HENRY FORD HEALTH SYSTEM

Survey Readiness Pocket Guide

Tools/Tips for Safety Practices

National Patient Safety Goals (NPSGs) 6

Standard: Record of Care 11

Standard: Rights and Responsibilities 13

Standard: Infection Prevention and Control 17

Standard: Human Resources 19

Standard: Medication Management 21

Standard: Provision of Care 25

Standard: Environment of Care/Life Safety 30

Standard: Performance Improvement and Patient Safety . . . 35

The goal of this reference guide is to support continuous survey readiness. Included for your review are general survey tips, National Patient Safety Goal information and Joint Commission chapter-specific information, and sample survey questions. Please take the time to review this content.

Thank you for supporting continual survey readiness!

Important contacts/phone numbers for my hospital/business unit:

The Survey Process

The Joint Commission's (TJC) objective is to improve patient safety and quality of healthcare by establishing clinical standards, evaluating healthcare organizations, rendering accreditation, and providing education and consultation to healthcare professionals. HFHS' ability to participate in the Medicare program and reimbursement for services is closely linked to TJC accreditation.

All HFHS hospitals are accredited by TJC. The duration of the onsite visit at each hospital varies based on scope of services, volumes, etc. Both inpatient and ambulatory services will be reviewed. The team will be made up of administrators, nurses, physicians and life safety specialists.

The survey team will use the "tracer methodology" process. The surveyors will follow, or trace, a sample of patients through the various transitions in care throughout the entire healthcare experience. They will review open records and examine the documentation of care you provided to the patient, from admission (or entrance into HFHS services) through each applicable department or area. They'll ask questions about patient care in your department, and how your department works with others.

They will tour your unit while they are there, checking for compliance with standards related to the environment of care, and key functions such as proper handling and storage of medications. They will be reviewing for consistency of safe practices from site to site; department to department. They will ask about performance improvement. Your role will be to clearly communicate the care you've given to patients and explain your documentation in the patient's e-medical record. In addition, you will be expected to explain how your unit maintains a safe environment. There is a possibility that a surveyor will want to watch you as you carry out tasks as you would normally.

The surveyor may also ask how you've been trained or prepared to perform a task or function for your position.

Example: The surveyor will ask for a current patient record, then 'trace" the steps of the patient's care. For instance, a trauma patient may enter the ED, have interactions with lab, imaging, the operating room, inpatient unit, respiratory therapy, pharmacy, PT/OT and discharge planning. The patient might then require various services in the ambulatory arena.

Acronyms and Definitions

Standard: Overarching regulatory requirement with which healthcare organizations are expected to comply. It is composed of individual elements of performance.

(TJC) The Joint Commission: The Joint Commission is a nonprofit organization that accredits more than 21,000 healthcare organizations and programs in the United States. (JCAHO is the old acronym.)

(EP) Element of Performance: The procedural steps you must use to become compliant with a standard.

(RFI) Requirements for Improvement: These are areas of non-compliance within the organization found during survey.

(FSA) Focused Standards Assessment: Self-evaluation accredited organizations must perform yearly in order to assess current compliance with Joint Commission standards. This self-evaluation is used to set the priorities for accreditation readiness and survey preparation.

(SAFER) Survey Analysis for Evaluating Risk: A new scoring methodology, the SAFER matrix prioritizes resources and focuses corrective action plans in areas that are in most need of compliance activities and interventions.

Performance Expectations and Tips for a Successful Survey

The following tips are intended to ensure a successful survey:

1. **Always wear your hospital ID Badge. (Visible, and at eye level)**

2. **Greet the surveyor with a smile and a warm welcome.**
   They are our guests and a positive approach will have a powerful impact.

3. **Answer any and all questions asked in positive terms.**
   If you are not sure of the correct answer, don't guess. You are not expected to know everything! Tell surveyors what you do know and try to direct them to the correct personnel. Instead of saying, "I don't know," respond with, "I am not sure, but I know where to get the information."

4. **Be aware surveyors will review open records while they are on a unit and may request to interview patients.**
   They will ask patients or family members about their understanding of their care, discharge planning education, and if they would come to a Henry Ford facility again for future healthcare needs. They will ask the patient's permission to participate in the survey.

5. **Know your responsibilities to protect and maintain patient confidentiality.**
   This applies to every area of the hospital, including elevators, hallways, stairwell and the cafeteria. Your responsibilities include choosing appropriate settings to discuss confidential patient information, insuring appropriate access to computer-stored information, and keeping information confidential in hallways by not leaving computer screens or documentation forms lying open when not attended. Close chart racks when not in use.

What should you do if a surveyor asks you a question?

- Smile!
- Continue to breathe.
- Think about the question. Ask for clarification if you do not understand the question.
- Show your pride in our hospital by answering positively.

Tips to Prepare for The Joint Commission Survey

1. **Be prepared!**
   Review policies and procedures. Any staff member can be questioned by the surveyor. Be ready to answer questions about your patients, your job and responsibilities. If you don't know the answer, find out now!

2. **Think carefully before answering questions!**
   Take time to consider what the surveyor wants to know. Ask him or her to repeat questions if you don't understand. Avoid vague phrases like, "We usually do _____." It is important that we portray what we do as the same for all patients. Simply say, "We do ____."

3. **Be honest!**
   If you don't know the answer, don't guess. Tell the surveyor you will get an answer. In most cases, you would ask your supervisor or manager.

4. **Be specific! Be confident!**
   Only offer information specific to the question asked. Only answer the question asked and try not give more information than needed.

5. **Refer to policies/procedures!**
   Whenever possible, mention policies and procedures to support your answer. Note, if the surveyor requests a policy, the scribe will facilitate getting the copy. Avoid giving copies of policies directly to the surveyor during their unit visit.

6. **Give examples!**
   For instance, if you are talking about performance improvement plans, mention one that was a success in your department. Show the surveyor story-boards, forms, reports, and other information related to the plan.

7. **Be ready to demonstrate procedures!**
   You should be able to describe procedures related to your job. But, in some cases, a surveyor may ask you to show him or her instead.

8. **Emphasize teamwork!**
   Let the surveyor know how you work with others inside and outside your department – to get the job done.

9. **Relax-You know your job better than anyone else!**

NATIONAL PATIENT SAFETY GOALS (NPSGs)

The Joint Commission (TJC) has identified high-risk, problem- prone processes that have led to serious adverse patient outcomes at other facilities. TJC requires all healthcare organizations to put safety measures in place to prevent these problems. Compliance with all safety goals is evaluated at the time of the survey.

2017 NATIONAL PATIENT SAFETY GOALS

Improve the accuracy of patient identification.

- Use at least two identifiers *(patient name and MRN or patient name and birth date)* whenever administering medications blood or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures. Use active communication.
- Label containers used for blood or specimens in the presence of the patient.
- Eliminate transfusion errors related to patient misidentification.
- Before initiating a blood or blood products transfusion:
    - Match the blood to the order, and match the patient to the blood
    - Use a two person verification process: one individual conducting the identification verification is the professional who will administer the blood to the patent, and the other is trained and qualified per the hospital.

Improve the effectiveness of communication among care-givers.

- Report **critical results** of tests and diagnostic procedures in a timely manner.

The policy for Critical Results Management addresses the definition and ranges for critical results per Henry Ford Health System, the process (by whom and to whom) for notification of critical results and the one-hour time frame within which notification occurs. A verification process for critical test results requires a "read back" of the complete test result by the receiving person must occur. Documentation that the physician or other care provider has been notified with the time of notification must occur.

Improve the safety of using medications.

- Label all medications, medication containers and others in peri-operative and procedural settings. Please note: This includes syringes, medicine cups and basins.
- Label all medications that are not immediately administered. (Immediately administered is defined as any medication that is prepared or obtained, taken directly to a patient and administered to that patient without any break in the process). *If it hits the table, you must label!*
- Label medications or solutions that are taken from the original packaging and transferred to another container.
- Labels must include:
    - Medication name
    - Strength
    - Quantity
    - Diluent and volume if not apparent from container
    - Expiration date when not used within 24 hours
    - Expiration time when expiration occurs in less than 24 hours

- Verify all labels verbally and visually. Verification must be done by two qualified individuals when the person preparing is not the person administering.
- Label all medications as soon as it is prepared unless immediately administered. D*raw, label, draw, label.*
- Discard any medications or solutions found unlabeled.
- Remove all labeled containers on or off a sterile field and discard their contents at the conclusion of the procedure.
- All medications and solutions on or off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications. *Hand- off*.

Reduce likelihood of harm associated with the use of anticoagulant therapy.

- Use only oral unit dose products, pre-filled syringes or premixed infusion bags when these types of products are available.
- Only use the approved protocol for the initiation and maintenance of anticoagulant therapy.
- Check that the patient's baseline coagulation status is completed before starting a patient on warfarin.
- Manage potential food and drug interactions for patients receiving warfarin.
- Use programmable pumps to provide consistent, accurate dosing when heparin is administered intravenously. *Preprogrammed by Pharmacy*.
- Educate patients/families re: anticoagulant therapy, including:
    - Follow up monitoring and compliance
    - Food-drug interactions
    - Potential for adverse drug reactions and interactions
- Evaluate, improve and measure anticoagulation safety practices. *Pharmacy coordinates anticoagulation therapy, nursing documents and any education that they complete.*

Maintain and communicate accurate patient medication information (medication reconciliation).

- Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or seen in an outpatient setting. *This is the medication list. or history. It is a mandated field in EPIC that the provider fills out during the admission process.*
- Compare medications the patient is currently taking with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies. *The physician reconciles previous medications with those ordered during hospital stay*.
- Provide patient/family with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of the outpatient encounter. *Pre-printed information is available to download and give to the patient or family.*
- *Tell the patient it is important to bring their up to date list of medicines every time they visit a doctor. This reminder is also contained in the Patient Rights and Responsibilities.*

Reduce the risk of healthcare–associated infections.

- Comply with the current Centers for Disease Control hand hygiene guidelines. At a minimum, *wash in, wash out of patient rooms or exam areas. Use alcohol-based preparation or soap and water (soap and water ONLY for C. diff).* You are expected to perform hand hygiene after ungloving – even if your hands appear to be visibly clean.

- Consistently use the hospital approved, evidence-based practices to prevent healthcare-associated infections due to multi-drug-resistant organisms in the hospital. Pay particular attention to hand hygiene, cleaning and disinfecting patient care equipment and the environment, and isolation precautions.
- Educate staff, patients and their families about healthcare-associated infection prevention strategies. *Stop anyone who does not wash their hands before having contact with a patient and again, after patient contact, and remind them to do so! This is consistent with "Wash In (before patient contact), Wash Out (after patient contact)." Use the information found in the patient handbook and document the education.*
- Participate in the surveillance program, monitor, and provide data to leaders, physicians and staff.
- Manage as sentinel events all identified cases of unanticipated death or major loss of function associated with the healthcare-acquired infection.

Implement evidence-based practices to prevent central line-associated bloodstream infections (CLABSI).

- Educate patients and families about central line associated bloodstream infection prevention. *Document education.*
- Consistently implement the hospital approved, evidence-based practices aimed at reducing the risk of central line-associated bloodstream infections.
- Participate in periodic risk assessments evaluating the effectiveness of the prevention efforts. Provide data to key stakeholders.
- Use the catheter checklist and standardized protocol, including equipment, sterile barrier protections, and disinfection of hubs and ports.
- Perform hand hygiene immediately before accessing any central line.
- Evaluate all central venous catheters routinely and remove non-essential catheters.
- Reinforce knowledge about associated bloodstream infections and prevention with staff and practitioners involved in managing central lines.

Implement evidence-based practices to prevent surgical site infections.

- Educate patients and families about surgical site infection prevention. *Document education.*
- Healthcare providers must have education about surgical site infection prevention. This must occur upon hire and yearly afterwards*. Make sure evidence of education is available in all employee's HR or credentialing files. May be electronically obtained.*
- Implement evidence-based practices aimed at reducing the risk of surgical site infections.
- Participate in periodic risk assessments and surveillance evaluating the effectiveness of the infection prevention efforts. Provide data to key stakeholders.
- Administer antimicrobial agents for prophylaxis according to evidence-based protocol.
- When hair removal is necessary, the *use of clippers (rather than shavers) is strongly encouraged.*

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

- Only use indwelling urinary catheters when absolutely necessary and for the shortest time possible.
- Perform hand hygiene before inserting a Foley catheter.

- Insert indwelling urinary catheters aseptically, according to evidence-based guidelines.
- Manage indwelling catheters according to policy, including securing for unobstructed flow, maintaining sterility of the collection system, replacing the collection system when required, and proper collection of urine samples.
- Participate in measuring and monitoring outcomes as indicated.
- Evaluate the necessity of catheter continuance daily. Make sure that catheters are removed as soon as medically possible. If a patient requires that a catheter remain in place longer than the suggested evidence-based guidelines, a physician order, with rationale for continuance, is necessary.
- Reinforce education of staff and practitioners involved in surgical site infections and prevention.

Eliminate wrong-site, wrong-patient and wrong-procedure surgery.

- Consistently use the established pre-procedure process to verify the correct procedure for the correct patient, at the correct site. The patient is actively involved in the verification process when possible*. When possible, the patient should verbally indicate his or her name, procedure, location and physician.*
- Use a preoperative verification process to confirm that appropriate documents (e.g., signed consent, H and P, nursing and pre-anesthesia assessment, pathology or biopsy reports, and imaging studies) are available. Ensure that any required blood products, implants, devices or equipment are available. Implement a process to ensure that *the physician marks the surgical site* and involve the patient in the marking process when laterality is involved.
- Prior to the start of any surgical or invasive procedure, conduct a final verification, a "time out," to confirm the correct patient, procedure and site, using active not passive communication techniques. This final pause, or "time-out" moment prior to commencing, ensures that patient, procedure and site are correct. This is done after the physician has arrived. ***All members of the team must pause and verbally participate.*** *The time out should be documented in EPIC in all sites where an invasive procedure is completed.*

Clinical Alarms.

- Develop a process to eliminate alarm fatigue.
- Identify the most important alarm signals to manage.
- Educate staff to the priorities listed in the policy.
- Ensure all staff adhere to defined preset rates for alarm parameters and that only authorized staff modify those rates.

SAMPLE SURVEY QUESTIONS

How do you verify patient identification?

- Two identifiers are used to verify identification. Patient name and MRN are used for inpatients. Name and Date of Birth are used for outpatients.
- If the patient is a child or unable to participate, a family member may participate in the identification process.
- Barcode scanning is used wherever it is available.
- Medication administration: patient name and MRN (or birth date) are used. Use of barcode scanner occurs at the patient's bedside.
- All written forms and communication must contain two patient identifiers.
- Laboratory specimens: each specimen container MUST BE LABELED AT THE BEDSIDE with:
    - Patient's full name (last name, first name);
    - Patient's MRN (or birth date in ambulatory services);
    - Date and time of specimen collection; and
    - Specimen description or anatomic site of the specimen (non-blood/body fluids, microbiology, cytology and surgical tissue specimens).
- Blood bank specimens: must be labeled with the same information and the collector's initials.

What is your process for taking critical test results for verbal/phone orders? Hear it – Write it – Read it.

- **Hear It** - listen closely without interruptions
- **Write It -** Write the verbal/telephone order or test results.
- **Read It** - Read back what is written (i.e., "five zero" not fifty)

How do you safeguard against wrong patient, site and procedure interventions?

- All disciplines responsible for verifying the patient's identity will collectively ask the patient to verbally state: the patient's complete name, birth date, procedure to be performed and location on the body that the patient understands the procedure will take place.
- Patient responses are checked against the completed consent form, other medical record documents as necessary and the patient's ID band.
- If the patient is unable to communicate, the healthcare team will attempt to complete verification with relatives and clinical documentation.
- The physician performing the procedure is responsible for marking the site. A single line is used to mark the site unless it is on the face.
- A "time out" is performed just prior to the start of the procedure. This is a focused moment of verbal communication among the entire surgical team, including the surgeon. During this time the patient's name will be stated along with the procedure to be performed and the site, including laterality. The time out will be documented.

For Invasive Procedures performed outside of the OR

- A "time out" is performed just prior to the start of the procedure and documented. The patient's name and procedure are verbalized and compared to the information listed on the consent and/or name band.

How do you reduce the risk of healthcare-acquired infections?

- The most important way to reduce the risk of infection is hand washing. Hands may be washed with soap or alcohol-based hand rinse. Hands are washed before and after any direct patient contact (even when gloves are worn); after sneezing; before eating; and after using the restroom.

STANDARD: RECORD OF CARE

Expect surveyors to ask for the following in EPIC during open chart review:

- Is there evidence of consent to treat? Did the patient sign the consent if the patient is alert? Is the consent timed? (*Scanned section*)
- Have appropriately timed assessments and reassessments been done?
- Initial assessments within 24 hours and reassessments with every shift/permanent change of staff.
- Is a plan of care completed within 24 hours of admission? Has it been individualized? Is it done with input from the patient and/or family? Updated? (Nursing, Medicine, Nutrition, PT, OT?)
- Were the appropriate disciplines involved in this patient's care?
- Is there evidence of collaboration between various disciplines?
- Is there evidence of physician obtaining informed consent for invasive treatment/procedures?
- Is there evidence the patient/family has been given a copy of their Patient Rights and Responsibilities and Visiting Rights?
- Is there evidence of an abuse screen?
- Is there evidence patient was asked if they had an advance directive? If the patient indicates 'yes,' is there a copy in the chart?
- Is there evidence of a suicide screen? If the patient is a possible suicide risk, has the assessment been completed?
- Is preferred language and ethnicity indicated? Cultural needs?
- If patient is non English speaking, is there evidence of an interpreter offered? If patient declined, is there documentation?
- Has the H and P been completed and in the medical record within 24 hours? (Inpatients)
- If H and P completed prior to admission, does it have an 'update note' by the physician indicating that the patient was re examined prior to procedure and no changes have occurred? (Ambulatory surgical or procedural patients).
- Has the patient been assessed for pain using numeric or other pain tool? Reassessed after intervention?
- Has the patient been assessed for fall risk? Reassessed per policy? (Daily)
- Has the patient been assessed for skin integrity? (Braden scale)
- Has the patient received appropriate education? Who provided this? Is there evidence of patient and family education in the medical record?
- What information is evident regarding discharge planning?
- For surgical patients: is there evidence of an anesthesia assessment prior to surgery?
- Is there documentation of an ASA score and Mallampati?
- Evidence of surgical post procedure note that contains all required elements?
- Evidence of anesthesia post procedure note?
- Are all orders complete and clear?
- Is every dose of medication administered, including the strength, dose/rate, administration route, and drug allergies/adverse reactions documented? Is time frame for administration followed? (Time-sensitive meds?)
- Do PRN medication orders indicate reason for use?
- Do titrating orders contain start dose, maximum dose and parameters for titration?

- Is therapeutic duplication evident? If yes, are there clear instructions as to when to administer one drug over another?
- Are high alert drugs checked by two professional prior to administration?
- Is there evidence of 'read back' when telephone orders are taken?
- Are all telephone orders co-signed within 48 hours?
- If protocols have been used, is there evidence that the protocol was ordered/authenticated by the physician prior to initiation?
- If patient is in isolation, is there evidence that the patient and family have been educated?
- If patient has been restrained, is there documented evidence of alternatives attempted, justification for use, orders and reorders, face-to-face exam, monitoring and assessing per policy?

Do you have a list of "do not use" abbreviations?

- Yes. The list can also be found on OneHENRY.
- These abbreviations are not to be used in any form of clinical documentation (e.g., written orders or prescriptions, faxes, progress notes, electronic documentation, pre-printed forms and communication forms.)

ABBREVIATIONS THAT SHOULD NOT BE USED*

Do not use these dangerous abbreviations or dose designations

Abbreviation/Dose Expression	Intended Meaning	Misinterpretation	Correct Usage
Q.D.	Once daily	Mistaken for Q.O.D.	Write "daily"
Q.O.D.	Every other day		Spell out "every other day"
AD, AS, AU	Latin abbreviation for right ear, left ear, both ears	Easily confused and often mistaken as the Latin abbreviations OD, OS, OU	Spell out "right ear," "left ear" and "both ears
OD, OS, OU	Latin abbreviation for right eye, left eye, both eyes	Easily confused and often mistaken as the Latin abbreviations AD, AS, AU. OD sometimes mistaken as QD	Spell out "right eye," "left eye" and "both eyes"
Trailing zero (X.0 mg), lack of leading zero (.X mg)		Decimal point is m missed	Never write a zero by itself after a decimal point (X mg); always use a zero before a decimal point (0.X mg)
U	Units	Mistaken for a zero, resulting in a ten-fold dosing overdose	Spell out "units"
Ug	Microgram	Mistaken for mg (milligrams) resulting in one thousand-fold dosing overdose.	Spell out "microgram or "mcg"
IU	International Unit	Mistaken as IV (Intravenous) or 10 (ten)	Write out "international unit"
DRUG NAMES			
MS or MS04	Morphine sulfate		Write "morphine sulfate"
MgS04	Magnesium sulfate		Write "magnesium sulfate"

*Approved by the Pharmacy and Therapeutics Committee

STANDARD: RIGHTS AND RESPONSIBILITIES AND INFORMATION MANAGEMENT

Did you receive HIPPA privacy training?

- All employees receive training on HIPPA. New employees receive training in orientation. Updates may be given in staff meetings.

Are there policies regarding patient privacy and information security?

- There are many policies and procedures related to patient privacy and information security. They can be found on OneHENRY under "policy manuals" and selecting "HIPPA" from the drop down box.

How would privacy concerns be reported?

- Concerns could be reported in RadicaLogic (Redform), to a supervisor, the Privacy Officer, the HIPAA officer, or the Compliance Hotline at (888) 434-3044.

Are there consequences to inappropriately accessing or releasing patient information?

- Staff could be dismissed as well as face civil or criminal penalties.

What steps are taken to protect patient information?

- Avoid discussing patients in public areas: cafeteria, halls, and elevators.
- Be cognizant of visual and auditory privacy in open areas (i.e., registration, ICU or Surgical Lounges, etc).
- Avoid the use of patient sign-in logs that use the patient's first and last name.
- Do not leave open records or computer screens with patient information unattended.
- Turn computer screen away from public view.
- Watch for unfamiliar faces looking at medical records; ask for an ID for anyone with whom you are not familiar.
- Shred papers with Protected Health Information (PHI).
- Only have the first name of patient's on a public 'white' board visible by the public.

Where can the Patient Rights and Responsibilities Statement be found?

- It is posted at all entries and in many lobbies/waiting areas throughout our facilities. It is also located within the Patient Handbook.

List several ways you can protect the rights of our patients.

- Focus on his/her needs/concerns.
- All patients have the right to know who their caregivers are, introduce yourself, and always wear your name badge.
- Knock on the patient's door before entering.
- Maintain strict confidentiality by not discussing patients in public areas, with those not involved in the patient's care or leaving confidential information in the open (i.e., computer screens, chart racks, sign in sheets, etc.).
- Provide privacy, including closing curtains/doors during treatment, exams or bathing.
- Provide a secure environment for patients and their belongings.

How do you ensure that patients know who their caregivers are?

- All employees wear their name badges at all times, at eye level.
- The patient's caregivers for the day and the name of their primary physician are clearly written on the white board in their room.
- All care providers introduce themselves when meeting a patient.

How would you communicate with a non-English speaking or a Deaf, DeafBlind or Hard-of-Hearing (HOH) patient/visitor?

- Qualified professional interpreters are available to all patients and companions free of charge.
- HFHS has contracted services to provide telephone access to qualified foreign language interpreters 24 hours a day, seven days a week. Dial (800) 264-1552 and state your access code or physical location (hospital, clinic/unit name).
- HFHS has contracted with several agencies to provide qualified in-person interpreters for American Sign Language and Foreign Language as needed. Orders for in-person interpreters are entered in Epic. For additional assistance or questions, call the Interpreter Services Hotline at (313) 916-1896.
- Fully bilingual professional staff may speak with their own patients in the shared language.
- Documentation in the medical record occurs any time a patient/family member is offered/uses interpreter services. Declination of such services is also documented.
- Patients have the right to participate in their care and treatment decisions, and the right to privacy of their medical information.
- Competent adult patients must sign their own consents and related forms (e.g., surgery, procedure or general consent, receipt and understanding of the Patient Bill of Rights, and HIPPA Privacy Practices). It is never acceptable to have a family member sign a consent form for a competent adult patient merely because the patient is unable to communicate in English. Obtain a qualified interpreter to ensure that patients can make their own healthcare choices.
- It is our responsibility to ensure that effective communication takes place.
- Auxiliary aids and services to support effective communication may include qualified interpreters (e.g., telephone, in-person or video remote interpreting), assistive listening devices (e.g., pocket talkers), note-takers and qualified readers (someone capable of reading and explaining written materials). Consult with the patient to determine what works best for them.
- ADA questions or concerns can be emailed to CommunicationAccess@hfhs.org or by calling (313) 874-4805.
- Additional information and access to tools, resources and ADA Program Facilitators can be obtained through the HFHS Interpreter Services page on OneHENRY: https://onehenry.hfhs.org/departments/interpreterservices.

If you identify an ethical situation involving a patient/family member, whom would you call?

- An ethics consult may be obtained by calling: _____.

To whom can patients complain about their care?

- Patients/family can register complaints about their care to anyone at their respective hospital/business unit.

- The Patient Rights document and/or Patient Handbook contain information regarding the process for filing complaints.
- Complaints should initially be directed to the manager of the unit or area providing the disputed care or service.
- If the complaint is not resolved immediately, patients/families may be directed to the Patient Advocates in Care Experience.
- If the Patient Advocate is not able to immediately resolve the complaint, a formal grievance may be filed.
- In addition, all patients/families are notified that they may contact TJC or the State of Michigan if they are unhappy with their care. Contact information is provided within the Patient Bill of Rights, located at all entries, in the Patient Handbook, or one page handouts given to patients at registration. Check with your hospital/business unit.

What is an Advance Directive?

- An Advance Directive is a written document in which a patient specifies what type of medical care they want in the future should he/she loses the ability to make their own decisions.
- A Patient Advocate is identified in the Advance Directive as the "Durable Power of Attorney for Healthcare" (DPOA-HC). The DPOA-HC is the legal decision maker when the patient is no longer able to make their own decisions.

What resources are available to assist patient with Advance Directives?

- Nurses, Doctors, Chaplains, Case Managers, Clinics, and Supervisors can assist patients and families with forms and information on Advance Directives.
- Informational pamphlets are available on nursing units, in registration, and in ambulatory practices and clinics and should be provided to patients upon request. Blank Advance Directives are also available on OneHENRY in English, Spanish, Arabic and Bengali.
- A copy of the patients' completed Advance Directive (If they have one) must be scanned into the patient's medical record. The DPOA-HC should be documented in the Patient Relationships section.
- If the patient has an Advance Directive but does not have it with them, a copy should be requested.

Who is responsible for the informed consent of patients to receive medical treatments and procedures?

- Individuals who can obtain informed consent include physicians performing the treatment or procedure, and mid-level providers (MLPs) for procedures they are credentialed to perform within their scope of practice. House Officers and MLPs with the requisite knowledge, skills and training for the treatment or procedure may be involved in the consent process. Specially-trained non-physician practitioners (e.g., RN with competency to insert PICC lines) may be involved in the consent process for delegated procedures they are performing.
- Informed consent is obtained for blood transfusion, medical, surgical or diagnostic procedures and anesthesia.
- The informed consent discussion is documented in the medical record.
- Only use approved HFHS consent forms for procedures that require a written consent:
    - Consent to Medical, Surgical or Diagnostic Procedures (eHFHS-06-0615). Surgical services may use the Epic note-

type titled “Surgical/Procedural Consent,” which should be printed for patient signature, date and time.
    - Consent to **MEDICAL** or Diagnostic Procedures (e-HFHS-503-0916)
    - Patient Consent for Blood Transfusion (e-HFHS-504-1016)
- Witnessing of the patient signature on the consent form is not required.
- If consent is obtained via telephone from a legal guardian, durable power of attorney for healthcare (DPOA-HC) or patient’s next of kin, two professionals should be on the telephone line. Record the name of the person providing consent on the consent form. Both professionals should sign the consent form as witnesses to the conversation.
- In emergency situations consent is implied by law. The provider must document the nature of the emergency and care provided in the medical record.

How are organ and tissue donations handled?

- When a patient dies, the Gift of Life program is notified. They determine the medical suitability for organ/ tissue donation. Unless the deceased’s medical condition contraindicate organs/tissue donation, the next of kin of any patient who expires will be asked to consent to donation.
- If the deceased patient had previously indicated the desire to donate organs and/or tissues via the Michigan Donor Registry, that designation supersedes the wishes of the family/next of kin.

What patients should be screened for abuse?

- All patients should be screened for abuse. All heath care workers screen for signs of child abuse/neglect, elder abuse/neglect and domestic violence. Screenings are conducted during the initial assessment of all patients. Direct observation, however, is the key to uncovering incidents.
- Social Work and Risk Management are notified if abuse is suspected.
- In ambulatory sites, information on how to seek assistance for abuse is strategically located in dressing rooms and restrooms for patient access.

Visitation

- HFHS has generous visitation opportunities. Effort is made to ensure patients have access to loved one’s visits, while still allowing ample time for patient rest.
- Every patient has the right to have one designated ‘comfort’ person remain with them 24 hours a day as long as it is not medically contraindicated or detrimental to the well being of the other patients.
- HFHS does not discriminate against visitors based on race, religion, culture, gender or sexual preference.
- There may be certain times when visitors may be asked to temporarily leave a patient based on medical discretion, therapeutic intervention or testing, change of shift, but these times are limited.

What types of things are you required to provide to a patient/family when they register for care?

- We give information related to
    - Advance Directives
    - Patient Rights and Responsibilities
    - Notice of Privacy Practices
    - Visiting information
- We also collect data related to primary language, race and ethnicity.

STANDARD: SURVEILLANCE, PREVENTION AND CONTROL OF INFECTION

Who coordinates the Infection Control Department for our organization?

- Infection prevention specialists coordinate infection control activities throughout HFHS. During office hours they can be contacted in the Infection Control Office. During weekends and evenings, an infection prevention specialist can be reached by calling the hospital operator.

Who provides Employee Health Services for our organization?

- Employee Health is open during normal business hours. Check your hospital/business unit for specific locations. Staff will assist with new employee physicals, TB testing, Flu Shots and follow up of blood and body fluid exposures. If Employee Health is closed, staff may receive emergency assistance through the Emergency Department.

What education have you had on Infection Control?

- New employee orientation
- Department-specific orientation
- Annual mandatory education

Classes include blood-borne pathogen training, types of isolation, information related to the National Patient Safety Goals for Infection Control, TB control and an overview of general infection control policies and procedures.

Other infection control educational programs are offered yearly, or as deemed necessary, including SARS, influenza, etc. Infection Control is part of yearly competency and is found on Henry Ford University.

Standard Precautions

Standard precautions must be used in ALL patient contact, including:

- Hand washing.
- Glove use: clean, non-sterile gloves are worn when touching blood, body fluids, secretions, and items contaminated with any of these things. Gloves also are worn when having contact with mucous membranes and non-intact skin. After gloves are removed, HANDS MUST BE WASHED!
- Used gloves should be removed when leaving the patient room, and not worn when transporting specimens, equipment, within the hallways or testing areas outside of the patient room. If a specimen, dirty piece of equipment, etc., must be transported down a hallway, it should be contained.
- Other personal protective equipment (PPE)
    - A mask, eye protection and/ or face shield should be used if splashes or sprays of body fluids are anticipated.
    - Gowns should be worn when contact with body substances or splashes of body fluids may be generated.
    - PPE should be worn for handling contaminated equipment, specimens, linen or waste.

What would you do if you had an occupational exposure to blood or body fluid?

- First aid first! Wash/rinse the site.
- Report to supervisor and complete RadicaLogic (Redform on-line).
- Call EHS or ED if EHS is closed.
- Testing and treatment will be provided, including chemoprophylaxis as appropriate.

- You must return to EHS for follow-up counseling, testing and treatment.

How is equipment cleaned, disinfected or sterilized in your department?

- Hard, non-porous, horizontal surfaces are cleaned using infection control approved disinfectants. Be aware of dwell time (also known as "wet contact time") for all disinfectants. Different products have different dwell times.
    - Super Sani-Cloths ("purple top") have a 2 minute dwell time.
    - Sani-Cloth AF3 ("grey top") are alcohol free and have a 3 minute dwell time.
    - Sani-Cloth Bleach ("gold top") has a 4 minute dwell time and can kill *C. difficile* spores.
    - Sani-Cloth Plus ("red top") has a 3 minute dwell time.
    - Sani-Cloth HB ("green top") has a 10 minute dwell time and is alcohol free.
- Always follow the manufacturer's recommendations for cleaning and disinfecting equipment.
- If non-critical patient care equipment needs to be moved from one patient to another, it must be cleaned with the antibacterial wipes when visibly soiled (e.g., blood pressure cuffs, etc.).
- If high level disinfection is performed in your area, employees performing these tasks must have completed the HFHS competencies for cleaning, disinfection and sterilization. Use of appropriate PPE and special equipment must be consistently enforced! If an Eye Wash station is in the area, it must be checked weekly and documented.
- Equipment stored in area after high level disinfection must be individually covered or wrapped. This equipment includes*:* non-disposable speculums, vaginal probes and blades used for intubations.
- Clean supplies must not be stored with dirty supplies!

Remember, check for expired items!

STANDARD: MANAGEMENT OF HUMAN RESOURCES

How were you oriented to your job?

- Orientation to HFHS. All staff members of HFHS attend a new hire employee orientation to help familiarize them with our health system and our standards. Topics include:
    - Organizational overview
    - Mission, Vision, Values
    - Infection Control
    - Patient Rights
    - Customer Service
    - Employment benefits
- Orientation to hospital: All staff members are oriented to the hospital and their department to acquaint them with the site specific policies and procedures, and expectations.
- Orientation to department/position
    - A list is generated of all key points to be covered, which is signed upon completion and retained in the area HR file.

What competencies do you need to work in this area?

- Hint: cleaning/disinfection, chemotherapy, room cleaning, ACLS, Cardiac Telemetry, etc.

How is competency assessed?

- Competency is the application of specific knowledge, skills and behaviors that are needed to fulfill organizational, departmental, and work setting requirements. Verification of competency in any area may be achieved by test taking, return demonstration, peer review, real time demonstration or conversation. A competency check list is generated of all key points to be covered, which is signed upon completion by the person determining competency and retained in the area HR file.

When are competencies assessed (at what times)?

There are a number of times a competency may be assessed:

- Upon hire.
- On an ongoing basis based on individual needs or specific unit/area requirements.
- When new equipment or skills, interventions with increased risk, and/or problematic areas on the job are implemented or discovered.

Annual Competencies (or Mandatory Education)

- Includes both general competencies that all departmental employees perform (e.g., all nursing, all housekeeping, all security, etc.) and unit-specific competencies that are decided by your unit/area (i.e., those working with moderate sedation, restraint, disinfecting equipment, etc.).

What classes, in services or other training have you attended this year?

- Answer as appropriate.

Tell me about some opportunities available to you for on-going education.

- Examples include tele-conferences, in services, on-line education, etc.

If you had a concern about compliance, ethical care, safety, etc. how would you report this?

- RadicaLogic (Redform online)
- Compliance Hotline (888) 434-3044
- Speak directly with HIPAA officer
- Ethics Consult : check with your hospital
- Patient Safety: contact the quality department at your business unit

Who orients vendors to the hospital?

- All vendors must adhere to the HFHS Vendor Policy. No vendor is allowed to visit HFHS unless they have registered through the system, attended vendor orientation, and are wearing a vendor badge issued by HFHS.

Who orients law enforcement staff to the hospital?

- The hospital security department is responsible for the orientation, which includes: confidentiality, how to interact with patients and staff; procedures for response to unusual clinical events and incident; channels of clinical security; and administrative communication.

What are staff rights?

- It is the right of an employee not to participate in an aspect of patient care and/or treatment due to the employee's cultural values, ethics, and religious beliefs. Staff must submit their request in writing to their manager for resolution.
- Staff is also informed that they have the right to contact TJC, or the State of Michigan if they have concerns about employment or patient care or safety.

What things have been done to recruit/retain employees?

Recruitment

- Marketing and advertising (US & Canada).
- Job fairs (US & Canada).
- Employee referral bonuses for certain positions.
- Nursing program affiliations/clinical rotations with colleges and universities.
- Presentations at colleges and high schools.
- Loan forgiveness programs.

Retention

- Career development (e.g., specialty training, nurse tech, etc.).
- Loan forgiveness.
- Education (CEUs offered).
- Personalized orientation.

STANDARD: MEDICATION MANAGEMENT

Also refer to information under NPSGs

How do you ensure patient safety during Medication Administration?

Prior to administering medication you must:

- Verify the medication selected is the correct one based on
  - The physician order or the MAR (Medication Administration Record), and
  - Label on the medication.
- Use 2 patient identifiers per policy
- **Match** the identifiers with the medication order/MAR
  - Verify that the medication has not expired.
  - Verify that the medication is not contraindicated.
- **Barcode Scanning** 100% in all available sites.
- Remember the 5 "Rs"
  - Right Patient
  - Right Drug
  - Right Dose
  - Right Route
  - Right Time

Label all medications that are not immediately administered. "If it hits the table, you must label!"

How long do you have to administer an ordered medication?

- Medications are generally given within one hour of ordered time. Certain medications, however, are "time sensitive." These would be medications that must be given at exactly the time they are ordered (within a 30 minute window).
- Time sensitive medications are denoted as such by the pharmacy on the MAR.

What precautions are taken for High Alert Medication?

- Identified by policy and classified when added to formulary.
- Many with specific use guidelines (e.g., anticoagulants, chemotherapy, etc.).
- Labeled as HIGH ALERT – med label, MAR.
- Independent Double Check required for select medications as indicated in the electronic medical record and per policy. Double check required that both licensed professionals independently review the provider order and MAR for the following:
  - Verification of right time. If the medication is ordered as needed (PRN), both licensed professionals must independently verify when the medication was given last.
  - Verification of right patient.
  - Verification of right drug.
  - Verification of right dose (may include calculating weight-based dose, or dose based on lab value, etc.).
  - Verification of right route.
  - Tracing of IV line (when appropriate).
  - Verification of infusion pump settings.

How do you store medications in your area?

Refrigerated Medications

- Daily monitoring of temperature is required. Temp track is used in the hospital. If you use a manual log, document what you do if the temperature is out of range.
- If temp is out of range for more than several minutes, pharmacy is notified in order to give instructions for the medications.
- Food should not be in the medication refrigerator.
- Refrigerators with medications must also be secure (i.e., locked or in a locked room).

Non-refrigerated Medications

- All medications, IV solutions and contrast are kept in a locked storage area.

Other Medication Information

- Medication preparation areas must be clean and uncluttered.
- All pill crushers and splitters must be clean and free of residue.
- Medications must be secure:
    - Medication rooms must be locked.
    - No medications should be found in patient rooms, on carts in halls or where accessible to the public.
- Multi-dose vials are good for **28** days after opening. They must be labeled with the date they are to be THROWN OUT.
- Multi-dose vials may be used for multiple patients if they are used outside of the immediate patient care area (i.e., medication room or alcove). Multi-dose vials that are used in the immediate patient care area must be used for an individual patient and discarded after use.
- Emergency medication boxes: emergency boxes, peds boxes and crash carts must be checked and recorded daily.
- Concentrated electrolytes are not stored in departments or nursing units unless approved by the local Pharmacy and Therapeutics Committee.
- Narcotics control is facilitated by the use of Pyxis. Ambulatory locations have double-locked cabinets and a process for securing controlled substances.
- Pharmacy oversees all medication preparation. Medications are not mixed by nursing staff on units unless in urgent or emergent situations (e.g., Code Blue, ICU stat pressor).

IV Medications

- IVs are considered a medication and must be kept secure at all times.
- All infusing IV solutions with medications must be labeled with the patient's identification.
- IV bag overwraps must be present until immediately prior to use.
- IV bags may not be used as irrigations for more than one patient.
- IV solutions should not be stored outside of the protective wrap. Those that have been removed from the protective wrap and not used, should be discarded. Once removed from their wrappers, IV solutions are considered sterile for 24 hours.

When asking patients about current medications, what should be included?

- Prescription drugs.
- Over-the-counter drugs.
- Alternative medications such as herbs and vitamins.
- Street drugs/alcohol.
- Herbs and vitamins.

If your patient is taking alternative medications, **what resources are available to identify potential adverse effects?**

- On line drug information.
- Pharmacy.

How would you report an Adverse Drug Reaction or Medication Error?

- Care for the patient first.
- Notify physician so that any care necessary can be prescribed.
- Notify Pharmacy.
- Complete a RadicaLogic (Redform) report.

How are range orders handled?

- Range orders are discouraged.
- If a range order is written by the physician, only a range in the dose is accepted. A range in both dose and time interval is not permitted.

How does an RN decide dosing when a range order is prescribed for pain medication?

- A standardized methodology is used when determining the dose of the medication to give. The lowest dose is often administered first, and the dose is increased according to the patient response.
- RN uses professional clinical judgment and pain assessment score to determine dosage.
- Consideration is also given to these factors:
    - Patient's response to previous dose if known.
    - Other medications which may potentiate analgesia or adverse drug reactions.
    - Patient age.
    - Patient weight.
    - Severity of pain (pain score).

How do you handle "as needed" medication orders?

- All "as needed" (PRN) medication orders must include the specific indication for use. The indication for use will be included in the "administration instructions" on the MAR.
- No single patient should have "as needed" (PRN) medication orders that have the same indication unless there are additional clarifying instructions in the order that clearly define when each medication should be used. This requirement includes pain scores. If an individual patient has two medications for pain, each order must have a unique pain score or other description of the type of pain it may be used for.
- Two "as needed" (PRN) medication orders for the same indication, on the same patient, that do not adhere to these guidelines will require clarification with the provider.

Examples

NOT Acceptable	*Acceptable*	*Rationale*
Acetaminophen 325-650 mg every 6 hours prn pain And HYDROcodone-acetaminophen 5-325 mg 1-2 tablets orally every 6 hours prn pain	Acetaminophen 325-650 mg every 6 hours prn pain score of 1 to 3 And HYDROcodone-acetaminophen 5-325 mg 1-2 tablets every 6 hours pain score 4-10	Each medication order has a unique pain score for use
Ondansetron 4 mg IV push every 8 hours prn nausea And Prochlorperazine 10 mg IV push every 6 hours prn nausea	Ondansetron 4 mg IV push every 8 hours prn nausea And Prochlorperazine 10 mg IV push every 6 hours prn for nausea not relieved by ondansetron	Additional clarifying instructions for when to use each medication
Acetaminophen 650 mg orally every 6 hours prn pain And Ibuprofen 600 mg orally every 6 hours prn pain	Acetaminophen 650 mg orally every 6 hours prn headache pain And Ibuprofen 600 mg orally every 6 hours prn joint pain	Additional clarifying instructions for when to use each medication

STANDARD: PROVISION OF CARE

How would you describe your department/practice location and scope of services provided?

- The Scope of Services provided in my department/practice location include: (list type of care you provide in your department).

Who are your customers?

- Answer as appropriate (e.g., inpatients, outpatients, neurology patients, others, etc.).

What are the age ranges of your customers?

- Neonate (birth – 1 month)
- Infant (1 month – 1 year)
- Child (13 months – 12 years)
- Adolescent (13 years – 19 years)
- Adult (20 years – 65 years)
- Geriatric (65+ years)

Do you serve a specific population of patients? Culturally? Ethnically? Religious affiliation, etc.? Did you receive education in cultural competence on this population?

- Answer as appropriate.

What are the most common diagnoses, treatments and procedures you encounter in your work area/practice location?

- Answer as appropriate.

How are patient care assignments made?

- Acuity of patients.
- Staff competencies (refer to unit employee files).
- Equipment/monitoring required for the patient.
- Continuity of care.

When should the initial patient assessment be performed on each patient? Patients in the ambulatory settings? When are patients reassessed?

Hospital Settings

- The initial Nursing Patient Assessment is completed within 24 hours of admission. Physical assessments should be completed within the first 8 hours.
- In ED or outpatient settings, an abbreviated assessment may be done as defined in departmental policy.
- A medical H and P must be completed and in the medical record within the first 24 hours of admission. For a patient scheduled for surgery or invasive procedure, an H and P performed within the last 30 days is acceptable, as long as it is reviewed by the surgeon after the patient is registered and before the procedure. In such cases, the physician must document that he/she has examined the patient, and that no changes have occurred in the patient's condition since the original H and P was completed. A heart and lung exam needs to be completed.
- Each patient is reassessed at regularly specified times related to the patient condition and unit practice standards. Minimally, reassessment occurs with every permanent change of nursing staff. (i.e., every shift).

- Reassessment is also completed if a significant change occurs in the patient's condition, diagnosis or level of care.
- In ambulatory and outpatient settings, a patient is assessed upon initial presentation and a reassessment with every visit.

Tell me about the Patient Plan of Care.

- The nursing patient assessment, along with relevant information from the patient history and medical physical exam, is utilized to develop an *individualized* patient plan of care.
- All admitted patients must have an individualized plan of care formulated within 24 hours of admission.
- The plan of care should relate to the primary problem/admitting diagnosis, as well as relevant co-morbid conditions or problems.
- The plan of care **must include the goals of patient** and/or their family in its formulation.
- The plan of care should contain interventions related to each problem, and be measurable. There should be evidence that the plan of care is a living 'road map' used to achieve outcomes; that it is reviewed, modified as necessary, and re-evaluated throughout the patient stay.
- The plan of care is reviewed daily by nurses and other clinical care staff and used to plan their care for that day.
- Discussion of the plan of care should be included into the 'hand off' between care providers at the end of the shift.
- Any patient who is in restraints should have their plan of care modified to reflect restraint use. Safety, goals for removal should be included.

How do you screen patients for potential nutritional problems?

- A nutritional screen is done as part of the initial patient assessment.
- Nutrition is consulted if indicated and completes a full nutritional assessment.
- Reassessment may occur if patient condition changes.

How do you complete the functional assessment?

- Functional screens are done as part of the initial patient assessment. If a patient fails the 'triggers,' then PT, OT and Speech Therapy will be consulted to complete a full functional assessment.

How can you demonstrate that patient care planning is interdisciplinary?

- Patient assessment is completed within 24 hours of admission.
- Admission screens indicate consultation by other disciplines (Case Management, PT, RT, Spiritual Care, etc.). These consults contribute to the development of the patient plan of care.
- The patient and/or their family is always included in care and treatment decisions.
- Interdisciplinary Rounds: other disciplines are consulted by this team during the hospital stay based on individual patient care needs.
- Case Management collaborates with the care team to coordinate patient discharge and post-hospitalization care needs.
- Collaborative communication on food/drug allergies involves Nursing, Pharmacy, Nutritional Services and the physician
- Pharmacy is an integral component of the care team and participates in the plan of care by assisting with discharge education related to medications and anticoagulation education.

Use of Restraints

- Restraints are considered a violation of patient rights and dignity. They will be used as the last resort and only when other appropriate alternatives have failed to meet patient safety needs.
- At times devices may be necessary for patient alignment during therapeutic intervention. This is not considered restraint. Respect for the patient's dignity and privacy will be assured at all times.

What is our policy on restraint?

- Alternatives to restraint use should always be considered prior to the use of restraints.
- The goal is to explore every option to avoid the application of the restraint.
- Use of restraints is always based on the current assessed needs of the individual patient.

For non-violent patients: protective restraint

- In cases where restraint consideration is emergent, a telephone order is acceptable based on RN assessment.
- A face-to-face evaluation of the patient is conducted by the physician. Completion of the exam within the first 24 hours is essential.
- Physician orders restraint.
    - Type, location, duration must be documented.
- PRN orders are not permitted or accepted.
- Reassessment (a new face-to-face exam) must be conducted every subsequent calendar day and documented. A new order is obtained every calendar day.
- The patient must be assessed a minimum of every two hours. All elements of the assessment are located in the policy and built into the EHR. Documentation of the two hour monitoring must occur at the time it is conducted.
- The patient plan of care must be modified to include restraint use.

Threat of harm to self or others: violent restraint

- In an emergency situation, a trained RN may make the decision to apply restraint. However, a physicians' order must be obtained within one hour of the restraint application, and the patient must be seen by a physician within one hour of the application of restraints, a face-to-face exam completed, and the restraint order signed or the restraint must be removed at the end of the hour.
- All mandated components of the face-to-face exams are built into EPIC.
- Order must include justification, type of device, and duration of order.
- Orders must not exceed:
    - 4 hours for adults.
    - 2 hours for adolescents.
    - 1 hour for children.
- After the initial order, the physician conducts a new face-to-face exam of the patient every 24 hours. Reorders in between the face to face exams may be taken by the RN via telephone and based upon nursing assessment.
- Any patient in violent restraint is continuously observed one on one to ensure patient safety.
- Monitoring is completed and documented every 15 minutes. Assessment is conducted every hour. Refer to the HFHS restraint policy.

- Death of a patient in restraints, or who has been in restraint in the previous 24 hours, or who has been in restraint anytime during their hospitalization, and the restraint directly contributed to their death, is reported to the Unit Manager and/or Risk Management (check your hospital procedure). That information is retained and/or communicated per CMS guidelines.

Documentation of all restraint MUST include:

- Alternatives tried.
- Description of patient's initial and ongoing condition/assessment that necessitates restraint use.
- Changes in patient condition.
- Removal of restraints and checks for adequate circulation, offer fluid/toileting and turning every two hours.

How do you assess for pain?

- Pain assessment is an on-going process from admission through discharge. The patient is assessed for pain on admission and routinely during their stay. On inpatient units, this reassessment occurs every shift and after an intervention. In ambulatory sites, pain is assessed when clinically indicated, when patients return with a complaint that has a possible pain component, and if a therapy or medication was prescribed to assess effectiveness.
- Pain is rated using a standardized scale and is documented as a numerical value. Special tools are used for infants and those patients who are cognitively unable to respond to the verbal pain scale.
- Pain is reassessed after a patient receives an intervention. This may be as soon as within 30 minutes or within an hour based on the therapy prescribed. If a patient is asleep, we use this as evidence that the therapy has been effective. Documentation must occur related to reassessment after intervention. This generally occurs in the anecdotal notes of the medical record, but may also be found on the MAR.

How do you assess for fall risk?

- Fall risk is assessed on admission and daily thereafter. If a patient's status changes, such as he/she undergoes surgery, assessment of the risk for falls is repeated.
- A standardized tool is used, and based on the number of affirmative responses, a value is obtained as to fall risk.
- If a patient is assessed as a fall risk, interventions are implemented. Standardized interventions include: a "Fall Precautions" sign placed outside the room, yellow slippers on the patient, and an armband. Additional interventions are available and are used as deemed necessary, such as bed or chair alarms.
- Patient and family education occurs regarding fall risk.
- The patient plan of care should reflect the fall risk and safety interventions.

How do you assess for skin integrity?

- The Braden Scale is used to assess skin integrity. The assessment is completed upon admission, and reassessment occurs throughout hospitalization. A patient is assigned a risk level based upon affirmative responses to the elements in the assessment. Depending on the risk level, interventions are implemented into the plan of care.
- Wound care specialists are also available to assist in formulating a plan and recommending specific interventions for patients with skin breakdown.

Moderate Sedation/Deep Sedation

Does your area/department provide moderate or deep sedation?

- If yes, refer to the policy/procedure for moderate or deep sedation.
- Patients receiving sedation must sign a consent for the procedure that includes the sedation.
- Deep sedation may only be given in the ED and Surgical Services.
- Only the PHYSICIAN may administer deep sedation. ED physicians must be trained, tested and privileged to administer deep sedation.
- Nursing staff must undergo sedation training before they can assist with procedures requiring moderate or deep sedation.
- One professional (generally a registered nurse) must be assigned to do nothing but monitor the patient during the sedation.
- A trained staff member assists the physician performing the procedure.
- The physician must document the ASA score, pre and post procedure note, including airway assessment, according to policy.
- Vital signs must be taken and documented every five minutes while the patient is under sedation.
- The patient must be recovered until pre-procedure status is achieved. (1:1 first 15 minutes)
- Emergency resuscitation equipment must be available.

Point of Care Testing

Do you do point of care testing?

- This is laboratory testing performed outside of the physical facilities of the clinical laboratory, but within the healthcare setting.
- Urgent care, physician practices, Neighbors Caring for Neighbors, and certain patient care units perform point of care testing.

What are examples of laboratory tests that are considered "point of care" testing?

- Blood glucose testing/screening.
- Urine pregnancy test.

Do you perform point of care testing in your practice location?

- Yes
- No

If yes, what tests are being performed on your unit/department?

- Answer as appropriate.

Who is responsible for performing these tests? What quality control method is performed for these tests and how often?

- Answer as appropriate.

Describe your initial training and ongoing competency assessment for performing Point of Care testing.

- Answer as appropriate.
- Competency should be in HR file. Point of care coordinators also have a copy.

STANDARD: ENVIRONMENT OF CARE/LIFE SAFETY

Know who coordinates safety activities for your hospital/business unit.

Roles and Responsibilities

Staff and LIPs can describe or demonstrate methods for eliminating and minimizing physical risks in the environment.

- Identify hazards by reviewing data, looking for trends and surveys. Perform risk assessments.
- Eliminate identified hazards or change work practices.
- Educate staff on safe work practices and reporting of incidents.
- REMEMBER: Safety is everyone's responsibility.

Staff and LIPs can describe or demonstrate actions to take in the event of an incident in the environment.

- We minimize potential of harm from fire by not allowing flammable furniture and decorations, conducting fire drills, and training in the use of fire extinguishers.
- Patients, employees and visitors are not allowed to smoke.
- The hospital and offsite locations maintain fire and unobstructed exits to the buildings.
- We have a written fire response plan (RACE).
- Staff have specific roles in case of fire outlined in the department specific plans.
- LIPs are not members of the First Response Team. If they encounter a small fire they are to use RACE and PASS acronyms to respond. Follow instructions from the fire response team including to evacuate to the appropriate smoke zone when directed.

Staff and LIPs can describe or demonstrate how to report risks in the environment.

- We report all risks to superiors immediately.
- We report risks in the RadicaLogic system.
- We report risks to the Safety Officers.

Is smoking allowed in HFHS facilities?

- HFHS does not permit smoking on hospital grounds.
- Henry Ford Health System is a designated tobacco-free workplace. This means that:
    - Potential employees are screened for tobacco use upon hire.
    - Established employees must make a concerted effort to stop tobacco use as part of their Health Engagement Plan.
    - Employees who arrive to work with the odor of tobacco evident will be sent home.

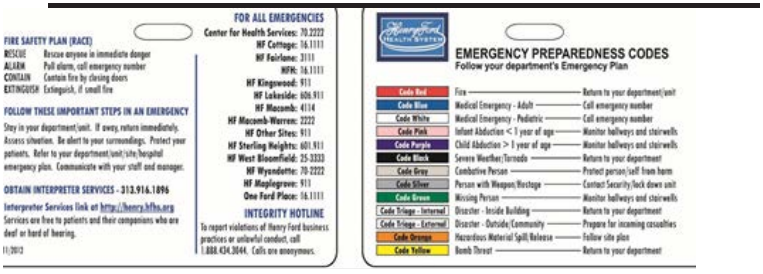
Emergency Management

What is the hospital's emergency management disaster plan?

- The Emergency Operations Plan describes the process by which the hospital staff responds to various potential or real disasters. A full version of this plan is located on OneHENRY.
- This plan addresses the hospital's response to a natural or a man-made event that significantly disrupts the normal care and treatment of patients.
- Types of emergencies may include: mass casualty, flooding, hazardous materials spills, radiation exposure, bioterrorism, chemical terrorism, severe weather, evacuation, bomb threat, power outages and IT-related incidents.

Where can you find information on Emergency Codes?

- A current **Departmental/Site-specific Emergency Preparedness Plan** should be located in each department or site detailing roles and responsibilities in that area. This can be found in the RED Emergency Binders or added to the Red Flip books. Contact your Emergency Management leader for further information.
- All employees have a color coded "badge buddy" dated 11/20/12



FIRE SAFETY PLAN (RACE)

RESCUE Rescue anyone in immediate danger
ALARM Pull alarm, call emergency number
CONTAIN Contain fire by closing doors
EXTINGUISH Extinguish, if small fire

FOLLOW THESE IMPORTANT STEPS IN AN EMERGENCY

Stay in your department/unit. If away, return immediately. Assess situation. Be alert to your surroundings. Protect your patients. Refer to your department/unit/site/hospital emergency plan. Communicate with your staff and manager.

OBTAIN INTERPRETER SERVICES - 313.916.1096

Interpreter Services link at http://henry.hfhs.org
Services are free to patients and their companions who are deaf or hard of hearing.

11/2013

FOR ALL EMERGENCIES

Center for Health Services: 70.2222
HF Cottage: 16.1111
HF Fairlane: 3111
HFH: 16.1111
HF Kingswood: 911
HF Lakeside: 606.911
HF Macomb: 4114
HF Macomb-Warren: 2222
HF Other Sites: 911
HF Sterling Heights: 601.911
HF West Bloomfield: 25-3333
HF Wyandotte: 70-2222
HF Maplegrove: 911
One Ford Place: 16.1111

INTEGRITY HOTLINE

To report violations of Henry Ford business practices or unlawful conduct, call 1.888.434.3044. Calls are anonymous.

EMERGENCY PREPAREDNESS CODES
Follow your department's Emergency Plan

Code Red	Fire	Return to your department/unit
Code Blue	Medical Emergency - Adult	Call emergency number
Code White	Medical Emergency - Pediatric	Call emergency number
Code Pink	Infant Abduction < 1 year of age	Monitor hallways and stairwells
Code Purple	Child Abduction > 1 year of age	Monitor hallways and stairwells
Code Black	Severe Weather/Tornado	Return to your department
Code Gray	Combative Person	Protect person/self from harm
Code Silver	Person with Weapon/Hostage	Contact Security/lock down unit
Code Green	Missing Person	Monitor hallways and stairwells
Code Triage - Internal	Disaster - Inside Building	Return to your department
Code Triage - External	Disaster - Outside/Community	Prepare for incoming casualties
Code Orange	Hazardous Material Spill/Release	Follow site plan
Code Yellow	Bomb Threat	Return to your department

Can you explain the term "SDS" and describe their purpose?

- You must recognize and understand hazards based on:
  - Knowing which hazardous chemicals are used in your work area.
  - Know how to find (Material) Safety Data sheet (SDS) on OneHenry home page: https://onehenry.hfhs.org under "Quick Links." Use HFHS Library or MSDSonline library.
  - Know how to read an (M)SDS. Read all relevant (MS)SDSs before starting a job that may require the use of hazardous chemicals (dangers, disposal and spill information).
  - Read product labels carefully. Follow all instructions. Heed warnings.
  - Complete all required hazardous chemical training sessions.

What is an example of a hazardous spill?

- Chemotherapy.
- Chemical spills in the Lab, Pharmacy or a patient care area.

If you were to have a hazardous spill, what would you do?

- Isolate the spill.
- Report it to my immediate supervisor & Hospital Operator as a Code Orange.
- Safeguard the area.
- Evacuate the area as appropriate.

Do you have "spill kits" on your unit?

- Insert location _____

What is regulated/medical (infectious) waste?

- Cultures and stocks of infectious agents and associated biologicals.
- Liquid human and animal waste including blood and blood products.
- Biohazard body fluids.
- Pathology waste.
- Sharps.

Remember: DO NOT store anything in biohazard bags that is not biohazardous! Non-biohazardous items must be stored in clear plastic bags!

LIFE SAFETY – FIRE SAFETY

If you spotted a fire in a wastebasket, what would you do?

Code Red Fire Response Plan

1. Follow the fire plan for your department.
2. Follow the RACE fire plan.
3. To use an extinguisher, use PASS.

RACE

- **Rescue –** Rescue anyone in immediate danger.
- **Alarm –** Activate by pulling a fire alarm, calling the emergency number for your hospital/business unit, and give exact location.
- **Confine** – Confine the fire by closing doors and windows.
- **Extinguish –** Extinguish a small fire only using the correct fire extinguisher.

Where is the nearest extinguisher?

- Insert location _____

Where is the nearest exit?

- Insert location _____

What smoke zone are you located in?

- Insert location _____

Explain the proper use of a fire extinguisher.

- **P**ull the pin.
- **A**im the nozzle at the base of the fire.
- **S**queeze the handle.
- **S**weep the fire with a side-to-side motion with the nozzle.

How often are fire extinguishers checked?

- Fire extinguishers are serviced annually (tagged on the outside).
- Monthly checks are also completed on the units and documented on the affixed tags.

Remember to always keep fire extinguishers, alarms and exits unobstructed!
NO HALLWAY CLUTTER

What are other things you can do provide fire safety?

- Keep hallways and exits clear of clutter.
- Supplies should not be stored within 18" of the ceiling.
- Doors are not to be propped open.
- Do not use electrical equipment brought in from home that has not been properly checked and cleared by Clinical Engineering.
- Know your area evacuation plan.

EQUIPMENT MANAGEMENT

How can you tell if a piece of medical equipment has been tested as required?

- Clinical Engineering applies a unique barcoded tag to each device they inspect. Additionally, a circular label is applied that indicates the planning maintenance interval and next inspection date for each device.

What do you do if you discover that a piece of equipment is defective?

ADAPT

- **A =** Assure patient safety.
- **D =** Discontinue equipment use and remove from use immediately.
- **A =** Acquire replacement equipment.
- **P =** Phone Clinical Engineering and report in RadicaLogic (Redform).
- **T =** Tag equipment (identifying problem and location of use-unit/room number).

Do you know what constitutes as a Safe Medical Devices Act (SMDA) reportable incident? How do you report it?

- An SMDA reportable incident is an incident in which a medical device or malfunction causes or contributes:
    - To a patient death,
    - Serious illness,
    - Serious injury,
    - Or is suspected of near miss (be proactive –report your suspicion).
- The incident must be reported in the RadicaLogic (Redform). Risk management should be notified immediately.

If you suspect that a device or piece of equipment has caused or contributed to patient harm, you should:

- Immediately sequester the piece of equipment, along with all connected tubes, plugs, cartridges, blades, etc. Do not change settings; do not disconnect attached items.
- Tag the item so it is not used on another patient. Call Clinical Engineering at your business unit. Clinical Engineering staff will remove the equipment and hold it until an investigation is completed.

Describe the training that you received in your department that enabled you to use patient care equipment.

- Answer as appropriate.

Do you receive competency assessment for the patient care equipment that you use?

- Answer as appropriate.

How is that documented?

- Answer as appropriate.

List the alarms that you will hear in your department.

- Answer as appropriate.
- What do they mean?
- What do you do if you hear one?
- What do you do about them when they alarm?

UTILITIES MANAGEMENT

(Electrical/Communication/Gas Systems)

What do you do when the emergency power generator is activated?

- All critical life support equipment should be plugged into emergency outlets at all times.

Where are the medical gas shutoffs located in your work area?

- Answer as appropriate.

Who is responsible for the medical gas shutoff in your department/clinic?

- The charge nurse or designee (clinical personnel, including nurses, physicians, PAs, respiratory therapists) is responsible for medical gas shutoffs in case of major emergency. Major emergencies include: fire and other life-threatening emergencies.

Remember that oxygen tanks must be secured in a stand to prevent tipping.

- They must not be unsecured/stand-alone or lying on patient carts.
- A maximum of 12 tanks are allowed per smoke zone.
- When not in active use, O2 tanks must be properly stored in designated safety cabinets where available, or suitable storage racks. Separate by "Full" or "Empty/Partial."
- Keep O2 tanks away from flammable materials.

Describe your role relative to patient safety and maintaining a safe environment for patients and co-workers.

- Answer as appropriate.
- Identify hazards, report and remove as appropriate.

Safety is EVERYONE's responsibility!

STANDARD: PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

What model or approach do teams use to improve a process?

- **P**lan the improvement.
- **D**o the improvement, collect and analyze data.
- **C**heck and study the results.
- **A**ct to make the improvement and continue to improve the process.

What has been done to improve care/service in your area?

- This is your opportunity to shine! Did your area do a quality poster? Did you change a process to improve safety?

Why was this project chosen?

- Answer as appropriate.

What changes have been made?

- Answer as appropriate.

How do you know if you've improved? How do you receive feedback?

- Answer as appropriate.

What type of data do you collect/display on your unit or in your clinic?

- Surveyors look for data regarding medication management, restraint use, invasive procedure "time out," and CORE measure data (i.e., AMI, CHF, SIP, pneumonia, etc.).

What is the Patient Safety/Quality Framework at HFHS?

- Patient safety is at the forefront of everything we do. Leadership, physicians, departments, processes and staff are committed to maintaining the safety of our patients during their care experience. We actively seek out opportunities to improve our processes and standardize care. We are embarking on a "high-reliability journey." We conduct Safety Huddle each business day to share real time or potential threats to patient safety.

We utilize a coordinated and priority driven approach to continuously improve patient safety and reduce risk to patients by encouraging and promoting:

- Standardization of process improvement to enhance performance and achieve highest quality outcomes.
- A teamwork environment which promotes a 'speak up' culture demonstrated by the Code of Conduct for physicians and employees, Chain of Command and Conflict Resolution process, Gallup survey and Impact planning, RadicaLogic and event reporting and development of multidisciplinary rounding structure.
- Structured communications and error prevention techniques such as SBAR (situation, background, assessment, recommendation), safety check lists, read back/repeat back, time-out and pre-procedure processes that focus on delivering safe care to each patient.
- Design of care process based on evidence based protocols, monitoring and evaluating patient safety and harm data, participation in national and statewide safety collaboratives, and implementation of best practices to achieve ongoing compliance with National Patient Safety Goals.

- Patient Engagement in safety efforts by obtaining feedback from patients and their families during Real Rounding and Safety Rounds, committee participation; satisfaction surveys; encouraging patients to speak up when questions arise and ensuring full and open communication around episodes of harm.
- Open, structured and consistent reporting and analysis of error and near misses, including sentinel events and root cause analyses, reducing identified risks to patient safety and monitoring of the effectiveness of responses to actual occurrences, closing the feedback loop to reporters and regular event reporting to the Patient Safety and Quality Committee and the Quality and Safety Committee of the Board of Trustees promoting discussion of system failures that resulted in harm and improvement plans to stop reoccurrence.

Occurrence Reporting (RadicaLogic/Redform)

- All employees have a responsibility to make HFHS a safer place for patients and employees. To help in this regard, all unusual occurrences need to be reported in RadicaLogic (Redform). Reporting should include not only those that result in actual injury, but those that "pose the risk of injury."
- RadicaLogic entries are analyzed, trended and utilized to improve systems, process and as the basis for education to reduce or eliminate errors.

Sentinel Event/Critical Incident

- A Sentinel Event is any serious unexpected occurrence involving or creating the risk of death or serious injury. Some examples include wrong side surgery, suicide, etc. When identified, a root cause analysis (RCA) is performed to identify the basic reason or cause for the event. By identifying the cause, we will be able to eliminate it and prevent further incidents from occurring.

Describe your role relative to patient safety.

- Answer as appropriate.

For additional questions related to regulatory readiness, please contact your accreditation lead at any of the HFHS hospitals/business units.

Thank you for your commitment to patient safety!

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all for you