## CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Introduction and “What’s New”</td>
</tr>
<tr>
<td>4</td>
<td>Mission, Vision, Goals, &amp; Values</td>
</tr>
<tr>
<td>5-6</td>
<td>Regulatory Survey Preparation</td>
</tr>
<tr>
<td>7-13</td>
<td>National Patient Safety Goals</td>
</tr>
<tr>
<td>14-21</td>
<td>Environment of Care and Life Safety</td>
</tr>
<tr>
<td>23-35</td>
<td>Emergency Management</td>
</tr>
<tr>
<td>36-39</td>
<td>Human Resources</td>
</tr>
<tr>
<td>40-45</td>
<td>Infection Control and Prevention</td>
</tr>
<tr>
<td>46-54</td>
<td>Information Management</td>
</tr>
<tr>
<td>55-57</td>
<td>Medication Management</td>
</tr>
<tr>
<td>58-59</td>
<td>Medical Staff</td>
</tr>
<tr>
<td>60-71</td>
<td>Provision of Care, Treatment, &amp; Services</td>
</tr>
<tr>
<td>72-73</td>
<td>Performance Improvement</td>
</tr>
<tr>
<td>74-78</td>
<td>Record of Care, Treatment, &amp; Services</td>
</tr>
<tr>
<td>79-82</td>
<td>Rights &amp; Responsibilities of the Individual</td>
</tr>
<tr>
<td>83</td>
<td>Transplant Safety</td>
</tr>
<tr>
<td>84</td>
<td>EMTALA</td>
</tr>
<tr>
<td>85-87</td>
<td>Index</td>
</tr>
<tr>
<td>88</td>
<td>My Emergency Response &amp; PI Page</td>
</tr>
<tr>
<td>89</td>
<td>Emergency Telephone Numbers</td>
</tr>
</tbody>
</table>
This guidebook has been prepared to provide easy access to key information, policies and procedures at OU Medical System as well as important regulatory standards from The Joint Commission. Please take the time to familiarize yourself with the important information in this guide.
**Mission**
Leading healthcare - now and for the future

**Vision**
OU Medicine will be the premier enterprise for advancing health care, medical education and research for the community, state and region. Through our combined efforts we strive to improve the lives of all people.

**Goals**
- Uncompromising Quality
- Exceptional Service
- Innovative Education
- Advancing Knowledge
- Institutional Strength

**Values**
- We believe that caring for our patients must be at the center of all we do.
- We act with honesty and integrity.
- We respect our colleagues and co-workers.
- We magnify our effectiveness through teamwork.
- We improve continually through harnessing innovation and encouraging high performance.
- We believe in open and effective communication.
- We are committed to providing outstanding educational programs.
- We will be a leader in the advancement of basic and clinical research.
About The Joint Commission
The Joint Commission accredits and certifies more than 17,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards.
(Source:www.jointcommission.org/AboutUs)

Continuous Readiness Activities:
• Make sure you know and understand the information in this guide.
• Ask questions if you do not know something or if you need clarification.
• Be familiar with The Joint Commission’s National Patient Safety Goals.
• Know how to locate and access policies and procedures
• Look around! Make sure your unit is clean and organized at all times.
• Never discuss patients in public or leave patient information in public view.
• Be familiar with your role in fire safety and disaster preparedness.
• Document timely, accurately, and completely.
• Use good hand hygiene and hold patients, visitors, and staff accountable for washing hands.

**During a regulatory survey on your unit:**
• Be confident in your skills and be able to discuss how they apply to patient safety. You do this every day!
• Be positive – do not argue or act annoyed.
• Do not scatter or run away – this gives the impression that you are not prepared.
• If asked a question, give a concise correct answer.
• If you don’t know the answer, ask for clarification or show the surveyor where you can find the answer.
• Do not embellish or volunteer unnecessary information.
• Do not make excuses or present false information.
• Be able to give examples of what you do to ensure patient safety.

It is important to be prepared, be professional, and use good manners during a hospital survey and always!
NATIONAL PATIENT SAFETY GOALS (NPSG)

Goal #1: Improve the Accuracy of Patient Identification
ALWAYS use 2 patient identifiers
✓ Name, Birth Date, and/or Medical Record Number
  (Name and Photo for Behavioral Health patients at Edmond)
✓ Ask the patient to verbally state their name and birth date when possible
✓ Identify the patient when doing the following:
  ◦ Administering medications or blood products
  ◦ Collecting blood samples or specimens for testing
  ◦ Providing care, treatment, or services
✓ The patient’s room number or physical location is NOT to be used as an identifier.
✓ Use two identifiers as part of the “TIME OUT” process
✓ Be able to talk about using two patient identifiers as part of medication administration process
✓ Label containers used for blood and other specimens in the presence of the patient.

Help eliminate blood transfusion errors
✓ Match the correct patient with the correct blood type at the bedside
✓ Verification process for blood or blood components prior to administration to the patient should be done by TWO qualified staff using TWO patient identifiers

Policy:
OUMS Policy 11-12: Patient Identification and Armbands
OUMS Policy 11-22: Blood Component Administration
Goal #2: Improve Effectiveness of Communication Among Caregivers

Quickly report critical tests and critical results
- Contact the physician or licensed caregiver as soon as possible
- Document the notification to the LIP

Policy:
OUMS Policy 11-73: Critical Results/Values

Goal #3: Improve the Safety of Using Medications

Label ALL medications
- Including syringes, cups, and basins
- This applies to ALL areas that complete procedures
- Label whenever a medication/solution is transferred from the original container to another container
- Applies even if only one medication is being used
- Labels should include name, strength, amount, expiration date (if not used within 24 hrs) and expiration time (if expiration occurs < 24 hrs)
- Verify verbally and visually by 2 qualified individuals when the person preparing the medication is not the person administering the medication.
- One medication or solution is labeled at a time
- Unlabeled medications are discarded immediately
- Medications, solutions and their labels are reviewed at shift change or break relief
- Original containers remain available until the conclusion of the procedure

Reduce harm for patients taking anticoagulants
- Use caution caring for patient on blood thinners
- Only use approved protocols for anticoagulant therapy
- Manage food-drug interactions for patients receiving anticoagulants
Maintain and communicate accurate patient medication information
✓ Obtain the patient’s current medication information upon admission or outpatient visit
✓ Compare the patient’s current medication list with medications ordered to identify and resolve discrepancies
✓ Provide the patient a written medication list upon discharge or after an outpatient visit
✓ Explain the importance of medication information to the patient upon discharge or after outpatient visit

Policy:
OUUMS Policy 12-01: Medication Management
OUUMS Policy 12-18 Anticoagulation Management
OUUMS Policy 12-12: Food-Drug Interactions
OUUMS Policy 12-16: Medication Reconciliation

Goal #7: Reduce the Risk of Healthcare-Associated Infections (HAI)
ALWAYS use good hand hygiene
✓ Wash hands before AND after patient contact
✓ Hand washing must be performed when hands are visibly soiled, after exposure to blood, secretions, excretions or non-intact skin, before and after eating and after using the restroom.
✓ Hospital-approved hand sanitizer can be used when hands are not visibly soiled, before and after contact with a patient’s intact skin and after removing gloves.
✓ No artificial nails or nail tips >¼ inch are allowed.

Prevent multi-drug resistant organism (MDRO) infections
✓ Use ABCD: Active surveillance, Barrier precautions, Compulsive hand hygiene, Disinfect environment
✓ Catheter-associated urinary tract infection (CA-UTI) prevention – monitor daily list of patients with Foleys
✓ Check ATLAS keyword **HAC** for current information on: CAUTI, CLABSI, C-Diff, VAP, MRSA

**Prevent central-line bloodstream infections and surgical site infections**

✓ Care bundle:
  
  o Hand washing and skin asepsis
  o Maximum barrier precautions
  o Site selection – avoid femoral lines
  o Daily assessment of line necessity, and prompt removal of unnecessary lines

**Policy:**

OUUMS Policy 09-01: Infection Control Plan
OR Policy OR.22-022: Surgical Hand Antisepsis/Scrub
OUUMS Policy 18-03: Isolation Precautions

**Goal #15: The hospital identifies safety risks inherent in its patient population.**

**Identify patients at risk for suicide**

✓ Initiate referral for patients who are a risk to self
✓ Screen for suicide risk factors
✓ Ensure the patient’s immediate safety
✓ Provide follow-up crisis information

**Policy:**

OUUMS Policy 11-71: Suicide Precautions: Patient Management Policy
Universal Protocol: Prevent Wrong Site, Wrong Procedure, Wrong Person Surgery

Conduct a pre-procedure verification process
- At the time the surgery/procedure is scheduled
- At the time of admission or entry into the facility
- Before the patient leaves the preoperative area or enters the procedure/surgical room

Licensed Independent Practitioner marks procedural site
- Applies to bedside procedures except when the LIP is in continuous attendance with the patient

ALWAYS perform a time-out before the procedure
- Correct patient identity, side, site, and position
- Agreement on the procedure to be done
- Correct implants, special equipment or requirements

Policy:
OUMS Policy 11-50: Surgical/Procedural Verification
OR Policy 21-006: Surgical Site/Side Verification in the OR
HOSPITAL-ACQUIRED CONDITIONS

Keeping our patients safe and free of complications or untoward events that may occur during hospitalization has always been a top priority. Being treated in a manner that is evidence-based, supported by research, safe and effective is how each of us would want to be treated and is the type of care our patients deserve. It’s simply the right thing to do.

The government has put incentives in place to ensure all healthcare facilities receiving payments through Medicare use evidence-based practice to protect patients and to do all possible to ensure positive outcomes of care.

Specifically, the Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payment for certain hospital-acquired conditions. CMS has titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC & POA). Section 5001(c) of Deficit Reduction Act of 2005 requires special attention to conditions that are:
(a) High cost or high volume or both,
(b) Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and
(c) Could reasonably have been prevented through the application of evidence based guidelines.
The 10 categories of HACs include:
1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Pressure Ulcers
5. Falls and Trauma
6. Glycemic Control
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following:
   • Coronary Artery Bypass Graft (CABG)
   • Bariatric Surgery
   • Orthopedic Procedures
10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)

OUMS has put in place several action plans designed to keep our patients safe and free from acquiring a problem during hospitalization. These actions include:
✓ Revised policies and procedures
✓ Additional staff training and competency validations
✓ Improved documentation systems
✓ Focused monitoring and follow-up
✓ Support/oversight by an administrative team

Monitoring and follow-up are in progress on each of the conditions. You can do your part by participating in the training provided, always practicing in a competent manner, identifying opportunities for improvement, and seeking clarification when questions arise.
ENVIRONMENT OF CARE (EC) and LIFE SAFETY (LS)

Safety
According to the Mutual Aid Memorandum of Understanding for Healthcare Facilities adopted by Homeland Security Regions 6 and 8, which includes OU Medical System, the following universal emergency code system shall be used:

- **CODE RED**: Fire
- **CODE PINK**: Missing Infant or Child
- **CODE BLUE**: Medical Emergency/ Cardiac/Respiratory Arrest
- **CODE BLACK**: Severe Weather
- **CODE YELLOW**: External/Mass Casualty Disaster
- **CODE ORANGE**: Hazardous Exposure Requiring Decontamination

In addition, OU Medical System also uses:

- **CODE PURPLE**: Disruptive/Combative Person

To report a code of any type, call:

- **11911** (Downtown) or **444** (Edmond)

Security
Security services are provided for staff, patients, and visitors by the OU Health Sciences Center Police and Edmond Security Services. Services include security, assistance with flat tires, and escorting to parking areas.

- **Downtown campus**: 271-4911
- **Edmond campus**: ‘0’ for the Operator
Smoking and Use of Tobacco Products

**OUMS Downtown Campus**
Smoking cigarettes, the use of electronic cigarettes and/or the use of other tobacco products is not permitted within any OUMS facility, within any OUMS parking structure or on the OUMS grounds or campus or OUMS-operated off-site locations, including but not limited to public or non-public areas, offices, cafeterias, restrooms, stairwells, driveways, sidewalks, and OUMS vehicles, with the exception of specially designated enclosed booth areas which include the south side of Children's Hospital directly behind the loading dock area and the east side of the OUHSC Facility Support Building directly across from the OUMS Adult Tower.

**OUMS Edmond Campus**
Smoking is permitted only in personal vehicles as there are no smoking booths available.

**Policy:**
HR Policy 07-09: Tobacco-Free Workplace
OUMS Policy 15-03: Tobacco Policy
Hazardous Materials and Waste

**Hazards Communication**
All OU Medical System employees will be informed of hazards from chemicals in their workplaces and measures they should take to protect themselves from potential hazards.

Every employee has the responsibility to:
- Learn, know and practice job tasks safely.
- Use personal protective equipment as required.
- Be aware of the precautionary information indicated on the manufacturer’s label and/or the MSDS for the chemicals being utilized in their work areas.
- Notify their supervisor of:
  - Symptoms of potential hazardous chemical over-exposure
  - Apparent exposures or potential accident-causing situations
  - Missing labels on containers
  - Malfunctioning safety equipment
  - Any damaged containers or spills

**Material Safety Data Sheets (MSDS)**
MSDS can be found on the OUMS intranet under Document Library>General>Material Safety Data Sheets

In an emergency, MSDS sheets can be obtained 24 hours a day/7 days a week by calling: 800-451-8346.
**Labeling**
Per Federal Regulation, labeling must be done on all hazardous chemicals that are shipped and used in the workplace.
- Labels must not be removed or defaced
- Chemicals not in original containers must be labeled with information from original containers
- Unlabeled chemical containers are not permitted

**Waste Types and Disposal**
Potentially Hazardous Medical/Biohazardous Waste: Red or Orange Tags or Biohazard Label

Chemotherapeutic/Antineoplastic/Cytotoxic Waste (Chemo Waste): White bags or containers with yellow Chemo labels.

**Radioactive Waste:** Handled by the OUHSC Radiation Safety Office

**Radiation Safety**
- All employees whose work involves potential exposure to ionizing radiation must receive radiation safety training.
- Designated workers are required to wear radiation dosimeters during procedures involving ionizing radiation.
- All radioactive materials must be secured against unauthorized access. These areas may include the blood bank, gamma knife, and nuclear medicine.
**Chemical Hygiene Procedures**

When handling chemicals, general precautions should be utilized to minimize exposure. However, review the chemical MSDS for specific instructions.

**Accidents and spills:**

- **Eye contact:** promptly flush eyes with water for fifteen minutes and seek medical attention

- **Ingestion:** drink large amounts of water

- **Skin contact:** promptly flush affected area with water and remove any contaminated clothing. If symptoms persist, seek medical attention

- **Clean up:**

  To help remember what to do in case of a hazardous materials spill, use the acronym **CLEAN**.

  C = Contain the spill

  L = Leave area unless properly trained to clean the spill

  E = Emergency medical treatment, seek if needed

  A = Access the Material Safety Data Sheet (MSDS)

  N = Notify the Operator at 1-4190 on the Downtown Campus and 444 on the Edmond Campus

- **Follow-up:** medical consultations and examinations are available in Employee Health.

**Policy:**

OUMS Policy 15-33: Hazards Communication
Fire Safety (CODE RED)

EMPLOYEE RESPONSIBILITIES IN THE PRIMARY FIRE AREA (RACE):
R Rescue anyone in immediate danger (if safe to do so)
A Activate the fire alarm (pull manual alarm pull box and call facility emergency #)
C Contain the fire (close all doors and windows)
E Extinguish the fire (if safe to do so)

TO EXTINGUISH THE FIRE WITH A PORTABLE FIRE EXTINGUISHER (PASS):
P Pull the pin
A Aim the nozzle at base of fire
S Squeeze the handle
S Sweep nozzle from side to side

EMPLOYEE RESPONSIBILITIES IN A SECONDARY FIRE AREA (CALM):
C Close all doors and windows
A Assure patients/visitors that situation is controlled
L Leave someone by the telephone
M Maintain normal operations
**DO**

- Stay between the fire and a path of safety.
- Follow the RACE, CALM, and PASS procedures.
- Ensure exit doors & stairwells are unobstructed.
- Remove materials or equipment that may become corridor obstructions.
- Prepare for possible patient evacuation orders if you are within the building of the fire alarm.

**DO NOT**

- **DO NOT** activate the fire alarm unless you actually see smoke or fire. If you smell smoke but do not see fire, call Facilities and Maintenance.
- **DO NOT** call the emergency operator after the initial call, unless another fire has been discovered.
- **DO NOT** unnecessarily alarm patients and visitors by shouting “Fire”.
- **DO NOT** use elevators in the building with the fire.
- **DO NOT** turn out corridor or room lights, as responding personnel will require lighting to find the fire site.
- **DO NOT** disable fuses or circuit breakers.
- **DO NOT** use the telephone unless it is imperative.
- **DO NOT** allow re-entry to an area in which evacuation has been completed.

**Policy:**

OUMS Policy 08-05: Fire Safety Management Plan
OUMS Policy 15-29: Fire Prevention Response
Medical Equipment
Any equipment on the premises of OU Medical System or any of its affiliated facilities shall be maintained in a safe and ready-to-use condition. Medical equipment used for diagnosis, treatment, and monitoring of patient care needs has a sticker with a Biomed inspection date. If inspection date is past due, contact Biomedical Engineering.

Lockout Tag-out
When any equipment or system is inoperable or taken out-of-service and whenever the unexpected start-up of this equipment could be harmful to personnel, the equipment, or the building, the equipment or system in question shall be tagged notifying personnel of this condition and locked closed if possible.

Policy:
OUUMS Policy 08-06: Medical Equipment Mgmt Plan
OUUMS Policy 15-02: Lockout/Tag-out

Medical Gas
Oxygen Shutoff
The individual in charge of the area will determine the necessity to shut-off the oxygen flow to specific patient rooms/areas in the event of a fire and/or disaster.

The responsible staff will notify Facilities and Maintenance, Respiratory Care, and the areas affected by the shut-off. If the individual in charge is unable to perform the shut-off, he/she may direct another trained individual to do so.
Time permitting, patients requiring oxygen will receive an alternate supply of oxygen prior to the shut-off.

**Policy:**
OUMS Policy 15-06: Oxygen Shutoff

**Utility Systems**

**Failure of Electrical Service**
The emergency generators should come on within 10 seconds. If this does not happen, contact the Facilities and Maintenance Dispatch at 14190 (Downtown) or 5527 (Edmond) as soon as possible.

Failure of Steam/Chilled Water
The Administrator-on-call will make arrangements for necessary services at the Downtown campus. At the Edmond Campus notify Maintenance at 5527.

Failure of Water Distribution System
In case of a main line break, reserve water supplies will be distributed from an outside vendor and water rationing will be in effect. In case of outside water supply contamination, the communication office will notify all staff not to drink the water or flush toilets.

**Emergency Loss of Communication**
The primary means of communication between departments will be the Meditech system. The black emergency phone system will also be initiated. At the Edmond campus, hospital issued and personal cell phones will be used for external communication and 2 way radios will be issued for internal communication between departments.
EMERGENCY MANAGEMENT (EM)

Emergency Preparedness Response Plan
OU Medical System has been designated the Disaster Center for the Oklahoma City Metropolitan Area by the Office of Emergency Management.

Policies in the Emergency Preparedness Plan are in place to address the means and methods by which we will train, organize and respond to the community during a catastrophe.

Each OU Medical System campus facility maintains an addendum specifying the logistical details (i.e., patient treatment areas, location of triage area, location of Command Center, phone numbers, etc.) to implement this policy within their facility. An annual Hazard Risk Assessment is performed to identify potential mass casualty incidents.

Evacuation
Evacuation of patients and staff may result from any of the following:
• Severe weather which renders the hospital unsafe
• Extended disruption of water, electricity, gas or other basic utilities
• Widespread and catastrophic illness, such as an infectious disease
• Chemical pollution/hazardous chemical spill
• Structural damage which renders a critical system unreliable or unusable
**Partial Evacuation** – Relocating from a dangerous area to a safe area within the facility; typically by moving from one smoke compartment to another.

**Total Evacuation** – Relocating all persons within the building to a safe area outside the facility; authorized by the facility Chief Executive Officer, or Fire Department Officials. This is used as a last resort.

**Horizontal Evacuation** – Lateral movement on the same floor; authorized by the person in charge of the area.

**Vertical Evacuation** – Downward movement away from danger and toward ground-level of the building; directed by Administrative Team, House Supervisor, or Fire Department.

**Policy:**
OUMS Policy 21-04: Evacuation

**Emergency Response - Internal**

Internal disaster: Any sudden occurrence, rendering one or more essential hospital services incapable. This may include loss of utilities, explosion, failure of a critical piece of equipment, or other unexpected event.

When an internal disaster occurs, the operator will announce, “This is an Internal Alert/ Disaster on (location)” Example: “This is an internal alert on 6W OUMS Tower”. The operator notifies the Facility Safety Officer, Campus Police/ Edmond Security, Facility Management Staff and the Director of the affected area who will respond to the scene.
During alternate hours, the Clinical Coordinator will report to the Command Center.

Appropriate clinical, administrative, and/or facilities management personnel may be asked to assist and a site coordinator will be appointed by the most senior person on the scene. The Facility Safety Officer will notify the appropriate persons of the disaster.

**Civil Disturbance Plan**
In a situation involving individuals who are armed and/or behaving in a threatening/violent manner and which disrupts our work place and poses a threat to staff, visitors, or patients, OUHSC Police Services / Edmond Security will be notified.

**Hostage Situations**
In the event of a hostage situation, hostages should adhere to the following guidelines:
- Stay calm and avoid displays of emotion
- Do not speak unless spoken to
- Cooperate, but do not be helpful
- Never argue or make suggestions
- You do not have authority to grant demands
- Remain facing your captor
- Be observant
- Expect noise and lights during rescue attempt
- When rescue occurs, fall to the floor immediately and stay there

**Policy:**
OUMS Policy 21-05: Emergency Response, Internal
OUMS Policy 21-02: Emergency Operations Plan
**Bomb Threat**

A bomb threat consists of a discovery of a suspicious object, written note, or a telephone call that a bomb has been placed somewhere within or outside of an OU Medical System facility or facility housing OU Medical System employees. It should be assumed that the person is making a serious threat to the life and safety of the inhabitants of OU Medical System.

**Discovery of a bomb or suspicious package:**
- Notify the departmental supervisor, who will in turn notify OUHSC Police or Edmond Security Services.
- OUHSC Police/ Edmond Security will notify proper facility contacts and the OKC/ Edmond Police Bomb Squad, and will coordinate a search of facility.

**If a bomb threat is received via telephone:**
- Remain calm and courteous.
- Obtain as much information as possible from the caller by prolonging the conversation.
- Complete the telephone bomb checklist, located in *OUMS Policy 15-13: Bomb Threat*, while the conversation is in progress, or immediately following, and notify the department director/supervisor, who will in turn notify the OUHSC Police Services/Edmond Security.
- DO NOT alarm patients, visitors or staff members.
- DO NOT discuss details of the conversation with anyone except personnel from the OUHSC Police or Edmond Security Services, Risk Management representative, or Administrator.
If a bomb threat is received via a letter or note:
• Immediately notify your departmental supervisor, who will notify OUHSC Police or Edmond Security Services.
• DO NOT handle the letter or note any more than is necessary so evidence is not destroyed.
• Remain calm and do not alarm patients, visitors, or staff members.
• DO NOT discuss details of the letter or note with anyone except personnel from OUHSC Police or Edmond Security Services, Risk Management representative, or Administrator.

Discovery of a suspicious device or article:
• DO NOT touch or move the device or article.
• Notify the departmental supervisor, who will in turn notify OUHSC Police or Edmond Security Services.
• The highest-ranking OUHSC Police Supervisor / Edmond Security Officer, with assistance from appropriate personnel, will coordinate evacuation of all persons from the building upon instruction from the OKC / Edmond Police Bomb Squad.
• Ensure that all windows and doors leading to the discovery area remain open at all time.
• Staff personnel in charge of the discovery area will notify patients, staff and visitors that a suspicious object is being investigated and remain calm and reassuring.

Policy:
OUMS Policy 15-13: Bomb Threat
**Duress Alarms**
Duress alarms are in place throughout OU Medical System to ensure timely reporting and prompt response in case of emergent safety and security incidents, including aggressive or suspicious behavior.

**How do duress alarms work?**
- Duress alarms quickly notify OUPD/Security that help is needed. Alarms are commonly located under the desk at nurses’ stations. When the alarm is activated, it provides a specific location to the responder.
- Duress alarms are tested monthly to ensure functionality and to help staff become familiar with the procedure and use of the alarms.

**Who can I contact with questions?**
Contact the Director of Hospital Safety Programs at 417-4829 (Downtown) or the Director of Plant Operations at 359-5590 (Edmond).

**Person Down**
If a visitor or staff member requiring or requesting immediate medical attention due to sudden illness or injury, the following steps should be taken:
- If you discover a “Person Down”, immediately call OUHSC Police at 1-4911 or Edmond Security at 444.
- If the person “down” is unresponsive, activate a Code Blue by calling 1-1911 Downtown or 444 at Edmond.
- Be ready to convey exact location, nature and apparent severity of injury/illness, if any, potentially hazardous situations, the individual’s age and status.

**Policy:** OUUMS Policy 15-15: Person Down
Infant or Child Abduction (CODE PINK)
If an infant or child is missing or abducted notify the hospital operator immediately at 1-1911(Downtown campus) or 444 (Edmond campus).

“Code Pink” will be announced overhead.
• Immediately check all adjacent stairwells and exits when a “Code Pink” is announced
• Remain on your unit and assist with the search
• Question any person with a large bag, purse, coat, jacket, etc. using the following phrase: “We are involved in a Code Pink. May I see into your bag?”
• If the person declines the search or exhibits suspicious behavior, DO NOT DETAIN him/her. Call OUHSC Police Services (1-4911)/Edmond Security at 444. Be prepared to give a detailed description.

Policy: OUUMS Policy 15-08: Infant/Pediatric Abduction

Severe Weather (CODE BLACK)
What is it?
The National Weather Service has issued a Tornado Warning for our area. A Tornado Warning indicates a tornado is in close proximity to the facility.

What will be announced?
“A Code Black has been issued. Initiate severe weather preparations at this time.”

How should I respond?
• Seek shelter in inside corridor rooms, stairwells, or basement areas away from outside windows.
• Protect patients who cannot be moved away from outside windows with extra blankets and pillows, or other rational means.
• Stay sheltered until “ALL CLEAR” is announced.

Policy: OUMS Policy 21-06: Severe Weather

Cardiac/Respiratory Arrest (CODE BLUE)
• Emergency intervention will be initiated in the event of any life-threatening situation. Basic Cardiac Life
• Support guidelines will be used to assess the patient.
• Advanced Cardiac Life Support / Pediatric Advanced Life Support guidelines will be used to meet the patient's needs.
• Upon discovery of an individual in cardiopulmonary arrest, staff will initiate CPR and activate “Code Blue”/Emergency Medical Services.

Policy: OUMS Policy 11-18: Code Blue

Hazardous Exposure Requiring Decontamination (CODE ORANGE)

What is it?
When a person is exposed to or contaminated from hazardous materials.

What will be announced?
“Code Orange: All available personnel please report to their assigned areas”

How should I respond?
Report to your unit and stay on your unit until “ALL CLEAR” is announced unless otherwise directed.
Victims will not be allowed to enter an OUMS facility until decontamination has been accomplished.

**External/Mass Casualty Disaster (CODE YELLOW)**

What is it?
A mass casualty incident or any situation in which the number of casualties is greater than the Emergency Department can handle.

What will be announced?
“Code Yellow: All available personnel please report to their assigned areas”

How should I respond?
Report to your unit and stay on your unit until “ALL CLEAR” is announced unless otherwise directed.

If an event in the community has occurred with reasonable potential that an External Disaster may need to be declared, OU Medical System is placed on alert and HICS (Hospital Incident Command System) may be activated accordingly.

Hospital Administration will activate the HAZMAT team, Trauma Team, HICS, satellite command center, any additional resources needed, and notify the appropriate persons to activate them if necessary.

Where will the command center be located?
The Downtown campus Command Center will be located in the OUMC Tower. The Edmond campus
command center will be located in Administration. Remaining towers will either have a command post or will serve as an alternate Command Center location. The command centers will control operations and distribution of resources for that facility.

If necessary, the EXTERNAL COMMAND CENTER will be located in OU Physicians Building.

Base stations for campus-wide radio communication will be set up in the Central Command Center, each Satellite Command Center, and each Emergency Department.

Preparation and Follow Up:
To help prepare for emergent situations, drills will be held two times per year and may be coordinated with scheduled citywide drills. The drills will be designed to test the entire OUMS campus and its ability to mobilize resources and conduct an appropriate response.

Following the termination of each disaster or disaster drill, the Emergency Preparedness Sub-Committee will meet to evaluate each phase of the hospital response.

**Patient and Employee Processes**
**How will patients enter & flow through the facility?**
Patients will be triaged from the Emergency Department according to severity of their injuries and treatment needed. If the disaster involves biological, chemical or nuclear decontamination, patients will be directed to the decontamination site.
Patients requiring decontamination WILL NOT be allowed to enter an OU Medical System facility until decontamination has been accomplished. Decedents will not be transported to a morgue without first being decontaminated.

An Administrator/designee will be assigned to each treatment area to facilitate communication, coordinate support, and relay requests/ information via radio from the area to the Command Center.

The Charge Nurse or physician will determine bed availability and determine patient priority list for discharge/transfer if needed. This will be communicated to the Command Center.

Admitting will issue patients a disaster number used to identify the patient throughout their stay. Information will be provided to the Command Center as to the whereabouts of a specific patient.

Each patient treatment area will maintain a record of patients in and out of that area, identifying patient tracking numbers and time of arrival/ departure.

Where will employees report during a disaster?
Most staff, including clinical staff, will stay on their unit or in their work area until requested by the Command Center to report to a different area.

Specific duties during the disaster will be divided among OUMS personnel based on the HICS model.

Policy: OUMS 21-02: Emergency Operations Plan
**Surge Capacity**

In the event of a flu pandemic, large-scale disaster, or emergency, it may be necessary to adjust current standards of practice to ensure that the care provided results in as many lives being saved as possible.

Because the specifics of any given situation cannot be fully anticipated and the scope of unexpected events may vary widely, OUMS will follow the established Emergency Preparedness Response Plan.

The goal of this plan is to ensure the allocation of scarce resources in a fair and clinically sound manner to save as many lives as possible. Standards of care traditionally dictate not only the care provided, but also who can provide care, to whom, when and where.

In the event of a mass disaster, alterations in standards of care may be required. These alterations could impact any or all of the elements listed above.

**Policy:**
OUMS Policy 21-08: Surge Capacity Plan
Disruptive Person (CODE PURPLE)

Patients:
If an agitated patient’s acting out behavior becomes unmanageable by staff in a particular working area, assistance will be provided by support personnel to reduce any threat to personal safety of the patient or others.

- **OKC Campus:** dial 1-4911 to notify OUHSC Police
- **Edmond Campus:** dial 444
- Staff trained in Non-violent Crisis Intervention and security personnel should also respond

The person calling the Code Purple will assume the role of code coordinator and assign roles/delegate as needed. At the OKC campus, OUHSC Police will assume this responsibility upon arrival.

Visitors:
Visitors displaying aggressive or threatening behavior will be given the opportunity to vent their concerns in a controlled manner. When the behaviors become uncontrolled, the visitor will be asked to leave the premises. If the visitor is unable to comply with the request, the OUHSC Police/Edmond Security will escort the visitor off the premises. Staff will not attempt to physically manage any visitor unless necessary for self-defense or protection of a defenseless patient.

Policy:
OUUMS Policy 15-58: Code Purple - Disruptive Person
HUMAN RESOURCES (HR)

One important role of the Human Resources Department is ensure that we have an adequate number of competent staff available at all times. Through development of clear, accurate job descriptions, recruitment and hiring, credential reviews, employee health services, orientation and on-going training, and provision of resources, we work to support the goals of OUMS and its employees.

Understand Roles and Scope of Practice
You should be familiar with your job description and review it with your supervisor or manager. Job descriptions help us understand the role and scope of practice for each employee. Understanding roles are important in determining safe delegation of duties.

Ensuring a Competent Workforce
On hiring – A review of the applicants experience, education, training and certifications are done to ensure the applicant meets requirements.

During orientation – Employees are provided with training and education as required for their position. Employees are provided general and departmental orientation specific to their job. This orientation includes OUUMS Policies and Procedures, Hospital Mission, Vision and Values, Ethics and Compliance, Infection Control, Patient Safety, and other important items.

Readiness Guidebook 2013 Page 36
Initial Competency Verification – Prior to functioning independently, new employees are monitored to verify they demonstrate job specific competencies required for their position. Job specific competencies include hand hygiene and environment of care. Clinical staff job specific competencies may include restraints, medication administration, and end of life care.

On-going Competency Verification – to ensure that staff maintains their level of competency on-going education is provided. A variety of formats is used for training, including live courses, poster presentations, computer learning modules, and in-services at staff meetings. Periodically staff is expected to demonstrate competencies for certain high-risk, low volume of problem prone tasks.

Promotions, Transfers, or Floating – training is provided and competencies are assessed when staff members are promoted, transferred, float to another unit, or any time when job duties change.

Population-Specific Competencies

It is important that our patients and families receive care that is appropriate to their individual situations. We provide care that is population appropriate. Specific population may be determined based on age, ethnicity, religion, or disease process. When competencies are verified we assess to determine that care givers can adjust their care to meet the specific needs of the population they are serving.
Population Specific Resources:

- **Age** – Policies and Procedures, Standards of Care, and Practice Guidelines address age-specific considerations.

- **Culture, Religion, and Ethnicity** – A link to a resource is available on the intranet that will assist in providing care specific to religious, ethnic or cultural considerations.

**Staffing**

Staffing plans are in place for every department. Leaders work to ensure the appropriate amount of staff with the proper training and credentials are available at all times. Staffing levels are reviewed for appropriateness on an on-going basis. This includes:

- Workload, or number of patients
- Complexity of the work, or acuity of patients
- Number of staff present
- Licensure, certification, and competency of staff

**Other Individuals in the Facility**

At times, other individuals may provide services with OUMS. For these individuals, a review of credentials, training, and competencies is completed.

- **Volunteers**: Coordinated through Volunteer Services
- **Contract Staff**: Coordinated through Contract Services Coordinator
- **Health Care Industry Representatives (HCIRS)** – Coordinated through Materials Management. The HCIR will wear a facility-issued, dated identification label during their visit to any area within the hospital,
including but not limited to patient care areas. HCIRs must check in and out for EACH visit to the facility using the Kiosks which are open 24/7.
• **Students** – Coordinated through Human Resources Student Programs Coordinator

**ID Badges & Access Cards**
All individuals providing service within OU Medical System are required to wear a photo ID, displayed above the waist, at all times when on OUMS campus. Stickers or any other objects may not be placed on the badge, lanyards or badge holders. Holes may not be placed in the badge.

Physician ID badges are issued through the OU Health Sciences Center at the Downtown campus and the Human Resources Department on the Edmond campus.

For medical staff, access cards must be utilized on primary doors into the hospital between the hours of 9:00 pm and 6:00 am. Anyone utilizing an access card is required to carry a valid photo ID. The access cards are the property of OUMS, are non-transferable and may not be shared with another person. Access cards are not an acceptable form of identification.

To receive an access card or replace a lost or stolen card, contact Medical Staff/Credentialing Services.

**Policy:**
HR Policy 2-11: Official Identification Badges/After Hours Access Card
INFECTION CONTROL AND PREVENTION (IC)

• Hand Hygiene is the single most important procedure to prevent the spread of infections.

• OUUMS advocates the use of alcohol-based hand sanitizer for routine cleaning of hands when not visibly soiled, in accordance with recommendations from the Centers for Disease Control.

• Hand washing with soap and water is recommended when hands are visibly soiled, dirty or contaminated, when caring for patients with C. difficile, and before eating and after using the restroom. Effective hand washing involves washing with soap and water for at least 15 seconds. The friction from rubbing the hands together is a critical component of effective hand washing.

• Gloves should be changed between patients and changed frequently while caring for patients.

• Wearing gloves is not a substitute for hand washing.

• Appropriate isolation measures should be taken for patients with infectious conditions.

• Artificial nails are not to be worn by direct care providers. Artificial is defined as anything other than plain nail polish. Nails are to be kept no longer than 1/4 inch in length from end of finger to tip of nail.
**Standard Precautions**

*To be used in ALL patient care*

- Wear gloves when likely to touch body fluids or mucous membranes.
- Wear gown when clothing is likely to be soiled.
- Wear mask/eye protection when starting, dc’ing, or manipulating invasive devices such as IV catheters, NG tubes, foley catheters, drains, etc.
- Place soiled linen in plastic laundry bag.
- Dispose of needles, syringes, and sharps in appropriate containers. **Do not recap needles.**
- Safety products, when available, must be utilized.

**Isolation Precautions**

In addition to Standard Precautions, the following Transmission-Based Precautions are utilized:

- **Airborne**-- known or suspected infection with microorganisms transmitted by airborne droplet nuclei; requires private room, negative airflow, and respiratory protection (N-95).
- **Droplet**-- known or suspected infection with microorganisms transmitted by droplets during coughing, sneezing or during certain procedures.
- **Contact**-- known or suspected infection or colonization with epidemiologically important microorganisms (i.e., MRSA/VRE/C. difficile/other MDRO’s) transmitted by direct or indirect contact with patient, environmental surfaces or patient care items.
- **Protective**-- for immunocompromised patients at increased risk for bacterial, fungal, parasitic and viral
infections from endogenous and exogenous sources. Requires private room and positive airflow.

**Policy:** OUMS 18-03: Isolation Precautions
OUMS Infection Control Manual - Meditech Library

**Blood-Borne Pathogens**
Blood-borne pathogens are organisms that can be passed from person to person in body fluids and tissues. Most body fluids including blood, semen, saliva, and open wound drainage are potential carriers.
- Examples include HIV and Hepatitis B.
- Personal protective equipment, such as gowns, gloves, masks and eye protection are provided. It is the responsibility of the health care provider to utilize this equipment.
- Dispose of infectious waste in appropriate infectious waste container (small red bag, sharps container or large biohazard container
- Use available sharps safety devices and needleless systems to minimize exposure.

**Policy:**
OUMS Policy 18-09: Management of Exposure to Blood and Body Fluids

**Tuberculosis (TB)**
Those interacting with known or suspected TB patients must wear appropriate protective devices.

OUMS employees are tested annually for latent TB infections by a Mantoux PPD test. Health care providers identified to be at risk for exposure complete
mandatory fit testing of approved respiratory devices for prevention of exposure to tuberculosis. A patient who has AFB smears ordered will be placed in airborne precautions until three smears are obtained and reported as negative.

**Policy:**
OUUMS Policy 18-01: Tuberculosis (TB) Control Program
OUUMS Policy 18-02: Respiratory Protection
For Tuberculosis (Fit Testing)

**MRSA**
MRSA impacts costs by prolonging hospital and critical care stays with complications. Eliminating MRSA transmission is as simple as **ABCD:**

**Active Surveillance Cultures:** Obtained on targeted high-risk patient groups (all NICU admissions, previous positive (>6 months), pre-op CABG, total knee/hip, spinal surgery, hemodialysis, bone marrow/stem cell transplant, neutropenic oncology patients admitted for complications.

**Barrier Precautions**
Patients with MRSA are placed on Contact Precautions. In addition to standard precautions:
• Wear clean non sterile gloves and gown when entering the room to avoid contamination by contact with the patient or room surfaces.
• Limit movement and transport of the patient from the room to essential purposes only.
• Use dedicated patient-care equipment
• Ask visitors to wear a gown when entering the room and remove before leaving

**Compulsive Hand Hygiene**
• Perform hand hygiene before and after patient and environmental contact
• Wear gloves for all contact with blood, body fluids and moist body surfaces. Change gloves when moving from dirty to clean site on the same patient.
• Ask visitors to wash or use an alcohol-based hand rub on entering and leaving the room.

**Decontamination of Environment and Equipment**
• MRSA can survive on surfaces (plastic chart, laminated tabletop, cloth curtain, etc) for 9-11 days.
• Patients on Contact Precautions should have equipment solely for them and decontaminated before leaving the room at discharge.
• Daily cleaning of patient rooms by environmental services staff is essential.

**AIM for ZERO**
The Aim for Zero program assists in meeting our goals for reducing or eliminating HAI’s. Part of this program is the use of **bundles of evidenced–based prevention measures utilized on all patients at risk for HAIs**.

The CDC estimates there are 250,000 Central line associated bloodstream infections (CLABSIs) yearly, killing over 30,000 people in the U.S.
Evidence-based practices that are a part of the bundle for reducing CLABSIs are:

- Performing proper hand-hygiene
- Draping the patient using aseptic technique with full body drape
- Using 2% CHG plus alcohol for skin antisepsis
- Wearing maximal barriers during the insertion, to include sterile gloves, impervious gown, cap, mask with eye protection
- Using sterile technique when applying a CHG antimicrobial patch or dressing to the insertion site post-procedure
- Verifying that all team members participating in the catheter insertion procedure follow aseptic technique and evidence-based safety precautions

Catheter Associated Urinary Tract Infection (CA-UTI) is the most common healthcare-associated infection in the U.S., accounting for 40% of all HAI’s and more than 13,000 deaths each year. Up to 70% are preventable.

Evidence-based practices that are part of the bundle for reducing CA-UTIs are:

- Perform proper hand hygiene
- Use urinary catheters only when necessary. Consider other methods of urinary drainage (e.g. condom catheters, intermittent catheterization, and use of bladder scanners)
- Aseptic insertion of a closed unobstructive drainage system kept below the level of the bladder at all times; secure catheter to prevent movement and urethral traction.
- Discuss number of catheter days during handover as a reminder to reduce duration.
INFORMATION MANAGEMENT (IM)

Information Security

• Treat all information as if it were your own
• Access only systems you are authorized to access
• Access only information you need to do your job
• Only share sensitive and confidential information with those who also have a “need to know.”

Meditech is our patient care system. It allows us to see and document patient charts.
• You are only allowed to use your own ID and password. It is against policy to share your password.
• Your access to Meditech is based on your “need to know” and required functions specific to your job.
• You may have access to some systems your co-workers do not. DO NOT share your password.
• Meditech contains confidential information. You are ONLY allowed to share this information with others who have a “need to know” for their job.
• It is against hospital policy to access your own Medical Record in Meditech. The proper method for obtaining it is to fill out a “Release of Information” form in the Medical Records Department.

Help Desk, 271-8660; Hours: M-F 0700-1700
After Hours (for emergency use only) - Call the hospital operator to reach the on-call technician
**HIPAA: Health Insurance Portability and Accountability Act**

OU Medical System is required by federal law to maintain the privacy of our patient’s health information and to provide patients with a description of our privacy practices.

HIPAA is designed to control access to and disclosure of **Protected Health Information (PHI)**. Health information that can identify or be linked to an individual is PHI. Identifiable information may contain, but is not limited to:

- Name
- Address including street, city, county, zip code
- Names of relatives and/or employers
- Birth date
- Telephone and/or fax numbers
- Electronic e-mail addresses
- Social Security Number
- Medical record or health plan beneficiary number
- Account number or certificate/license number
- Any vehicle or other device serial number
- Web Universal Resource Locator (URL)
- Internet Protocol (IP) address number
- Finger or voiceprints
- Photographic images
- Any other unique number, characteristic, or code

**Notice of Privacy Practices** brochures will be given to patients at each visit. Patients sign a form confirming receipt of the notice.
**Treatment, Payment and Operations** – OU Medical System may use medical information to provide treatment or services and may disclose information to doctors, nurses, technicians, medical students, or other practice personnel involved in the patient’s care and have a need to know to perform their job.

OU Medical System may also provide a partner physician a copy of various reports for the purpose of peer review, plan of treatment consultation, and/or to substitute care in the physician’s absence. Members of the medical staff and/or quality improvement team may use information in a patient’s health record to assess the care and outcomes of the case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. Wherever possible, identifying information will be removed to protect patient privacy.

**Need to Know** - Any member of the workforce with a legitimate need to know to perform their job responsibilities may access a patient’s health information. However, the amount of information accessed should be limited to the minimum amount necessary to perform their job responsibilities.

**Telephone Inquiries** - Patient information can be released in two ways. If the caller has a patient’s full name (first and last), and the patient is not confidential, the hospital can provide the location of the patient and one word description of the patient’s condition; “good”, “fair”, “serious” or “critical”.

*Readiness Guidebook 2013*  Page 48
If a patient is designated as confidential, the patient and the fact of his/her admission shall be treated as confidential information and will not be confirmed or denied. Personnel may state “I am sorry; we do not have any information on an individual under that name”. All flowers, gifts, and mail shall be rejected.

Physical Workspace & Information Security
• Computer screens should be positioned so PHI is not readable by the public or other unauthorized viewers.
• Printers should be positioned in protected locations so that printed information is not accessible or viewable by an unauthorized person.
• Patient information should not be communicated via personal cell phone or by texting on personal devices.
• Text messages sent to pagers from any internet-based system (such as Metro-Call) are not secure. Patient information should not be sent to pagers.

Visitors to Patient Care Areas
Ensure that visitors, including vendors, suppliers, and our own friends and family, do not access areas where protected patient health information is visible or enter areas where patient information is displayed, such as work stations where computer screens are visible and meeting rooms where patient information is displayed.

Policy:
OUMS Policy 20-10: Privacy Sanctions for Privacy & IS Violations
Photographing/Videotaping

Photographing patients or patient test results with any device is prohibited and considered a violation of HIPAA. OUMS asserts the following guidelines:

1. Photographs/videotapes may be taken for educational or informational purposes with the consent of the patient and/or visitor. Consent must be obtained even if the picture does not depict the face or other identifiable image.

2. These photographs/videotapes will not be duplicated or publicized without the appropriate consent from the patient/visitor.

3. If commercial use is intended, Public Relations will obtain written consent from patient or physician.

4. Consent to photograph/videotape the patient must include a properly completed Authorization for Release of Protected Health Information form.

5. Patients/visitors have the right to request cessation of recording or filming.

6. Patients/visitors have the right to rescind consent before the recording or film is used.

7. Photographs taken for personal use or with personal devices are prohibited.

Please note: Displaying and/or distributing images of patients without approval is not permitted. This includes images taken by others and images on non-OUMS computers. Demonstrating respect and confidentiality of all patient information and images is expected of all employees at all times.
Policy:
OUMS Policy 20-19: Photographing, Video Recording, Audio Recording, and Other Imaging of Patients, Visitors, and Workforce Members

Media Contact/Press Release
Only the Public Relations/Marketing Department or the Clinical Coordinators are authorized to respond to media inquiries.

All employees should direct questions from the media concerning any patient’s condition to the on-call Public Relations representative at 559-2111 for the Downtown campus and 359-5580 on the Edmond campus. After hours and holidays inquiries should be referred to the Clinical Coordinator via the Hospital Operator. Recognize the confidential nature of all matters pertaining to the condition or care of patients and discuss such matters only with authorized persons.

Inquiries concerning present and former employees must be directed to the Human Resources Department.

Policy: OUMS Policy 10-10: Media Contact/Press Release

Vendors
- Vendors must check in and out for EACH visit
- Staff must verify appropriate vendor badge at least chest high before entering their hospital area.
- Vendors who do not have the appropriate dated badge should be directed to the Materials Management Department, to complete necessary paperwork for access.
• **Social Media Guidelines**

**General Provisions**

Unless specifically authorized, employees are restricted from speaking on behalf of HCA or OUUMS. Employees may not publicly discuss patients, employees, or other stakeholders outside of Company-authorized communications. Employees are expected to protect the privacy of HCA and its patients, employees and other stakeholders and are prohibited from disclosing patient information, personal employee and nonemployee information and any other proprietary or confidential information to which they have access.

**Monitoring**

Employees are reminded that they should have no expectation of privacy while posting information to social networking sites. Postings often can be reviewed by anyone. As described in HCA Policy EC.026, HCA and OUUMS reserve the right to use content management tools to monitor comments or discussions about the Company, its employees, its patients and the industry posted on the Internet.

**Reporting Violations**

OUUMS strongly urges employees to report any violations or possible or perceived violations to supervisors, managers or the HR department, to the Facility Privacy Official (if patient information is involved) or to the Ethics Line (800-455-1996).
Consequences
OUUMS investigates and responds to reports of violations of EC.026, these Social Media Guidelines and other related policies. Violations may result in disciplinary action up to and including termination.

Personal Use of Social Media
HCA and OUMS respect the right of employees to participate in blogs and use social networking sites during non-working hours and does not discourage self-publishing or self-expression. Employees are expected to follow these guidelines and policies to provide a clear distinction between you as an individual and you as an employee.
• Personal Responsibility. You are personally responsible for your commentary on social media. You can be held personally liable for commentary that is considered defamatory, obscene, proprietary or libelous by any offended party, not just HCA.
• Non-threatening. Employees should not use blogs or social networking sites to harass, threaten, discriminate or disparage employees or anyone associated with or doing business with HCA or OUMS.
• Disclaimer. When you identify yourself as an employee of HCA or an affiliate, some readers may view you as a spokesperson for HCA and/or that affiliate. Because of this possibility, you must state that the views expressed by you through social media are your own and not those of the Company, nor of any person or organization affiliated or doing business with HCA and/or an affiliate.
• Privileged or Confidential Information. Employees cannot post on personal blogs or other sites the name, trademark or logo of HCA, its affiliates, or any business with a connection to HCA or its affiliates. Employees cannot post Company-privileged or confidential information, including copyrighted information, Company-issued documents, or patient protected health information.

• Workplace Images. Employees must follow OUMS Policy10-09: Photographs/Videotaping regarding images taken in the workplace.

• Advertising. Except as authorized or requested by HCA or an affiliate, employees may not post on personal blogs and social networking sites any advertisements or photographs of Company products, nor sell Company products and services.

• Patient Information. Do not use your personal social media account to discuss or communicate patient information with one of your patients, even if the patient initiated the contact or communication. Always use Company-approved communication methods when communicating with patients about their health or treatment.

• Security. Consult the Information Security site on Atlas for social media information security tips.

If you have any questions relating to these guidelines, a personal blog or social networking, ask your supervisor, another member of management, your HR Advisor, Marketing Director, ECO or FISO.
MEDICATION MANAGEMENT (MM)

Do Not Use Abbreviations
• Be familiar with the list of prohibited abbreviations and how to access it for review.
• Use only approved abbreviations. Stedman’s Abbreviation Books are available for reference.
• If an unapproved abbreviation is used in an order, contact the physician for clarification.
• Ensure preprinted orders use proper abbreviations.

⇒ Never use “u” or “U” for “units”-May look like “0”, “4”, or “cc”
⇒ Never use “IU” for “International Unit”-May look like “IV” or “10”
⇒ Never abbreviate drug names
⇒ Never use “MS”, MSO4” or “MgSO4”-Spell out “morphine sulfate” or “magnesium sulfate”- Abbreviations may be confused
⇒ Never use “QD”/“qd” for daily or “QOD”/“qod” for every other day
⇒ Never use a trailing zero (X.0 mg) or leave off a leading zero (.X mg) - The decimal point is often missed

Policy: OUUMS Policy 17-03: Abbreviations

Medication Administration
1. Call and question orders that are not readable
2. Use proper hand hygiene
3. Use two patient identifiers (name, birth date, or med. record number) prior to giving medication
4. Scan the patient’s armband and medication
5. Educate the patient about the medication
**Adverse Drug Reactions (ADR)**
- Call the pharmacy or ADR Hotline – 1-8186 (Downtown) or 6308 (Edmond)
- Provide patient’s name, medical record number, suspected drugs, description of reaction, treatment
- File a QM in Meditech and update patient’s profile

**Medication Security**
Medications should be stored behind a locked door or in an area where unauthorized individuals do not have access. Access to these areas is restricted to ONLY those employees who need to access them in order to perform their routine job duties.

When job duties require that you access these areas, it is important that you ensure the security of medications by:
- **NEVER** leave area unlocked if unattended
- **NEVER** share the door combination to medications rooms with other staff
- **NEVER** allow individuals to access these areas unless they are authorized to be there

**Medication Storage**
- Initial, date, and time all open vials with date opened and discard within appropriate timeframe
- Document Pyxis discrepancies
- Assure med refrigerator daily temperature log is complete with actions noted
- No expired meds
- No food, specimens, or supplies stored with meds
Look Alike / Sound Alike Medications
• Know which meds are easily confused with each other and should be stored away from one another.
• “Look-Alike/Sound-Alike” posters are placed in medication rooms for quick review.
• Contact Pharmacy for questions about med orders.

High Alert Medications
High-alert medications are defined medications which are involved in a high percentage of errors and/or sentinel events, as well as medications that carry a higher risk for abuse or other adverse outcomes.

Processes ensuring the safe selection/procurement, storage, ordering/transcribing, preparation/dispensing, administering and/or monitoring of high-alert medications within OUMS are in place at all times.

Crash Carts
• Lock is in place and the lock number is accurately recorded on the log
• Daily log is complete and accurate
• Oxygen equipment is available
• Defibrillator is plugged in & checked appropriately
• Emergency meds are secured in crash cart or “emergency med” tackle box with break-away lock

Definition of a Medication
• Traditional prescription/over the counter medications
• IV solutions, including Normal Saline vials/syringes
• Oral and IV Contrast Media
• Medical kits containing medication components
• Vaccines, Herbal Remedies, Vitamins
• Any product designated by the FDA as a drug
MEDICAL STAFF (MS)

Medical Staff/Credentialing
The Executive Chief of Staff and the Medical Staff Services/ Credentialing Department establish a master file of practitioners and their privileges.

Practitioner privileges can be accessed by the nursing staff in the E-Priv and I-Priv Systems. It is imperative that you review both systems in order to ensure the practitioner has been credentialed to work.

If you have questions regarding a practitioner’s medical staff membership and privileges, contact Medical Staff/Credentialing Services at 271-3741.

Impaired and/or Disruptive Practitioner
OU Medical System will provide assistance to practitioners seeking self-referral, identify impaired practitioners, investigate reports of suspected impairment, refer practitioners for diagnosis, treatment and rehabilitation when warranted, investigate reports of uncooperative and disruptive behavior, track and monitor disruptive incidents, and educate practitioners on the prevention of impairment and disruptive behavior.

Impairment includes any physical, psychiatric, emotional or behavioral disorder that interferes with the practitioner’s ability to engage safely in professional activities.
**Disruptive Behavior** interferes with the regular operations of the hospital. It may consist of one incident, a series of incidents or a pattern of behavior. Examples include, but are not limited to:

- Physical attacks on patients, visitors, employees or other practitioners
- Inappropriate physical contact which is threatening, intimidating or unwanted.
- Verbal attacks on patients, visitors, employees or other practitioners, including non-constructive criticism which intimidates, demeans, undermines confidence or belittles
- Use of profanity, gestures, or language with inappropriate overtones.
- Refusal to provide care to certain patients or to accept assignments or responsibilities when under an obligation to do so.
- Impertinent or inappropriate entries in the medical record that may impugn quality of care or attacking particular practitioners, nurses, or hospital policies.

**Reporting:** Any employee, visitor, practitioner, patient and/or family member, who suspects that a practitioner is impaired, is unable to work cooperatively with others or has exhibited disruptive behavior shall promptly provide a written confidential report to the Director of Medical Staff Services giving a factual description of the circumstances.

**Policy:** OUMS Policy 19-08: Impaired Practitioner
OUMS Policy 19-03: Disruptive Practitioner
PROVISION OF CARE, TREATMENT, AND SERVICES (PC)

*Excel Standards*
Specific goals have been developed to assist us in achieving our goals of making OU Medical System a great place for employees to work, physicians to practice medicine and patients to receive care. Excel Initiatives assist us in achieving these goals.

*AIDET*
*Five Fundamentals of Consistent Communication*

<table>
<thead>
<tr>
<th>Safety</th>
<th>A</th>
<th>Acknowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease Anxiety</td>
<td>I</td>
<td>Introduce</td>
</tr>
<tr>
<td>Increase Compliance</td>
<td>D</td>
<td>Duration</td>
</tr>
<tr>
<td>Quality</td>
<td>E</td>
<td>Explanation</td>
</tr>
<tr>
<td>Patient Loyalty</td>
<td>T</td>
<td>Thank You</td>
</tr>
</tbody>
</table>

These are five behaviors to use in *every patient/staff interaction* to anticipate, meet, and exceed expectations of patients, family members, co-workers and reduce anxiety of patients/families.

*Patient and Family-centered Care:*
• People are treated with dignity and respect.
• Health care providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful.
• Patients/family members build on strengths through experiences that enhance control and independence.
• Collaboration among patients, family members, and providers occurs in policy and program development, professional education, and in the delivery of care.

**Care Planning**
The interdisciplinary plan of care will be reviewed daily and revised as necessary. After collaboration with other team members, Nursing will prioritize and document care needs. Interdisciplinary communication regarding patient/family needs and assessment is ongoing and occurs through both formal and informal methods. Methods may include:

- Documentation in patient medical record
- Documentation in Meditech
- Interdisciplinary team meeting
- Phone consultations/referrals
- Rounds

**Patient Education**
All patient education should be documented including:

- Discharge planning instructions
- Patient’s response and understanding
- Potential food and drug interactions
- Use of medications and medical equipment
- Personal Hygiene
- Condition-specific information

**Policy:**
OUMS 11-27: Patient and Family Education
**Pain Management**

- **Adult patients**: **Numeric Pain Distress Scale**. A 0 – 10 scale where 0=no pain and 10= worst pain imaginable.
- **Children and cognitively impaired adults**: **Wong Baker FACES Scale**. This is also a 0 – 10 scale with 0 being no pain and 10 the worst pain imaginable.
- **Pediatric and non-verbal patients**: **FLACC Scale**.
- ** Patients 24-60 week’s gestational age**: **EDIN Scale**.

- Please assist in making your patients comfortable by using appropriate scales to document your patient’s pain goals, scores and the effectiveness of pain management interventions (re-assessments) in the electronic medical record.
- Contact the Pain Management Nurse for pain management issues, questions or educational needs
- Contact the Pain Management Service for a formal pain management consult with an order from the primary team at **523-0385**, 24 hours a day, 7 days a week.

**Policy**: OUMS 11-51: Pain Management Guidelines

**Response to changes in a patient’s condition**

**Rapid Response**

The purpose of the Rapid Response Team (RRT) is to assess and assist with the non- Intensive Care, Labor and Delivery, or Emergency Department patients experiencing acute respiratory, cardiovascular, or neurological changes or any other changes causing concern to the patient, staff or families.

**Policy**:
 OUMS Policy 11-67: Rapid Response
Abuse and Neglect

Assessing for Signs of Abuse and Neglect

Look for injuries that are: inconsistent with the story given, in various stages of healing, or are part of a pattern.

Child Abuse or Neglect

- Physical evidence of abuse such as welts, human bite marks, burns, bruises on the face, ears, back, buttocks, genital area, thighs, and back of legs.
- Injury may indicate type of abuse, for example, spiral fracture from twisting, whiplash from shaking.
- Conflicting stories as to how injury happened.
- Injury inconsistent with the history; such as bruises on face, back and chest from falling off a bed or fracture from falling off a couch.
- History of injury is inconsistent with the developmental level of child.
- A complaint other than the one associated with the abuse, "He has diarrhea" and there is evidence of a black eye and a broken arm.
- Repeated visits to different emergency facilities.
- Neglect evidenced by loss of weight, a failure to gain weight, or unkempt appearance.

Elder Abuse or Neglect

- A caretaker’s refusal to allow visitors to see elder alone.
- Elder's report of being abused or change in behavior.
- Physical abuse including bruises, black eyes, lacerations, rope marks, welts; bone fracture; broken eyeglasses or frames; open wounds, cuts, punctures, untreated injuries/bleeding.
- Sexual abuse; bruises around the breasts or genital areas; unexplained venereal disease or genital infections; vaginal or anal bleeding; torn or bloody underclothing.
• Emotional abuse; patient is emotionally upset or agitated; extremely withdrawn and non-communicative; or shows unusual behavior such as sucking, biting, rocking
• Neglect; torn clothes, unkempt personal appearance, loss of weight.
• Financial exploitation, unexplained insufficient funds.

**Domestic Abuse**
• Physical evidence including bruises, black eyes, lacerations, welts, rope marks, bone fractures, open wounds, cuts, punctures, untreated injuries, sprains, dislocations, and internal injuries/bleeding.
• The spouse's/partner's refusal to allow patient to be alone with medical staff.
• Reluctance to seek medical attention for injuries.
• Reluctance to discuss injuries in front of other family members.
• Spouse/partner speaking for the suspected victim.
• Conflicting or inconsistent stories about the injury.
• Complaint other than abuse.

**Assault**
• A person's report of being assaulted.
• Physical evidence of assault, such as bruises, black eyes, rope marks, lacerations, fractures, open wounds, cuts, punctures, internal injuries/bleeding, gunshot wounds.

**Rape and/or Sexual Molestation**
• A person's report of being raped or molested.
• Bruises around the breasts or genital areas.
• Unexplained vaginal or anal bleeding.
• Torn or bloody underclothes.
• Reluctance to seek medical attention.
• Reluctance to talk about the incident.
• An injury inconsistent with the history such as bruises on face, back and chest from falling off a bed or fracture from falling off a couch.
• A complaint other than the one associated with abuse.
• Repeated visits to different emergency facilities.

**Every hospital staff member is responsible for reporting possible abuse, neglect, or maltreatment through their chain of command.**

• On evenings, nights or weekends – call the clinical coordinator and/or administrator on call.
• Social Services may assist assessment and reporting by phone at: 271-4518 (TCH), 271-4610 (POB). At the Edmond campus, call the operator by dialing “0” and they will notify the on-call person
• Or you may call the Department of Human Services directly at: 1-800-522-3511
• Abuse or injuries that are the result of criminal conduct, (gunshot wounds, sexual abuse, or suspicious injuries) should also be reported to the OUHSC Police Department at 1-5711 or on the Edmond campus at 359-5470 or 200-3551.

The **confidentiality** of the patient is protected at all times.

**Policy:**
OUMS Policy 11-02 A: Abuse, Neglect, and Harassment: Recognition and Response
OUMS Policy 11-02 B: Protecting Patients from Abuse and Harassment
End of Life Care

OU Medical System provides care that optimizes the dying patient's comfort and dignity and addresses the patient's and his/her family's psychosocial and spiritual needs, recognizing that the patient has the right to physical and psychological comfort.

Goals (key desires) of patients and families at the end of life may include the following:

• Pain and symptom management – patients want assurance that physical discomfort will be relieved.
• Family involvement – most patients want their families involved in decision-making. Family may mean different things to different individuals. The patient’s view of “family” should be respected.
• Care at home – when asked, most patients express a desire to receive their end of life care at home or in a home-like environment.
• Completion – patients want the opportunity to say good-bye and leave some kind of legacy.
• Affirmation of the whole person – patients want to be recognized as still having something to contribute.

Social Services, Chaplains and Child Life Specialists are available to assist with end of life issues.
Operative or High-Risk Procedures Requiring Sedation or Anesthesia: Time-Out

A time-out must be conducted prior to invasive procedures including:

- Lumbar Puncture
- Endoscopy and Bronchoscopy procedures
- Central Line, PICC line, or chest tube insertions
- Bone Marrow procedures
- Biopsy
- Cardiac Catheterization
- Medical device implantation
- Fracture reduction

Immediately prior to the start of any invasive procedure, a final verification process, where members of the surgical/procedural team verbally confirm the correct patient, procedure and site will be conducted.

The surgical/procedural site will be marked to verify the correct patient, correct procedure, and correct site. If possible, the patient should be involved.

Time-out documentation includes:

- The participants in the “time out” process.
- The oral confirmation of:
  - correct patient,
  - correct surgical/ procedural side/site,
  - correct procedure,
- The time of “time-out” and time procedure began
- Any discrepancies and actions taken

Policy:

OUMS Policy 11-50: Surgical/Procedural Verification
Restraints and Seclusion

If restraints are used, they will always be used in a manner that respects the patient’s privacy, dignity and well-being to the extent possible. Chemical restraint, the use of psychoactive medication that is not a customary part of a medical diagnostic or treatment procedure and that is used to restrict a patient’s freedom of movement, is an inappropriate use of medication.

There are situation-specific differences between restraints used in the provision of acute medical and surgical care and those used to manage behavioral symptoms.

Restraints may never be written as PRN or standing orders. A patient must be continually monitored, assessed and reevaluated with a goal of release from the restraint or seclusion at the earliest possible time.

Please review OUMS Policy 11-06 for detailed requirements related to restraints/seclusion for violent or self-destructive behavior and restraints for non-violent, non-self destructive behavior.

Death Reporting Requirements:
The following information must be reported to the Center of Medicare and Medicaid (CMS) for all deaths associated with the use of seclusion or restraint, except for soft wrist restraints:
• Each death that occurs while a patient is in restraint or seclusion.
• Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
• Each death known to the facility that occurs within 1 week after restraint or seclusion where it is reasonable to assume
that use of restraint or placement in seclusion contributed directly or indirectly to a patient’s death.

Each death must be reported by the Clinical Manager or Unit Director to the CMS regional office by telephone no later than the close of business the next business day following knowledge of the patient’s death.

When no seclusion has been used and when the only restraints used are soft wrist restraints, the following information must be documented on the “death with restraint” log within 7 days of the date of death:

• Any death that occurs while a patient is in restraint.
• Any death that occurs within 24 hours after the patient has been removed from restraint.
• The patient’s name, date of birth, date of death, attending physician, medical record number, and primary diagnoses must be documented on the log.

Staff must document in the patient’s medical record the date and time the death was reported to CMS or the date and time the death was reported on the log.

At the time of discovery of the patient’s death, staff are also to complete a patient notification in the QM module in Meditech.

Policy:
OUMS Policy 11-06: Restraints and Seclusion
Blood Administration
It is the policy of OU Medical System that a signed consent form shall be obtained from all patients before blood and/or blood component transfusions.

The attending physician/physician designee of the service that is ordering the transfusion shall be responsible for obtaining the appropriate completion of the consent.

Where it is evident in the opinion of the treating physician that immediate treatment is necessary to prevent immediate and serious impairment of the patient’s health and consent cannot be readily obtained or has not been obtained during admissions or clinic visits, treatment may be provided.

After the attending physician/designee has been consulted and is in agreement with the treating physician’s opinion and consent in such instances is implied, the attending physician/designee must document necessity of transfusion in the patient’s medical record.

Policy:
OUMS Policy 10-16: Blood/ Blood Component Transfusion Consent
**Stroke Awareness**

**Signs and Symptoms of Stroke**
- Numbness and /or weakness in face or extremities
  - One side of the body may be affected
  - Facial droop may be minor or whole side of face
- Confusion
- Difficulty seeing, speaking, and/or walking;
- Lack of coordination
- Severe headache, with no cause

**Risk Factors for Stroke**
- Advancing age and/or family history of stroke
- Diabetes, hypertension, and/or high cholesterol
- Obesity and/or Inactivity
- Smoking
- Coronary Artery Disease (CAD)

**Types of Stroke**
- **Hemorrhagic:** Rupture of blood vessels in the brain
- **Ischemic** (most common): Blocked blood vessels in brain

**What can you do?**
- Watch for changes in your patients
- Educate patients/families to recognize signs of stroke
- Chart all education including patient/family response
- Chart all observations, interventions, and results
- Call ER and page a Stroke Alert for the Neurology Stroke Team if you see signs of stroke:
  - 417-6796 (Downtown) or 444 (Edmond)
- Call Rapid Response if you need help maintaining ABC’s
- Contact the OUMS Stroke Coordinator with questions at:
  - 271-8001 x 37333

Note: Patients must receive written instructions on all stroke medications on discharge.

*Readiness Guidebook 2013*  Page 71
PERFORMANCE IMPROVEMENT (PI)

OU Medical System uses the Lean Six Sigma methodology for performance improvement. To determine the priorities of the project to study, we gather and analyze data (historical, variance, patient complaint/satisfaction survey, or issues/areas of High Volume, High Risk, or Problem-Prone) and examine our patient populations and top DRGs. The Six Sigma structured approach is DMAIC.

D– Define
M– Measure
A– Analyze
I– Improve
C– Control

**OUMS PI projects include, but are not limited to:**

- Decrease Risk Adjusted Mortality Index (RAMI)
- Eliminate Hospital Acquired Conditions (HAC)
- Handovers
- Clinical Information Systems

Be sure to add your department’s PI projects to page 90.
Core Measures

Core Measures are performance based quality measures that are mandated by both the Center for Medicare and Medicaid Service (CMS) and the Joint Commission. OUMS’s results are publicly reported on the internet at: www.hospitalcompare.gov

OU Medical System’s Core Measures include:

✓ Acute Myocardial Infarction
✓ Heart Failure
✓ Pneumonia
✓ Surgical Care Improvement (SCIP)
✓ Outpatient SCIP
✓ Children’s Asthma Care
✓ Perinatal Care
✓ HBIPS – Hospital-Based Inpatient Psychiatric Services (Edmond)
✓ Immunizations
✓ Outpatient AMI and Chest Pain
✓ Outpatient Stroke
✓ Outpatient Pain Management
✓ Outpatient ED Throughput

Results for each of the Core Measures can be found on the OUMS intranet.
RECORD OF CARE, TREATMENT, AND SERVICES (RC)

Medical record complete and timely
The medical record is vital for accurately documenting the patient’s course of treatment at OU Medical System.
• Make sure you completely and accurately document patient care information including patient education and interdisciplinary care

Verbal orders
Verbal orders are only taken in emergency situations. When verbal orders are given, the receiver will legibly write down the complete order and read it back to the dictating physician for confirmation.

Policy: OUMS Policy 11-26: Verbal/Telephone Orders

Translation Services and Interpreters
For non-English speaking patients
• Interpretation services are made available to OUMC inpatient, outpatient and all ancillary services. Spanish language assistants are available to patients upon request and as determined to be necessary by hospital personnel.
• Additional languages are addressed on an as needed basis and are coordinated via MARTTI video and audio interpretation system with the service support of Language Access Network.
When should interpreters be used?
OUMS may exercise discretion as to when an interpreter is necessary since routine care may not require extensive communication.
Situations in which an interpreter should be used include, but are not limited to, the following:
• Determining a patient’s history or description of ailment or injury;
• Obtaining informed consent or permission for treatment;
• Provision of patient’s rights;
• Explanation of living wills or powers of attorney (or their availability);
• Diagnosis or prognosis of ailments or injuries;
• Explanation of procedures, test, treatment, treatment options or surgery;
• Explaining administration and side effects of medications, including food or drug interactions;
• Discharge instructions or planning;
• Explaining and discussing advance directives;
• Explaining blood donations or apheresis;
• Explaining follow-up treatment, test results, or recovery;
• Discussing billing and insurance issues; and
• During educational presentations (i.e., classes about birth, nutrition, CPR, smoking cessation, etc).

EVERY time an interpreter is used for conveying important information to the patient, documentation should be placed in the patient’s chart.
Who can interpret?
• Only qualified competent interpreters/translators, who have passed a written and verbal competency assessment will be utilized to provide interpretation or translation services. No one under 16 years of age is permitted to formally interpret at OUUMS.
• Family members, friends, advocates, case managers, physicians and other people who are at the hospital to support the patient may assist with basic communication, but for situations listed as requiring an interpreter they are not appropriate or qualified interpreters, regardless of their language abilities.
• Asking such persons to interpret may represent a HIPAA violation, denies the patient the support they need, and compromises the accuracy and effectiveness of OUMC staff communications with the patient.

For hearing impaired patients
• OUUMS will provide qualified sign-language interpreters and other auxiliary aids to persons who are sensory impaired, when necessary, to ensure equal opportunity to benefit from the services provided.
• OUUMS will inform sensory impaired patients and the sensory impaired relatives of patients of the availability, at no cost to them, of interpreters and telecommunication devices for the deaf and to provide such services promptly upon request.
• If a person uses sign language, all medical and psychiatric evaluations or discussions regarding a patient’s symptoms, treatment (including individual and group psychotherapy), diagnosis, progress and
prognosis must be communicated through the use of a qualified sign language interpreter.
• If a person who is deaf or hard-of-hearing refuses OUMS’s offer of a free, qualified interpreter and prefers to use a friend or family member to interpret, the hospital shall secure a written “Waiver of Interpreter Services” which appears on the opposite side of the attached “Notification of Services” form.
• A request to use family or friends by the person who is hearing impaired following the offer by OU Medical System to provide an interpreter will be documented and honored unless OUMS staff determine the person selected is not sufficiently qualified and elects to provide another interpreter. No payment will be made by OUMS when the person volunteers his/her own resources for translation services.
• In case of emergencies, or while awaiting the arrival of an interpreter, other auxiliary aids may be used. These aids may assist in communication but are not a replacement for interpreters. These aids may include:
  • Flashcards/Communication boards
  • Telephone amplifiers
  • Telecommunication devices/Braille
  • Taped materials/Large print materials
  • Reading aloud to patient
  • Lip reading/Note writing/Use of gestures

Policy:
OUUMS Policy 10-33a: Interpreters and Translation: Low English Proficiency
OUUMS Policy 10-33b: Interpreters and Translation: Deaf and/or Hearing Impaired
Informed Consent

The explanations of the procedure to the patient, in addition to the signature on the form, are both components of the informed consent process.

This explanation should include:
• Potential benefits and risks
• Potential problems related to the recuperation
• The likelihood of success
• The possible results of non-treatment
• Significant alternatives

The patient will be informed of:
• The name of the physician primarily responsible for the patient’s care
• The identity and professional status of individuals responsible for performing the procedure
• Any relationship to another healthcare provider or institution that might suggest a conflict of interest

The patient, witness, and physician must sign, date, and time the informed consent document.

It is the responsibility of the practitioner performing the procedure (attending physician/operating physician/nurse performing the procedure, and/or the anesthesiologist) to obtain informed consent.

Policy:
OUUMS Policy 11-05: Informed Consent
**Do Not Resuscitate (DNR)**

It is the policy of OU Medical System to comply with valid DNR requests made by patients or their representatives.

**All DNR orders will be appropriately recorded in the patient’s medical record and shall be signed by the patient’s attending physician.** At anytime, a patient, parent or guardian of a minor child, a mature minor or a representative of an incapacitated person may revoke a DNR order or DNR Consent Form.

The physician will conduct and document an ongoing assessment of the patient’s condition in the progress note section and shall review a DNR Order at a minimum of every seven days on general medical/surgical units and every 48 hours for pediatric patients. The physician shall modify or discontinue a DNR Order as appropriate.

Patients will be identified by means of a blue armband as to their DNR status. Without the order or blue armband, full resuscitative measures will be carried out.

**Policy:**
OUMS Policy 10-01: DNR
OUMS Policy 10-02: Life Sustaining Treatment, Withholding, or Withdrawal
Advanced Directives

Upon admission to the OU Medical System every patient age 18 years or older, or emancipated minor, will be asked if they have a completed Advance Directive. If they do not, they will be asked if they would like additional information regarding advance directives and/or assistance with executing an Advance Directive. If so, they will be directed to the Chaplains/Pastoral Care Services on the Downtown campus and Social Services on the Edmond Campus.

Advance Directives are honored on all patients with a properly executed advance directive once the patient's attending physician and a second physician determines that the patient is terminally ill or persistently unconscious.

In the absence of the actual Advance Directive, the substance of the directive will be documented in the patient's medical record. The lack of an advance directive will not hamper access to care. Advance Directives are not honored if the form is incomplete or if the patient is pregnant and has not delivered.

Policy:
OUMS Policy 10-06: Advanced Directives
RIGHTS AND RESPONSIBILITIES OF THE INDIVIDUAL (RI)

Patient Rights and Responsibility

We ensure that patient rights are respected by using open communication with patients and families and making them active participants in their care.

Some of the patient rights include:
• The right to impartial access to treatment
• The right to considerate, respectful care
• The right to reasonable safety and security insofar as hospital practices and environment are concerned
• The right to pain assessment and management
• The right to be free from all abuse or neglect

Some of the patient responsibilities include:
• The responsibility to provide accurate and complete information
• The responsibility to report unexpected changes in his/her condition
• The responsibility to follow hospital rules and regulations
• The responsibility to be considerate of others

Patients are given a copy of the Patient’s Bill of Rights upon admission. This information is also posted in several locations throughout the hospital.

Policy:
OUUMS 10-04: Rights & Responsibilities of the Patient
**Risk Management**

Notification reports (occurrences) are used to identify opportunities to improve patient care, to minimize risk exposure, and to enhance safety for the patient, medical staff, house staff, visitors, or volunteers of the facility. These reports are not intended to be used in a punitive manner.

Notification reports should be completed in the Risk Management section of the QM Module in Meditech. The utmost care should be given to protecting the confidentiality of these reports. Reports should **NOT** be referenced or permanently placed in the medical record or photocopied and given to anyone.

**General types of events that should be reported include, but are not limited to:**
- Unforeseen changes arising out of the health care management of the patient
- Variance from established policies and procedures that involve patient care. Examples include medication errors, treatment delays, and IV-related complications
- An accident with or without personal injury
- Falls
- Mishaps due to possible faulty/defective equipment or environmental equipment
- Unexpected adverse results of professional care and treatment that necessitate additional hospitalization or a significant change in patient treatment regimens
- Damage or loss to hospital property or equipment
Specific examples of Patient Notifications to be reported include:
1. Invasive diagnostic or surgical procedure performed on wrong patient or wrong body part.
2. Absent or improper evidence of informed consent.
3. Injury due to documented improper technique, personnel error, equipment failures, instrument breakage/malfunction, or unexplained cause.
5. Leaving against medical advice.
6. Surgery for removal of a foreign object left in operative site unintentionally; sponge, needle, foreign object or other material left in operative site unintentionally or because of impossible retrieval; incorrect sponge/needle count.
7. Delay in responding to an emergency situation.

Policy:
OUUMS Policy 15-04: Occurrence Reporting

Ethical Issues of Care
The Ethics Committee, comprised of a multidisciplinary team representative of each facility at OU Medical System, is available to address ethical issues concerning the care of our patients. Staff, patients, visitors, physicians or family members can request review from the Ethics Committee by contacting the on-call member through the communications operator.

Policy:
OUUMS Policy 10-05: Ethical Issues of Care
Patient Complaints and Grievances

Patients/families are informed of the right to voice complaints without fear of retribution, to have complaints investigated and resolved promptly.

Patients/families may contact any OUMS employee to express a complaint. Each employee is expected to resolve a complaint immediately as appropriate to his/her scope of service. If beyond their scope of service, they should follow their chain of command.

Employees should report ALL complaints through their chain of command with a “Track It” form located on the intranet.

If a substantive complaint is not properly resolved to the satisfaction of the patient and/or family and the complainant wishes to proceed, the complaint will formally become a grievance. The grievance will be documented in writing by the complainant, reviewed by the responsible Administrative Officer and a written response given within 7 days.

Examples may relate to any of the CMS Conditions of Participation:
- Quality of care concerns
- Premature discharge
- Patient rights or privacy violations

Patients/families have the right to contact the Oklahoma State Department of Health or The Joint Commission directly if they are not satisfied with the response they receive.

Policy:
OUMS Policy 10-03: Patient Complaint and/or Grievance Resolution
TRANSPLANT SAFETY (TS)

Organ, Body and Tissue Donation

It is the policy of the OU Medical System that every hospital death will be recognized as a potential organ/tissue donor.

It is the responsibility of the hospital administrator/designee or chaplain, in concert with the attending physician, to inform the legal next of kin of potential donors of the opportunity to participate in the organ retrieval program for every eligible death.

The option to donate organs or tissues will be done by a certified requestor at the hospital or can be referred to the Organ Procurement Organization (OPO) to officially request. Personnel who have been certified as a requestor may be given the authority to act for the hospital administrator in consulting with the family. A person does not have to be certified to bring up the subject.

OU Medical System involves the patient and/or family about end of life decisions. If the decedent is a candidate for organ/tissue donation, and family agrees, a witnessed consent for organ/tissue donation must be completed for each organ and/or tissue to be donated. Consent may be made before or after the official pronouncement death.

Policy:
OUMS Policy: 10-07: Organ, Body, and Tissue Donation

Readiness Guidebook 2013 Page 85
EMTALA (Emergency Medical Treatment and Active Labor Act)

Screenings, Duty to Accept, and Transfers

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), patients must be provided an emergency medical screening exam and necessary stabilization and treatment; even if it's been determined they can't pay.

If you work in the Emergency Department, Labor and Delivery, or otherwise might provide emergency care, please be familiar with and follow our facility-specific policies.

Policy:
OUMS Policy 11-41: EMTALA Signage
OUMS Policy 11-43: Provision of On-Call Coverage
OUMS Policy 11-44: Provision of Central Log
OUMS Policy 11-45: EMTALA Medical Screening Examination and Stabilization Policy
OUMS Policy 11-47: EMTALA Transfer Policy
## INDEX

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviations</td>
<td>55</td>
</tr>
<tr>
<td>Abuse and Neglect</td>
<td>63-65</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>78</td>
</tr>
<tr>
<td>Adverse Drug Reactions (ADR)</td>
<td>55</td>
</tr>
<tr>
<td>AIDET</td>
<td>60</td>
</tr>
<tr>
<td>Aim for Zero</td>
<td>44-45</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>67</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>8</td>
</tr>
<tr>
<td>Blood Administration</td>
<td>70</td>
</tr>
<tr>
<td>Blood-borne Pathogens</td>
<td>42</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>7, 70</td>
</tr>
<tr>
<td>Bomb Threat</td>
<td>26-27</td>
</tr>
<tr>
<td>CALM</td>
<td>19</td>
</tr>
<tr>
<td>Care Bundle</td>
<td>9</td>
</tr>
<tr>
<td>Care Plan</td>
<td>61</td>
</tr>
<tr>
<td>Catheter-associated Urinary Tract Infection (CA-UTI)</td>
<td>9, 45</td>
</tr>
<tr>
<td>Central line-associated bloodstream infection (CLABS)</td>
<td>44</td>
</tr>
<tr>
<td>Civil Disturbance</td>
<td>25</td>
</tr>
<tr>
<td>CLEAN (Hazardous Spills)</td>
<td>18</td>
</tr>
<tr>
<td>Code Black</td>
<td>29</td>
</tr>
<tr>
<td>Code Blue</td>
<td>30</td>
</tr>
<tr>
<td>Code Orange</td>
<td>30-31</td>
</tr>
<tr>
<td>Code Pink</td>
<td>29</td>
</tr>
<tr>
<td>Code Purple</td>
<td>35</td>
</tr>
<tr>
<td>Code Red</td>
<td>19-20</td>
</tr>
<tr>
<td>Code Yellow</td>
<td>31</td>
</tr>
<tr>
<td>Command Center</td>
<td>31</td>
</tr>
<tr>
<td>Competencies</td>
<td>36-38</td>
</tr>
<tr>
<td>Complaints</td>
<td>82</td>
</tr>
<tr>
<td>Computers</td>
<td>49</td>
</tr>
<tr>
<td>Continuous Readiness</td>
<td>5-6</td>
</tr>
<tr>
<td>Core Measures</td>
<td>73</td>
</tr>
<tr>
<td>Crash Carts</td>
<td>57</td>
</tr>
<tr>
<td>Credentialing</td>
<td>58</td>
</tr>
<tr>
<td>Critical Tests</td>
<td>8</td>
</tr>
<tr>
<td>Disaster</td>
<td>30-33</td>
</tr>
<tr>
<td>Disruptive Person</td>
<td>35, 59</td>
</tr>
<tr>
<td>DMAIC</td>
<td>72</td>
</tr>
<tr>
<td>DNR</td>
<td>77</td>
</tr>
<tr>
<td>Duress Alarms</td>
<td>28</td>
</tr>
</tbody>
</table>
Emergency Drill 32
Emergency Preparedness Plan 23
EMTALA 84
End of life care 66
Ethical issues 81
Evacuation 23
Excel Standards 60
External Disaster 31-33
Fire 1-20
Hand Hygiene 9, 40
Hazardous Exposure 30-31
Hazardous Materials / Waste 16-18
Healthcare-associated Infection (HAI) 9, 12-13, 44
Healthcare Industry Representatives (HCIR) 40
High-alert Medications 57
HIPAA 47-49
Hospital Incident Command Structure (HICS) 31
Hostage Situation 25
ID Badges 39
Impaired Practitioner 58
Infant/Child Abduction 29
Information Systems 46
Informed Consent 76
Internal Disaster 24
Interpreters 74-75
Isolation Precautions 41-42
Joint Commission, The 5
Labeling, Hazardous Materials 17
Labeling, Medication 8
Lock-out Tag-out 21
Look Alike, Sound Alike (LASA) 57
Media Contact 51
Medical Record 46, 74
Medication Administration 55
Medication Reconciliation 10
Medication Security / Storage 56
MRSA 43-44
Material Safety Data Sheet (MSDS) 16
Multi-drug resistant organisms (MDRO) 9
National Patient Safety Goals (NPSG) 7-11
Organ donation 83

*Readiness Guidebook 2013*  Page 88
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen shutoff</td>
<td>21</td>
</tr>
<tr>
<td>Pain</td>
<td>62</td>
</tr>
<tr>
<td>PASS</td>
<td>19</td>
</tr>
<tr>
<td>Patient and Family-centered Care</td>
<td>60</td>
</tr>
<tr>
<td>Patient Education</td>
<td>61</td>
</tr>
<tr>
<td>Patient Identifiers</td>
<td>7</td>
</tr>
<tr>
<td>Patient Rights</td>
<td>79</td>
</tr>
<tr>
<td>Performance Improvement (PI)</td>
<td>72</td>
</tr>
<tr>
<td>Personal Health Information (PHI)</td>
<td>47</td>
</tr>
<tr>
<td>Person Down</td>
<td>28</td>
</tr>
<tr>
<td>Photographs</td>
<td>50</td>
</tr>
<tr>
<td>Policy and Procedure Access</td>
<td>3</td>
</tr>
<tr>
<td>Press Release</td>
<td>51</td>
</tr>
<tr>
<td>RACE</td>
<td>19</td>
</tr>
<tr>
<td>Radiation</td>
<td>17</td>
</tr>
<tr>
<td>Rapid Response</td>
<td>62</td>
</tr>
<tr>
<td>Respiratory Arrest</td>
<td>30</td>
</tr>
<tr>
<td>Restraints and Seclusion</td>
<td>68-70</td>
</tr>
<tr>
<td>Risk Management</td>
<td>80-81</td>
</tr>
<tr>
<td>Security</td>
<td>14</td>
</tr>
<tr>
<td>Smoking</td>
<td>15</td>
</tr>
<tr>
<td>Social Media</td>
<td>52-54</td>
</tr>
<tr>
<td>Spills</td>
<td>18</td>
</tr>
<tr>
<td>Staffing</td>
<td>38</td>
</tr>
<tr>
<td>Standard Precautions</td>
<td>41</td>
</tr>
<tr>
<td>Stroke</td>
<td>71</td>
</tr>
<tr>
<td>Suicide</td>
<td>10</td>
</tr>
<tr>
<td>Surge Capacity</td>
<td>34</td>
</tr>
<tr>
<td>Time-out</td>
<td>11, 67</td>
</tr>
<tr>
<td>Tornado Warning</td>
<td>29</td>
</tr>
<tr>
<td>Translation</td>
<td>74-75</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>42-43</td>
</tr>
<tr>
<td>Universal Protocol</td>
<td>11</td>
</tr>
<tr>
<td>Utility Failure</td>
<td>22</td>
</tr>
<tr>
<td>Verbal Orders</td>
<td>74</td>
</tr>
<tr>
<td>Videotaping</td>
<td>50</td>
</tr>
<tr>
<td>Volunteers</td>
<td>38</td>
</tr>
</tbody>
</table>
My Emergency Response and PI Page:

- The fire extinguisher in my work area is located: ________________________________

- The fire alarm in my work area is located: ________________________________

- The oxygen shutoff in my work area is located: ________________________________
  ________________________________

- The evacuation route in my work area is: ________________________________
  ________________________________

- My Department Employee Safety Officer (DESO) is ________________________________

- Performance Improvement (PI) activities in which myself or my unit are participating:
  ________________________________
  ________________________________
EMERGENCY TELEPHONE NUMBERS

❖ Code Red/Code Blue/Code Pink
  o Children’s 1-1911
  o OUUMS 1-1911
  o POB & Clinics 9-911
  o Edmond 444

❖ Medical Emergency
  o Children’s 1-1911
  o OUUMS 1-1911
  o POB 9-911
  o Edmond 444

❖ Page Operators
  o Children’s 1-3636
  o OUUMS 1-5656
  o Edmond 0

❖ Security/Police
  o Downtown 1-4911
  o Edmond 444

❖ Facilities & Maintenance
  o Downtown 1-4190
  o Edmond 5527

❖ Facility Safety Officer
  o Downtown 417-4829
  o Edmond 5527

❖ Radiation Safety Officer 271-6121

❖ Ethics Line 800-455-1996

❖ IS Helpdesk 271-8660

❖ Poison Control 271-5454 or 800-222-1222