hazard for anyone not familiar with the magnet environment. For safety purposes, entry into the MRI magnet room is prohibited unless an MRI technologist is present and you have been properly screened for metal, implants, and/or devices in or on your body that may become affected by the powerful magnet of the MRI system. This restriction applies to housekeeping and maintenance workers both during and after hours.
  - Examples of items restricted from the MRI system room include magnetic objects such as wheelchairs, stretchers, cell phones, beepers, scissors, pocket knives, paper clips, hair pins, and safety pins, as well as, implants/devices such as heart surgery pace makers and defibrillators, certain heart valves, aneurysm clips (but not coils) in the brain, deep brain stimulators and metal shavings in the eye sockets of welders or machine workers.
  - Although it is a myth that hip and knee replacements are not allowed in the MRI magnet room, these joint replacements are made of surgical steel or titanium and are not affected. Much information has been published regarding joint replacements and MRI safety. To enhance MRI safety, persons with surgically implanted items should have an “implant card” for their specific implanted item. This card should have the name of the implant, the manufacturer, and the model and serial number of the implant so that it can be researched for MRI compatibility.
The following material is to be reviewed by patient care providers only. All other employees may skip this portion to complete the mandatory testing required for this module.

ALL employees are required to complete the test at the end of this module.
An interdisciplinary team is composed of members from various practices that pool information to arrive at a consensus.

Effective patient care planning and education requires an interdisciplinary approach that accelerates collaborative practice and timely patient outcomes.

**Goals to Interdisciplinary Care Planning**
- Guide and support the patient’s ongoing interdisciplinary assessment, care, and education.
- Promote collaboration between and among staff in the integration of information to identify and appropriately prioritize patient care needs.
- Focus care on achievement of specific, defined outcomes.
- Facilitate seamless patient transition to the care level most appropriate for the individual’s needs.

**Components of the Plan of Care**
- **Assessment**
  - Patient DataBase
  - Interviewing, physical assessment, diagnostic studies, information from all clinical health care personnel
- **Problem / Need Identification**
  - Diagnosis
  - Collecting data, reviewing and analyzing data, synthesizing data
- **Planning (Goals and Actions / Interventions)**
  - Formulate goals / expected outcomes
- **Setting priorities**
  - Identify nursing interventions
  - Implementing Intervention
- **Evaluation**

**Collaborative / Interdisciplinary Approach**
- Interdisciplinary Team Dynamics
  - Types of Members
- Goals to Interdisciplinary Care Planning
  - Guide and support the patient’s ongoing interdisciplinary assessment, care, and education
  - Promote collaboration between and among staff in the integration of information to identify and appropriately prioritize patient care needs
  - Focus care on achievement of specific, defined outcomes
  - Facilitate seamless patient transition to the care level most appropriate for the individual’s needs.
I. Food and Drug Interactions
II. Sound-Alike, Look-Alike Medications
III. Medication Orders
IV. Adverse Drug Effects
V. Medication Occurrences
VI. Critical Tests & Critical Results Reporting

All medications are selected, procured, stored, ordered/prescribed, prepared/dispensed, administered, monitored, and documented in a safe and effective manner, at all times adhering to standards of care and standards of practice. Each patient care staff member monitors the effects of the medication, recognizing and taking appropriate action for adverse drug reactions, and medication occurrences.
POLICIES:
Patients will receive written instructions and verbal counseling on potential food-drug-herbal interactions during hospitalization and food-drug-herbal interaction education before discharge on drugs designated by the facility to have potential food-drug-herbal interactions.

PROCEDURES:

**Nutrition Care Committee/Pharmacy and Therapeutic Committee**
- Determines process for education of patients:
  - Designates interdisciplinary team members who educates patient.
  - Reviews and approves patient educational materials.
  - Reviews food, drug and herbal interaction program annually and revises the materials as needed.

**Dietitian, Pharmacist or Nurse**
- Counsels the patient and/or family on potential food-drug-herbal interactions and documents education in the medical record.
- For patients who are taking herbal supplements, notify the patient’s physician of this practice. From this information, the physician may order a consult on drug-herbal interaction as appropriate.
- For patients who bring herbal supplements into the hospital, notify the patient’s physician, nurse and pharmacist.
- For patients receiving Coumadin therapy, education includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions.

**Dietitian or Technician**
- Modifies patient meal pattern or diet as needed.
- Ensures that the patient menu follows recommendations for Vitamin K intake follows information outlined in the Morrison Manual of Clinical Nutrition Management 2013. These recommendations include serving no more than 1 serving of foods identified to contain high levels of vitamin K per day and no more than 3 servings of foods identified to contain moderate levels of vitamin K per day (Reference: National Health Institute: Warren Grant Magnuson Clinical Center).
- Ensure that patients receiving anticoagulant therapy receive no more than 1 cup of cranberry juice per day. (Reference: Zhaoping Li, Seeram NP, Carpenter CL, Thames G, Minutti C, Bowerman S. Cranberry does not affect prothrombin time in male subjects on warfarin. J Am Diet Assoc. 2006; 106:2057-2061).
Look-alike, sound-alike drugs or reagents/chemicals that may be mistaken for other medications are using labels, and/or separated as appropriate to avoid confusion and errors. Alternate brands may be purchased if available to reduce the risk of error. Look-alike, sound-alike charts (produced by USP) are posted in medication areas. Staff are educated about look-alike, sound-alike medications specific to their area using PYXIS and MAR comments and to risk reduction strategies taken to prevent errors such as separating medications in PYXIS.

**LOOK ALIKE SOUND ALIKE**

**Table I**

1. Adrenalin (epinephrine) and Ephedrine
2. Apresoline (hydralazine) and Vistaril (hydroxyzine)
3. Flagyl (metronidazole) and Glucophage (metformin)
4. Insulin products: Humulin and Humalog; Novolin and Novolog; Novolin and Novolog Mix

**Table II**

1. Avandia (rosiglitazone) and Coumadin (warfarin)
2. Catapres (clonidine) and Klonopin (clonazepam)
3. Celebrex (celecoxib) and Celexa (citalopram) and Cerebyx (fosphenytoin)
4. Dilaudid (hydromorphone) and Astramorph, Duramorph, Infurmorph (morphine)
5. Zyprexa (olanzapine) and Zyrtec (cetirizine)
6. Ativan (lorazepam) and Xanax (alprazolam)
7. Topamax (topiramate) and Toprol XL (metoprolol)

**Table III: Supplemental List**

1. Cardura and Coumadin
2. Effexor XR and Effexor
3. Mucinex and Mucomyst
4. Wellbutrin SR and Wellbutrin XL
It is the ordering physician’s responsibility to ensure that there is a documented diagnosis, condition, or indication for use for each medication ordered. This may be documented with the order, in the history and physical, in consultation reports, or progress notes, unless specifically required with the type of medication ordered.

All medications to be administered must be ordered by a physician or other appropriately privileged medical staff member. These orders will mostly occur through the electronic medical record. However, some instances require hand written orders. In these cases, orders should be written clearly in ink on the physician’s order sheet, must be legible. All orders must display only approved abbreviations. In the event an unapproved abbreviation is used, the order must be considered incomplete and nursing or pharmacy must contact the prescriber for clarification prior to processing the order(s). Orders must contain an appropriate signature prior to processing the order. Exception: See verbal orders and Code Blue orders.

Medication orders must be explicit. The Pharmacist or patient care professional must address any questions concerning a medication order, such as legibility, dosage, or interaction, to the physician who wrote the order. Should a question persist, the supervisor, or nursing manager(s) must also be notified.

A physician's order is necessary to initiate, discontinue or omit a drug. (For exception to this policy reference "Automatic Stop Orders")

Medication Orders:

- Orders for medication must include:
  - Patient's full name and location
  - Date ordered
  - Drug name (generic or Brand)
  - Dose
  - Method of administration
  - Frequency of administration
  - Signature of physician
  - Parameters for use (PRN medication)
  - Indications for use must be readily available in the medical record or written with the medication order as appropriate.
**Verbal/Telephone Orders:**

A licensed nurse may take orders for medications verbally or by telephone if a physician is unavailable to write the order and delay in initiating treatment/order would compromise the care of the patient. Verbal orders may be taken only from the physician or other appropriately credentialed staff member. However, verbal or telephone orders are discouraged and are to be minimized. Verbal orders should be reserved for those situations where orders are communicated during sterile procedures when the prescriber is scrubbed and during emergency or code situations. When taking a verbal order, the receiving clinician places or writes the order using the computerized physician order entry system or on the Physician’s Order Sheet. The order will include:

*The order must include:*

- The date and time the verbal order was taken.
- The name of the drug, dosage, route of administration, frequency, if specific times are required for when the drug should be given, and parameters for use if a prn order and or indication.
- The order must be read back and verified with the physician for confirmation.

The nurse or other appropriate professional notes V.O. (indicating verbal order) and/or T.O. (indicating telephone order). The physician’s name is written followed by read back and verified (must be written completely) followed by the professional's first initial and last name and title. Alternately, the order may be entered electronically. In doing so the professional should choose the ordering provider as well as the appropriate order source, i.e. telephone order/read back and verified or verbal order/ read back and verified. Verbal and telephone orders that have been documented as read back and verified must be signed by the physician within 30 days.

Other professionals that may accept verbal orders pertaining to their departments are as follows: Pharmacy, Respiratory Therapy, Lab and Radiology technicians, rehab therapists and dieticians.

**Blanket Reinstatement of Previous Medication Orders:**

"Resume home meds" and "resume pre-op meds" orders or other types of resume orders may not be accepted. Orders for medications must be specifically written.

**Weight-Based Dosing of Pediatric Orders:**

Weight-based dosing is required for pediatric patients for appropriate medications (e.g., antibiotics and analgesics). Daily weights are obtained on pediatric patients and documented according to policy.

**Code Blue Orders:**

A nurse or other health care professional transcribes physician orders taken verbally during a Code Blue to the Code Blue record. Both the physician and nurse/health care professional sign the Code Blue record. It is not necessary to rewrite these orders on the Physician's Order Sheet. The Code Blue record becomes a permanent part of the patient's medical record.
Medication reactions and occurrences must be reported immediately to the physician prescribing the medication or the physician on call. Documentation of physician notification and entries noting the administration of the medication and the reaction must be recorded in the patient's medication record. All unexpected or significant adverse drug events must be reported to the Food and Drug Administration and to the manufacturer.

**Definition:** An adverse medication event is defined as any undesirable or unintended effect of a drug that results in a change of dose, discontinuation of the drug, systemic treatment, or prolongs the hospital stay.

A medication interaction may be defined as: clinical reactions between two or more drugs, which may negate, reduce, or enhance the activity or effectiveness of either of the components individually.

- All drug events must be reported immediately to the department manager/charge nurse, supervisor, physician and pharmacy department.

- Nursing personnel monitors the patient's condition and records pertinent information in the nurse's notes. An "Adverse Drug Reaction Report" (MRMC #1235) must be prepared and forwarded to the pharmacy department. The Medication Hotline x 5400 may also be used to report these events. Pharmacy personnel prepare and report all adverse reactions to the Pharmacy Physician Advisor.

- The Pharmacy Physician Advisor and Pharmacy Director or designee evaluate the "Adverse Event Reports" and recommend appropriate action for each individual case.

- All significant reactions, defined as life threatening or fatal reactions, or unusual increases in number or severity must be reported to FDA using form "1639 or 1639A" DRUG EXPERIENCE REPORT. These reports will be sent to:

**BUREAU OF DRUGS FOOD AND DRUG ADMINISTRATION**

5600 Fishers Land

Rockville, MD 20852
Potential occurrences and occurrences that do not cause harm may be communicated during the next round made by the attending physician. Physicians must be contacted timely to obtain orders when an error occurs that reaches the patient and monitoring is required to confirm no harm or intervention to preclude harm. Medication occurrences that cause harm or death must be reported immediately to the attending physician in accordance with written procedures. MRMC encourages the documentation of medication occurrences in a non-punitive environment so that all medication occurrences are available for evaluation of system process problems.

A medication occurrence is a dose of medication taken by the patient (except errors of omission) that deviates from the prescriber's written order.

- A significant medication occurrence is a medication occurrence that results in harm to the patient requiring extension of medical care and/or extended stay in the hospital.
- A potential medication occurrence is a mistake in medication prescribing, dispensing or planned administration that is detected and corrected through intervention (by another health care provider or patient) before actual medication administration.

Process for Reporting/Documentation of Medication Occurrences:

- Prompt attention to the patient and supportive treatment are paramount when medication occurrences occur.
- Medication occurrences that contribute to or cause harm or death should be reported immediately to the physician responsible for the patient.
- The physician responsible for the patient must assess the patient for evidence of harm and document the findings in the patient's medical record.
- Entries in the medical record - Entries must include the routine information recorded for doses administered correctly (e.g. name of drug administered, dose administered, site, route, date, and time). Patient medical records may not refer to "wrong" doses of drugs or "errors" and may not indicate that a medication occurrence report was filed.
- Occurrences will be documented using the MIDAS system. In the event an adverse outcome (patient injury or death), Risk Management shall be notified immediately.
- Potential occurrences are be reviewed and tabulated as separate events from actual occurrences (occurrences that actually reach patients) so as to identify opportunities to correct problems in the medication – use system before they occur.
- Medication occurrence reports must be kept confidential and not be filed in the medical record.
- The department manager, supervisors, pharmacists or other qualified individuals must promptly review medication occurrences to determine the causes of occurrences and how they could have been prevented. This investigation is documented on the occurrence report.
- The Director of Pharmacy/Risk Manager/Patient Care Services designee reviews all medication occurrences for trends. Recommendations are made to the Physician Advisor for any changes in the medication use system if flaws or weaknesses in the medication process are recognized as contributing to medication occurrences.
- All medication occurrences must be summarized and presented to the Interdisciplinary Patient Care Committee for review and recommendations.
TYPES OF MEDICATION OCCURRENCES DEFINITION

- Contraindication (prescribing) occurrence: Inappropriate drug selection (based on indications, contraindications, known allergies, existing drug therapy and other factors, doses, dosage form, quantity, route, concentration, rate of administration or instructions for use of a drug product ordered or authorized by physician or other legitimate prescribers.

- Administration Occurrence: Omission Occurrence - The failure to administer an ordered dose to a patient (assumes no prescribing error). Unless the patient refuses the drug or the drug is contraindicated (refusal or contraindication should be noted in the medical record.)

- Unauthorized/Wrong Drug Occurrence - Administration to the patient of a dose of medication not authorized by legitimate prescriber for the patient (this would include a dose given to the wrong patient, unordered drugs and doses given outside a stated set of clinical parameters).

- Extra Dose Occurrence - Administration of duplicate doses to a patient (i.e., one or more dosage units in addition to those that were ordered).

- Wrong Dose Occurrence - Administration to the patient of a dose that is greater than or less than the amount ordered by the prescriber.

- Wrong Rate Occurrence - Incorrect rate of administration of a drug product to the patient.

- Wrong Route Occurrence - Administration to the patient of a drug by a route other than that ordered by the physician.

- Wrong Dosage Form Occurrence - Administration to the patient of a drug product in a different dosage form than was ordered by the prescriber.

- Wrong Time Occurrence - The failure to administer a medication dose within a predefined interval from its scheduled administration time.

- Dispensing and Preparation Occurrence: Dispensing the wrong drug, wrong dosage form, or wrong dose. Occurrences in labeling drug, improper preparation of the drug, unavailability of doses for administration at the scheduled time.

- Deteriorated/Expired Drug Occurrence - Administration of a drug for which the physical or chemical dosage-form integrity has been compromised.

- Other Medication Occurrence: Any medication occurrence that does not fall into one of the above-predefined categories.
CRITICAL RESULTS

Critical Results
Critical results will be directly communicated to the licensed caregiver in charge of the patient’s care, the time from the identification of the critical result and the reporting of the result should not exceed the time frames indicated in this policy. The licensed caregiver will be asked to document and read back the critical result to the technologist to verify correct communication.

Lab, or Cardiopulmonary tests results are communicated by the technologist to the licensed caregiver (RN, LPN) caring for the patient
- Imaging results are communicated by the radiologist to the ordering physician.
- All results from any test should be reviewed with the patient’s welfare in mind.

If the patient’s nurse is unavailable, the charge nurse or another RN, LPN on the unit will be contacted. If unavailable, contact the Nursing supervisor. It will be the responsibility of the RN, LPN to place a call to the physician to convey the critical result.

Critical results will not be communicated to a non-licensed individual.

Exceptions to Critical Result Procedure:
- Some results may be over the normal variation but be clinically normal for a patient (i.e. a “PTT” within therapeutic range for a patient on a heparin drip or a “Magnesium” level within therapeutic range for a patient on a magnesium drip). The first critical result will be called to the physician as a critical result. Thereafter, if the result is “expected” as abnormal, this will be documented. The subsequent results will not be called to the physician, unless so ordered.
- The time frame from discovery of the critical result to notifying the physician should be done within 60 minutes.
Report Results of Critical Tests and Diagnostic Procedures on a Timely Basis

- Hospital defines **critical tests** and **critical results and values** (Laboratory, Radiology, Cardiopulmonary)
- Acceptable length of time for reporting critical results is 60 minutes from time results received.
- Must document that you called results and actions (orders or no orders)