Welcome to Riverside Community Hospital

Agency, Vendor, Instructor, Student
ORIENTATION MANUAL

Riverside Community Hospital

Department of Education
4445 Magnolia Ave
Riverside, CA 92501
(951) 788-3152

1/2014
Dear Agency, Vendor, and Student:

On behalf of all the employees, medical staff and volunteers at Riverside Community Hospital, welcome to our organization! We are pleased you have chosen our hospital!

We have been providing the finest quality service to our community for over 100 years, making us the first choice for health care in the Inland Empire. Riverside Community Hospital was founded in 1901. We are a 373 licensed bed, full-service acute care hospital in the heart of the Inland Empire. We work with over 500 physicians on staff, representing over 200 specialties and employ over 1,800 employees.

Our fine reputation throughout the community is based upon the quality of care we provide to our patients and visitors every day and the extraordinary level of customer service practiced by our employees. As we continue to build upon the successes of our organization, we look to you working alongside our employees to contribute your ideas and enthusiasm, as you conduct yourself in an ethical and professional manner.

This orientation package is provided to help you develop into a part of the hospital team by becoming familiar with some of our policies, guidelines, and procedures. We want you to understand your responsibilities while in the hospital setting.

While all information is valuable, you will find that we have categorized specific information in such a way as to use your time in the most efficient manner. You are ultimately responsible for all the information presented in this orientation manual.

You must return all required forms (HIPPA, IT&S Security, Confidentiality Agreement, and Attestation Forms) to the Education Department or appropriate contact person (clinical instructor), completed in full, prior to your first work or clinical day in the hospital. You cannot report for work or attend clinical at Riverside Community Hospital until you have completed and turned in these forms.

We hope this information will provide you with a smooth transition into your responsibilities here at Riverside Community Hospital. Our goal is to provide outstanding care to the community of Riverside and support your educational needs. Please provide us with feedback and follow-up in regard to ways we can improve your experience.

Again, Welcome!

Sincerely,

Fran Paschall, MSN, RN
CNO, Senior Vice President
Riverside Community Hospital
4445 Magnolia Ave.
Riverside, CA 92501
(951) 788-3430
(951) 788-3152
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RIVERSIDE COMMUNITY HOSPITAL
Agency, Vendor, Student Orientation Manual
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MISSION STATEMENT

Riverside Community Hospital is committed to the care and comfort of our patients and improving the overall health of our community by providing healthcare services with integrity, compassion, and excellence.

OUR VISION

Riverside Community Hospital will be the employer and provider of choice by offering comprehensive healthcare services whose cornerstones are quality, safety, compassion, and service excellence.

OUR VALUES

Riverside Community Hospital values include:
- Passion for Excellence
- Integrity
- Dignity
- Teamwork
- Diversity
- Initiative
- Community Partner
- Financial Responsibility

OUR SERVICES

We are a 373 licensed bed, acute care hospital, some of our services include:
- Level II Trauma Center,
- Level IIIc Neonatal Intensive Care Unit (NICU),
- Cardiac Cath Lab (CCL),
- Open-heart surgery & Heart Care Rehabilitation Program (HCR),
- Transplant Unit (kidney & pancreas),
- Observation Unit (OBS Unit),
- Breast Center,
- Radiology Oncology Center
- Bariatric Care (Center of Excellence)
- Certified Primary Stroke Center
PATIENT CARE DEPARTMENT

As you join Team RCH, you will be collaborating with us to provide quality care to our patients. We have developed this package to be your working reference as you orient to your new responsibilities.

PATIENT CARE SERVICES VISION

The professional nursing practice at Riverside Community Hospital strives for excellence in the delivery of patient care. This is accomplished through professional collaboration and teamwork while partnering with our community.

NURSING PHILOSOPHY

Professional nursing practice is a caring art that employs scientific and business to promote the health and well being of individuals, families and communities. Goals are achieved through:

- Incorporating professional values as articulated in the American Nurses Association’s Social Policy Statement, Standards of Practice and Code for Nurses, into policies and practice;
- Creating a work environment that facilitates and encourages the involvement of staff into critical thinking to enhance professional nursing practice;
- Partnering with patients, families and other healthcare providers to ensure the involvement of patients/families in the care process and the coordination of comprehensive care and services across the continuum;
- Respecting the rights and sensitivities of religious/ethical/cultural beliefs of our diverse patient community; integrating new knowledge into our practice and contributing to the emerging body of nursing knowledge through participation in education, research and communication about nursing practice;
- Examining individual nursing associates’ commitment to the delivery of quality care and accountability for their practice; proactively developing the response to our dynamic healthcare environment; managing resources cost-effectively; collaborating and integrating with other professional disciplines and functional areas and;
- Becoming involved with professional and community initiatives that are both internal and external to the hospital.

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PARKING

ALL students and faculty will park off-site if on campus **Monday-Friday, DAY shift.** The designated parking lot for students/faculty is the “yellow” Lot 33 located on 3rd & Market. Shuttle service will transport to and from the parking lot to the hospital from **5:30AM to 8:30PM.** Those who have **weekend/night shift clinical rotations** will park **in the lot at 4000 14th St.** or **in the lot in front of Church** (parking fee). Parking sticker decals are not required.
Chain of Command

- For most staff, the first link in the chain of command is their supervisor or charge nurse.
- For students, the first link in the chain of command is their preceptor and clinical instructor.
- If further action is needed or an issue is unresolved, the department’s manager would be notified.
- The next level from here is the department’s director.
  - If a manager or director are unavailable and the supervisor/charge nurse is unable to resolve the issue, there is an administrative liaison (supervisor) on premises 24 hours a day and on weekends.
  - A director and/or manager are always available during the day, are on call, and may be reached via the operator, in the evenings and on weekends.
- Above these professionals are Famy Bialon, V.P. of Patient Care Services, Fran Paschall, V.P. and Chief Nursing Officer, and, Dan Bowers, Chief Operating Officer.
- The charts above are to acquaint you to the organizational structure and familiarize you with our chain of command.

### PILLARS OF SUCCESS

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- **PEOPLE**
  - Staff Satisfaction
  - Turnover Rate
  - Patient Satisfaction
  - IP HCAHPS
  - OP Surgery
  - ED
  - Test & TMT
  - Physician Satisfaction
- **SERVICE**
  - Cath Associated UTI
  - Central Line Bloodstream Infections
  - VAP
  - Patient Falls
  - Hospital Acquired Pressure Ulcer
  - Core Measures Composite
- **QUALITY**
  - Operating Expenses (Less Bad Debt) Per APD
  - SWB
  - Supplies
  - Other
- **FINANCE**
  - Volumes
  - ADC
  - Admissions
  - APD
  - Surgeries
  - ED Visits
  - Deliveries
  - OP Visits

9
Improving Patient Centered Treatment

“iMPaCT” – iMproving Patient- Centered Treatment – which has to do with the patients’ entire experience, including their clinical care and how every member of our staff interacts with them.

The logo for iMPaCT, which includes 4, increasing in size, semi-circles that flow off the “i” like a ripple in water. They signify the impact an action we make can have on our patients and how that action can extend well beyond our intentions.

As health industry professionals, whether we are caregivers or administrative workers or part of the environmental services team, our actions and choices have an impact on our patients. We can each have a positive impact at our facility by building on our tradition of caring, which means that we all need to work together to create a positive effect that results in the best patient experience.

Some of your goals as a health team member at RCH are:

- Patient-centered quality care at the heart of what we do
- Work each day to have a positive impact on the patient experience.
- Make a real difference in our patients’ perceptions of their experience and of RCH
- To understand and respect our patients’ expectations and perceptions

“HCAHPS” stands for “Hospital Consumer Assessment of Healthcare Providers and Systems.”

Not every patient will participate in the HCAHPS Survey but patients are selected at random to complete the survey after discharge. Survey results are submitted quarterly to the Centers for Medicare & Medicaid (CMS). CMS then publishes the results on the internet (www.hospitalcompare.hhs.gov) allowing patients to compare hospitals in their community on how patients perceive the care and service they have received.
Riverside Community Hospital strives to provide the best patient experience possible through excellent patient care and service.
By providing a level of care that meets patients’ expectations means our patients feel cared for and cared about, no matter what area of our organization is working with them.

The HCAHPS survey measures eight categories:

- Communication with nurses,
- Communication with doctors,
- The responsiveness of hospital staff,
- The cleanliness of the hospital environment,
- The quietness of the hospital environment,
- Pain management,
- Communication about medication and
- Providing effective, clear discharge information.
Although all eight categories are important to the patient, we’ve found through internal research that three of them have the greatest impact on a patient’s experience.

**The three categories that produce the greatest impact are:**
- Communication with nurses,
- Cleanliness, and
- Pain management.

**Why do you think these categories have the greatest impact on a patient’s experience?**
- Nurses have the most contact with patients
- Patients don’t always know who the nurse is; anyone in a uniform might be perceived as a nurse
- Lack of communication increases anxiety
- If the room is not clean the patient may wonder what else is not clean
- Fear of infection from unsanitary conditions
- No one wants to be in pain
- Uncontrolled pain increases patient anxiety

**What’s important is that these HCAHPS categories touch on the job duties, effectiveness and service of all employees, not just medical staff and nurses.** In fact, many patients have a difficult time distinguishing between the many different healthcare professions and roles. That’s that “ripple effect” in the impact logo we were talking about. To them, each and every one of us is the hospital.

Take the category of “cleanliness” as an example. What’s one thing that each of us could do – regardless of our jobs – to have a positive impact on patients’ perceptions of cleanliness at our facility?
- Pick up garbage when we see it
- Inform appropriate staff if an area needs attention
- Keep my personal workspace clean
- Keep myself clean and professional
- Don’t publically complain about an untidy area

**Remember:** the cleanliness of a facility can be viewed by the patient as a reflection of the people that work in the facility and how much they care.

The HCAHPS survey helps us in **building up our culture of service.**

**First,** providing an excellent care experience is the right thing to do; it’s the way we would want ourselves or our own family treated. Our survey results help us focus on what we’re doing right and where we can do better.

**Second,** HCAHPS is now the publicly-reported avenue by which we can share our commitment to service. Through our results, consumers will be able to see our ability to create a positive care experience, compared to other competitive facilities in our market.

**Third,** patient perceptions of care are related to patient outcomes. Studies show that patients who feel more engaged in their care are more likely to ask questions, identify potential problems and raise concerns. In other words, the better patients feel about their care, the better their outcome.
Finally, good performance is good business. Wanting to score well on the HCAHPS survey is, of course, the right thing to do. However, HCAHPS scores are also tied to public reporting and will likely be linked to Medicare reimbursement in the future. Employers and commercial payers are already using this information to determine participation in premium networks. The Joint Commission has also incorporated HCAHPS performance into their S3 hospital reports.

Put yourself in your patients’ shoes: if you’ve ever had a bad experience in a hospital, doctor’s office or restaurant, you may have had negative feelings. So think how the patients perceive your actions day to day.

Here are some questions to consider:

- What do patients think when they see a dirty floor or room?
- What do patients think when it is too noisy for them to rest?
- What do patients think when they do not understand what they are supposed to do after they leave the hospital?
- What do patients think when the nurse or doctor doesn’t take the time to listen and seems in a hurry to leave?
- What do patients think when people enter and care for them without telling them why they are there or who they are?
- What do patients think when their food is not the correct temperature or is not delivered at an expected time?
- What do patients think when they do not understand items listed on their bill?

What actions can you take to positively impact patient satisfaction?

- Smile
- Be kind/friendly/approachable
- Treat the patient as you’d want your family or yourself treated (i.e., with compassion and respect)
- Communicate what you’re doing in a way the patient will understand and accept
- Show compassion and courtesy
- Don’t assume patients know who you are and what you do
- Explain things that may just seem routine to you
- Be consistent – do these things always
- Manage the expectations of patients and caregivers

Here are some actions that have been proven to improve our patient’s perception of care, which we call the “Caring Model.” The Caring Model outlines key actions each of us can take to have a direct and positive impact on the patient experience.

The “Caring Model” is the model for HCA” and at RCHs we also use the AIDET model.

The Caring Model includes five actions, they are:

- Introducing yourself to the patient and discussing your role in his/her care that day;
- Always calling the patient by his/her preferred name;
- Sitting eye level at the patient’s bedside;
- Using touch appropriately (a handshake or a touch on the arm);
- Speaking positively about another caregiver in the patient’s presence.
“AIDET” (Knock First)
- A = Acknowledgment
- I = Introduction / Welcome
- D = Duration (of time you will spend with the patient)
- E = Explanation (of why you are here/what you will be doing)
- T = Thank you
  *Always end with, “Is there anything else I can do for you? I have the time”*

We all have the opportunity to use the Caring Model, even if we don’t provide direct patient care. Each RCH employee is essential to the care of our patients and has an impact on the patient experience through their interactions directly with patients or indirectly through coworkers, physicians, and others at our facility.

One important skill in any RCH team member is Active listening. Active listening is not the same as listening. We actively listen by clarifying patient statements/questions, summarizing/paraphrasing patient statements/questions, through body language (i.e., leaning forward, positive/responsive facial expressions) and asking follow-up questions. Responsiveness and therapeutic communication (i.e., communication that helps patients and their families know that someone cares about them and understands their needs and feelings) are very important to patient satisfaction?

The patient’s perspective on their care experience is the one that counts.
- They need to feel good about the care they received
- They need to feel good about the people who delivered it.
- They need to feel cared for and cared about, whether they are receiving a medical procedure, or receiving a call about their billing.
- We all play a part, and we all have impact.

We have learned a lot about how our actions can impact the patient experience and their perceptions of our service and care on a daily basis. To maintain our tradition of caring, we must ensure that our patients, their families and the communities we serve are aware of and experience our unwavering commitment to care. The way we do that is for everyone in our facility to use the actions we have discussed today to have a positive impact when dealing with patients and their families. Thanks for participating in the training and maximizing your impact on our patients!
Ethics & Compliance (Code of Conduct)
The Ethics Committee helps resolve conflicts of opinions as they relate to issues such as the end-of-life issues or risk/benefits of treatment plans. Any staff member, patient, or visitor can access the Ethics Committee by calling Patient Care Services or Social Services.

We follow the HCA Code of Conduct, which guides our daily activities within appropriate ethical and legal standards.

We all have the responsibility to report any activity that appears to violate applicable laws, rules, regulations, or standards. If you need guidance on an ethics or compliance issue or have any concerns about our conduct, contact:

Russ Young – Chief Financial Officer (CFO) & Ethics Compliance Officer: ext. 3360
Corporate Ethics Line: 1-800-455-1996
Janeille Kilgore – Assistant Ethics Compliance Officer: ext. 3167

Code of Conduct Session:
“Linking to Tradition…the Path to Healthy Conduct”

The purpose of our Code of Conduct is to provide guidance in carrying out our daily activities within appropriate ethical and legal standards. The Code can help you make the right decisions at the right times and remove doubt about questionable situations.

By signing the attestation you are acknowledging that:
- You participated in this modular instruction
- You understand the Code represents mandatory policies, and
- You agree to abide by it.

The Code of Conduct is just one part of our Ethics and compliance Program. The Program elements include:
- Setting Standards
- Communication and Awareness
- Measuring Program Effectiveness
- Organizational Structure

Process for reporting concerns:
- Follow chain of command
- Ethics Line – 800-455-1996
- HCA committed to fair resolution of issues with no retribution…you will be given a copy of the false claims act for the State of California. If you have questions about ‘false claims’ please see your ECO.
Each individual has a “personal obligation to report” concerns. We must take responsibility for our own actions and be responsible to report violations of laws, rules, regulations, standards, or this code.

There are a variety of Committees at the Corporate and facility level dedicated to creating and implementing our Ethics program.

Our Ethics and Compliance Officer is: Russ Young (ext. 3360) and Assistant Ethics and Compliance Officer: Janeille Kilgore (ext. 3167)

**HCA’s Mission & Values:**
Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve. In pursuit of our mission, we believe the following value statements are essential and timeless.

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

HCA Stakeholders – Who are “Stakeholders”? Stakeholders are the groups of people who count on us to uphold the Code of Conduct. Each day our actions can impact many ‘stakeholders’…remember that our actions and words affect those around us. Examples include:

- Patients,
- Regulators,
- Suppliers,
- Colleagues,
- Third-party payers,
- Joint-venture partners,
- Communities we serve,
- Volunteers,
- Physicians,
- Shareholders
Patients: When we talk about ‘stakeholders’, it doesn’t get any more important than what we do for our patients. The Code of Conduct says a lot about patients and how we can best serve and protect our patients. It talks about:

- Quality of care, patient safety and patient rights
- Patient Information
- EMTALA/Emergency Treatment

Let’s look at each one:

1. The opportunity to provide quality and safe care are everywhere, from how we mop the floors to how we prepare for surgery. We can only be good at it if **everyone** takes responsibility for it!

2. Patient Health Information/Protected Health Information/HIPAA:
   - Our Facility Privacy Officer is: Janeille Kilgore
   - Make sure you are doing all you can to protect information appropriately and legally.

3. EMTALA/Emergency Treatment – Under the Emergency Medical Treatment and Active Labor Act (EMTALA), patients must be provided an emergency screening exam and necessary stabilization and treatment (even if it’s been determined they cannot pay).
HCA and Physicians

Physicians

Excellent work environment
Physician Relationships

Business courtesies (gifts and entertainment)

Like patients, physicians are one of our key ‘stakeholders’. The Code discusses physicians in terms of the work environment and business relationships.

HCA’s Mission and values expected by the Code of Conduct:
1. Respect
2. Dignity
3. Kindness
4. Compassion

The Code of Conduct asks you to:
- Identify how our actions impact a patient’s perception of care provided by our facility.
- List actions we can take to provide best-in-class service and promote a positive, caring patient experience.
- Begin to look at situations through a patient’s eyes.

Communication and Avoiding Conflict of Interest:

Permitted Communication

- Patient billing matters
- Performance of EMTALA-related responsibilities
- Physician credentialing and privileging
- Development of electronic health record databases
- Improvement of patient safety or quality of patient care
- Emergency preparedness planning or community emergency response
- Medical research projects
- General trends in the healthcare industry
- Non-business matters

Prohibited Communication

- Prices
- Costs
- Employee salaries, wages, or benefits, compensation policies, staffing policies or terms of collective bargaining agreements, employment contracts or severance agreements
- Terms of managed care contracts
- Terms of equipment, supply or service contracts
- Allocations among competitors of customers, services or territories
- Exclusion of any existing or potential competitor or a supplier from the market
- Joint bidding or joint venture arrangements
<table>
<thead>
<tr>
<th>Summary of Other Code Sections</th>
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</thead>
<tbody>
<tr>
<td><strong>Controlled Substances</strong></td>
</tr>
<tr>
<td>• Prescription and controlled medications and supplies must be handled properly and only by authorized individuals to minimize risks to us and to patients.</td>
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<tr>
<td>• If one becomes aware of inadequate security of drugs or controlled substances or the diversion of drugs from the organization, the incident must be reported immediately.</td>
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<tr>
<td>• HCA facilities strictly enforce the reporting of any violations of diverting medications by facility staff or privileged practitioners.</td>
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<tr>
<td><strong>Corporate Opportunities</strong></td>
</tr>
<tr>
<td>• Colleagues are prohibited from taking for themselves personally opportunities that are discovered through the use of HCA property, information or position for personal gain and completing with HCA.</td>
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<tr>
<td><strong>Diversity and Equal Employment Opportunity</strong></td>
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<tr>
<td>• We provide an inclusive work environment where everyone is treated with fairness, dignity, and respect.</td>
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<tr>
<td>• We create and maintain a setting in which we celebrate cultural and other differences and consider them strengths of the organization.</td>
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<tr>
<td>• HCA is an equal opportunity workforce and no one shall discriminate against any individual with regard to race, color, religion, sex, national origin, age, disability, sexual orientation, gender identity, genetic information or veteran status with respect to any offer, or term or condition, of employment.</td>
</tr>
<tr>
<td>• We make reasonable accommodations to the known physical and mental limitations of qualified individuals with disabilities.</td>
</tr>
<tr>
<td><strong>Hiring of Former and Current Government and Fiscal Intermediary/Medicare Administrative Contractor Employees</strong></td>
</tr>
<tr>
<td>• Colleagues should consult with the Corporate Human Resources Department or the Legal Department regarding such recruitment and hiring.</td>
</tr>
<tr>
<td><strong>Ineligible Persons</strong></td>
</tr>
<tr>
<td>• We do not contract with, employ, or bill for services rendered by an individual or entity that is excluded or ineligible to participate in Federal healthcare programs; suspended or debarred from Federal government contracts and has not been reinstated in a Federal healthcare program after a period of exclusion, suspension, debarment, or ineligibility.</td>
</tr>
<tr>
<td>• Colleagues, vendors, and privileged practitioners at one or more HCA facilities are required to report to us if they become excluded, debarred, or ineligible to participate in Federal healthcare programs.</td>
</tr>
<tr>
<td><strong>Insider Information and Securities Trading</strong></td>
</tr>
<tr>
<td>• Colleagues may not discuss non-public, material information with anyone outside of the organization. Within the organization, colleagues should discuss this information on a strictly &quot;need to know&quot; basis only with other colleagues.</td>
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</table>
who require this information to perform their jobs.
- If an HCA colleague obtains access to non-public, material information about the organization, or any other company while performing his or her job, the colleague may not use that information to buy, sell, transfer, gift or effect other transactions of securities of HCA or that other company.

**Personal Use of HCA Resources**
- As a general rule, the personal use of any HCA asset without prior supervisory approval is prohibited.
- The occasional use of items, such as copying facilities or telephones, where the cost to HCA is insignificant, is permissible.
- Community or charitable use must be approved in advance by one’s supervisor.
- Use of organization resources for personal financial gain is prohibited.

**Relationships Among HCA Colleagues**
- No one should ever feel compelled to give a gift to anyone, and any gifts offered or received should be appropriate to the circumstances.
- No one should ever be compelled to participate in fund-raising efforts undertaken by individual colleagues.
- No one should be compelled to contribute to the charitable organizations supported by HCA.

**Research, Investigations, and Clinical Trials**
- Physicians conducting clinical trials of investigational products and services are expected to fully inform all subjects of their rights and responsibilities of participating in the clinical trial.
- All potential subjects asked to participate in a clinical trial are informed of: alternative services that might prove beneficial to them; potential discomforts; the risks, expected benefits, and alternatives; and the procedures to be followed, especially those that are experimental in nature.
- Any HCA facility or colleague applying for or performing research of any type must: follow all applicable research guidelines and privacy policies; maintain the highest standards of ethics and accuracy in any written or oral communications regarding the research project; and engage in human subject research in conjunction with IRB approval and consistent with Company policies regarding human subject research and IRBs.

**Substance Abuse and Mental Acuity**
- All colleagues must report for work free of the influence of alcohol and illegal drugs.
- Reporting to work under the influence of any illegal drug or alcohol; having an illegal drug in a colleague’s system; or using, possessing, or selling illegal drugs while on HCA work time or property may result in immediate termination.
- We may use drug testing as a means of enforcing this policy.

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**California False Claims Law Summary**

**FALSE CLAIMS LAWS**

One of the primary purposes of false claims laws is to combat fraud and abuse in government health care programs. False claims laws do this by making it possible for the government to bring civil
actions to recover damages and penalties when healthcare providers submit false claims. These laws often permit qui tam suits as well, which are lawsuits brought by lay people, typically employees or former employees of healthcare facilities that submit false claims.

There is a federal False Claims Act and a California state version of the False Claims Act. Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds is liable for significant penalties and fines. The fines include a penalty of up to three times the Government’s damages, civil penalties ranging from $5,500 to $11,000 per false claim, and the costs of the civil action against the entity that submitted the false claims. Generally, the federal False Claims Act applies to any federally funded program. The False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid.

One of the unique aspects of the federal False Claims Act is the “qui tam” provision, commonly referred to as the “whistleblower” provision. This allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government. The purpose of bringing the qui tam suit is to recover the funds paid by the Government as a result of the false claims. Sometimes the United States Government decides to join the qui tam suit. If the suit is ultimately successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered. Because the Government assumes responsibility for all of the expenses associated with a suit when it joins a false claims action, the percentage is lower when the Government joins a qui tam claim. However, regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower’s share of the proceeds if the court finds that the whistleblower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his employment as a result of the employee’s lawful acts in furtherance of a false claims action. The whistleblower may bring an action in the appropriate federal district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination, such as litigation costs and reasonable attorneys fees.

A similar federal law is the Program Fraud Civil Remedies Act of 1986 (the “PFCRA”). It provides administrative remedies for knowingly submitting false claims and statements. A false claim or statement includes submitting a claim or making a written statement that is for services that were not provided, or that asserts a material fact that is false, or that omits a material fact. A violation of the PFCRA results in a maximum civil penalty of $5000 per claim plus an assessment of up to twice the amount of each false or fraudulent claim.

California has a state version of the False Claims Act that mirrors many of the provisions of the federal False Claims Act. The actions that trigger civil and criminal penalties are identical to those of the federal False Claims Act. However, under the California Act, a person or entity may also be liable if he or she is a beneficiary of an inadvertent submission of a false claim to the state, subsequently discovers that the claim is false, and fails to disclose the false claim to the state within a reasonable time after discovery of the false claim. The California False Claims Act also differs from the federal act.
False Claims Act in that it does not apply to any claim of less than $500 in value or claims involving workers’ compensation or against public entities and employees.

The California False Claims Act also has a whistleblower provision. Like the federal False Claims Act, the California law includes provisions to prevent employers from retaliating against employees who report their employer’s false claims.

The State of California has also adopted several other false claims statutes that are intended to prevent fraud and abuse in Medi-Cal, the California Medicaid program. These laws generally prohibit the filing of any false or fraudulent claim or documentation in order to receive compensation from Medi-Cal.

**REPORTING CONCERNS REGARDING FRAUD, ABUSE AND FALSE CLAIMS**

The Company takes issues regarding false claims and fraud and abuse seriously. The Company encourages all employees, management, and contractors or agents of the Company’s affiliated facilities to be aware of the laws regarding fraud and abuse and false claims and to identify and resolve any issues immediately. Issues are resolved fastest and most effectively when given prompt attention at the local level. The Company, therefore, encourages its affiliated facilities’ employees, managers, and contractors to report concerns to their immediate supervisor when appropriate. If the supervisor is not deemed to be the appropriate contact or if the supervisor fails to respond quickly and appropriately to the concern, then the individual with the concern should be encouraged to discuss the situation with the facility’s human resources manager, the facility’s ECO, another member of management, or with the Company’s Ethics Hotline (1-800-455-1996).

Employees, including management, and any contractors or agents of Company-affiliated facilities should be aware of related facility policies regarding detection and prevention of health care fraud and abuse. These policies and procedures can be accessed on Atlas, the Company’s Intranet site, or the Company website at [www.hcahealthcare.com](http://www.hcahealthcare.com). The following are some of the policies that are relevant to this policy and to the prevention and detection of fraud and abuse: (1) EC.012-Correction of Error Related to Federal Healthcare Program Reimbursement; (2) EC.025-Reporting Compliance Issues and Occurrences to the Corporate Office Policy; (3) EC.003-Self-Reporting; (4) REGS.BILL.005-Confirming and Processing Overpayments; (5) REGS.GEN.001-Billing Monitoring; and (6) RB.009-Errors in Reporting.

**Privacy Protected Elements & Information Security**

**I. Health Insurance Portability and Accountability Act (HIPAA)**

A federal law that ensures the protection of patient privacy rights (effective 4/14/2003). A major goal of the law is to assure that individuals’ health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public’s health and well being.

Everyone is responsible for protecting patients’ individually identifiable health information. You must understand what is considered Protected Health Information (PHI) and remember the requirements related to the HIPAA privacy regulations.
If you reveal any Protected Health Information (PHI) to someone who does not need to know it, you have violated a patient’s confidentiality and broken the law. This includes information in any form; written, spoken, on computer, texting, facebook or any other means of written or electronic communication.

II. Need to Know Rule
Before looking at a patient’s health information, ask the question “Do I need to know this to do my job?” If the answer is no, STOP! If the answer is yes, use it, but don’t share it with anyone who doesn’t need to know. Even though you may have access to the entire medical record or admitting/billing information, you may only legally look at the information you need to perform your job. The need to know rule applies to every individual in the organization; employees, contractors, and volunteers. We are all responsible for following the Patient Privacy Policies and principles.

1. If you spot someone breaking the rules, report him or her either to your supervisor or directly to the Facility Privacy Official. If you see patient information in an open trash container, tell a supervisor, and then place it in the proper container for disposal. No one knows who might see the trash once it leaves the building. Discarded paper with patient information on it should be locked in the confidential waste bin until destroyed or shredded.

III. Ways to protect patient’s Protected Health Information (PHI)
1. Don’t write patient names on boards that can be viewed by the public. Secure notebooks, logs, test results, patient labels, anything with patient information on it from public view. Don’t leave patient records or medication administration books open.
2. If you are logged into a computer that contains patient information, never walk away from the computer without signing off. Never share your password. Do not access your own medical record (against policy). Typically, employees do not have a “need to know” their own medical information for the performance of their job. Employees may fill out the appropriate consent in Health Information Management (Medical Records) and obtain a copy of their records.
3. We may disclose the minimum amount of information required for treatment, payment or healthcare operations. Disclosure for any other reason is protected and requires a patient’s authorization.
4. Don’t ask PBX to page, "Smith family please call the GI Lab." The unit sometimes indicates the medical condition. Instead, ask the operator to page "Smith family, please call Extension 1234".
5. Don’t allow PHI to be seen by others. Put discarded paper with PHI and business paperwork confidential to RCH in locked waste bins (slit in top). This paper is shredded.
6. Do NOT leave charts open or any patient information on the top of a cart, counter or anywhere patient information can be seen by others
7. Do not discuss a patient’s PHI in public places. That includes elevators, cafeteria, public restrooms, gift shop, and other areas.

IV. E-mail is considered public information. HCA does NOT permit protected health information (PHI) to be sent via e-mail outside the company. Requests received by e-mail may be accepted and responded to via fax or mail.
V. Faxing – if you have to fax protected health information, verify the fax number and recipient (including name, organization, and fax number). Always include a cover sheet with the confidentiality statement:

“The documents accompanying this transmission contain confidential private information. The information is the property of the sender and intended only for use by the individual or entity named above. The recipient of this information is prohibited from disclosing the contents of the information to another party. If you are neither the intended recipient or the employee or agent responsible for delivery to the intended recipient, you are hereby notified that disclosure of contents in any manner is strictly prohibited. Please notify sender by calling sender’s phone number immediately if you received this information in error.”

1. If receiving FAX information, be sure the FAX is located in a secure area, not accessible to the public.
2. If Fax is sent in error or sent to an incorrect party, reasonable efforts must be made to obtain the copies from the recipient and see that they are destroyed. If information is sent to a Patient Restricted Party or recipient where there is a risk of release of PHI (e.g. newspapers), the Privacy Official should contact Legal Services.
3. Maintain a log of faxes that were sent to the wrong phone number or in error. Include a summary of mitigation actions taken to secure the information.
4. Wait for confirmation that the fax has been sent.

VI. Answering Machines – While you are not prohibited from leaving messages for patients on their answering machines, you must take reasonable safeguards to ensure the individual’s privacy. If the patient is not available and you must leave a message with a family member or other person who answers the phone, you must use professional judgment to assure such disclosures are in the best interest of the individual and limit the information disclosed.

Note: Patients have the right to request the facility communicate with them at an alternative address or by alternative means, such as only being contacted at work or only being reached by fax.

VII. Verification of External Requestors
1. We must verify the identity of any person or entity outside the facility who is unknown to the employee if they are requesting protected health information (PHI), either in person, verbally, or via written request. Here are some approved methods to identify verification (see policy IND.501)
   A. Valid State/Federal Issue Photo ID (driver license, passport), agency badge or photo.
   B. Requestor must provide at least 3 information items. Must have patient name, social security number, and a third item, such as an account number or date of birth.
   C. If request is made in writing, signature must match patient signature on conditions of admission.

VIII. Requirements to Protect Patient Privacy
1. Patients will identify who their information can be discussed with, including family.
2. Patients will be assigned a four-digit passcode that will be needed before we will give out patient information. The passcode will be the last 4 digits of their account number (changes with each visit).
3. The patient is responsible for distributing the passcode to family or friends.
4. This may change during treatment and the patient is allowed to change his/her mind regarding who can be given patient information. Hopefully, this will not happen too often, but should it occur, please forward the request for change on designated form to Janeille Kilgore, the Facility Privacy Official (FPO).
5. Be sure inquirers have the four-digit password before information is given out. The password is the last 4 numbers of their account number (which changes with each visit).

IX. Patient’s Right to Access
1. A patient may request a copy or to inspect their medical record. This may be requested verbally or in written form. Patient requests are forwarded to the FPO.

X. Patient’s Right to Amend
1. Although a patient cannot delete or change documentation in the medical record, the patient has a right to write an amendment or addition to the medical record. This amendment must be included in all future releases of the medical record. Requests to amend the medical record should be forwarded to the FPO or HIM Department.

XI. Right to Confidential Communications
1. Patients have a right to request they be contacted at a place other than their home phone number or than by mail to their home address. Once the form is completed, it must be used for all future contact. The patient does not need to provide any reason for alternate communications.
2. Patients also have the right to opt out of the hospital directory, which lists patients by name and room number (e.g. clergy, information desk, phone operator). The patient will have a confidential flag in the computer. Even if the patient is asked for by name, no information is to be given out.

XII. What we may disclose
1. For Treatment – we may disclose medical information to caregivers who are involved in taking care of you in the hospital or after you are discharged.
2. For Payment – we may give information about your treatment and services to bill and collect payment from you or insurance companies.
3. For Health Care Operations – we may use information to help improve the quality of care, for educational purposes, or to review the competence of health care professionals. We may use information to assess your satisfaction with our services or to remind you of appointments for medical care.
4. Business Associates – we may disclose medical information to contracted services so they can perform the job we’ve ask them to do (e.g. tests). We require the business associate to safeguard your information.
5. Directory – we may include limited information in our directory to provide to members of the clergy and to other people who ask for you by name. You may request an Opt Out Form if you do not want your presence in the facility known.

XIV. California Privacy Act
1. A state law that works in concert with HIPAA and is actually stricter than HIPAA. If you violate patient confidentiality and reveal patient information to someone without a “need to
know” you can PERSONALLY be fined up to $250,000! California also requires a self-report by the facility to both the state and the patient (the federal laws do not) within 5 business days of when it becomes known (The California Privacy Laws SB541 & AB211 became effective 1/1/2009)

XV. **HITECH (Health Information Technology for Economic and clinical Health) Act**
1. Title 13 of the American Recovery and Reinvestment Act of 2009 (ARRA). The development of health information technology (e.g., electronic health records, personal health records, & health information exchanges) has resulted in additional risks in violating a patient’s privacy or confidentiality. The HITECH Act mandates a federal breach notification requirement for stored health information that is not encrypted or otherwise made indecipherable, as well as increasing penalties for violations. The regulations require health care providers and other HIPAA covered entities to promptly notify affected individuals of a breach, as well as the HHS (Health and Human Services) Secretary and the media in cases where a breach affects more than 500 individuals. Breaches affecting fewer than 500 individuals will be reported to the HHS Secretary on an annual basis.
2. The Laws lists anything that would identify an individual and his health related issues as Protected Health Information (PHI). **Health Information may be considered individually identifiable if any of the following are present:**
   - Name, address, zip code
   - Names of relatives or employers
   - Birth date
   - Telephone or fax numbers
   - Fax Numbers
   - E-mail address
   - Social security or health plan number
   - Medical record or account number
   - Health plan beneficiary number
   - Reason for hospitalization, types of treatment
   - Certificate or license number
   - Any vehicle or device serial number
   - Web Universal Resource Locator (URL)
   - Internet Protocol (IP) address number
   - Finger or voice prints
   - Photographic images
   - Any other unique identifying number or code
   - Past hospitalization visit information

XVI. **Privacy Officer**
Janeille Kilgore is the Privacy Officer at Riverside Community Hospital. She may be reached at extension 3167

XVII. **Passwords are Private**
1. Don’t share or divulge your system password to anyone, including Information Technology staff. Don’t be afraid to say “No”. If in doubt call your manager or the Information Services Department. Use of someone else’s password is Fraud since it represents your legal signature in many situations.
2. Don’t walk away from a computer without logging off. If you think there has been a breach in security – call Information Services HELP Desk (4357).
3. Report unusual events and security concerns to your RCH Security Official or the HELP desk.
4. Take time to select the correct printer – as printers are added, it changes the order of the printers on the screen. Verify the correct printer so confidential patient information is only sent to the correct party.

XVIII. Social Engineering
1. Social engineering is the art of manipulating people into performing actions or divulging confidential information, usually about computer system access. This is commonly done over the phone, but can also take place in person. How do you protect yourself from these “con artists? Con artists are good at what they do, and they know how to make you believe them. They will sound friendly and trustworthy, and sometimes they will appear to be doing you a favor.

If you think you have witnessed an attempted or successful breach of security, please report it immediately to the Information Security Official (FISO), or to the Information Services Help Desk at x4357.

Warning Signs of Workplace Violence

All threatening comments or behaviors should be taken seriously – never dismiss them as “harmless” or “just blowing off steam”. We take a proactive stance to prevent violence. Report the following:

- Direct or verbal threats of harm
- Intimidation of others by words or actions
- Refusing to follow policies
- Carrying a concealed weapon or flashing a weapon to test reactions
- Hypersensitivity or extreme suspiciousness
- Often verbalizes hope for something to happen to the other person against whom the employee has a grudge
- Expression of extreme desperation over recent problems
- Intentional disregard for the safety of others
- Destruction of property

Harassment

RCH is committed to a work environment that is free of discrimination and maintains a strict policy which prohibits all forms of unlawful harassment, including sexual harassment, harassment based on race, color, religion, national origin, or age.
Harassment may occur regardless of whether the behavior was intended to harass: unwelcome sexual advances, verbal or physical conduct of a sexual or otherwise offensive nature, any behaviors that create a hostile or offensive work environment - it can be in the form of jokes, innuendoes, printed materials, emails.
Harassment Policy HR 155 applies to all hospital agents, including employees, medical staff, contract services. The policy prohibits unlawful harassment in any form, including verbal, physical and visual harassment.
Safety Hotline Ext: 3383

Report any safety issues or concerns to your manager or liaison. If the issue is not resolved, use the Safety Hotline (3383) to report any safety issue or concern. Patient’s families and physicians are also encouraged to use the hotline. You may identify yourself or leave the message anonymously. Safety issues may also be reported directly to the California Dept. of Health Services and/or then to The Joint Commission: (800) 994-6610 or to jointcommission.org

Mandatory Reporting

Dependant Adult and Child Abuse
Abuse is defined as the intentional maltreatment of an individual which may cause injury (either physical or psychological) and includes: Mental abuse, physical abuse, sexual abuse, neglect, abandonment, fiduciary (finances), isolation, and domestic violence (assault or abuse by a family member).
If you are a health care professional and have knowledge of/or reasonably suspect abuse/neglect, you must (by law) report abuse to the proper authorities to be investigated:
- Child abuse-report to Child Protective Services/Child Abuse Hotline before child leaves the hospital.
- Elder/Dependent abuse (any hospitalized patient 18 years or older) – report to County Adult Protective Services, Long-term Care Ombudsman, or Police.
- Domestic Violence-report to local law enforcement by telephone and in writing, while the patient is in the hospital. Also report any possible abuse incident to Social Services Department.

If you need information on recognizing signs and symptoms of abuse, there is a learning module entitled “Recognizing and Reporting Abuse Across the Life Span” in the nursing library.
Please read the Employee Statement – Child Abuse Reporting and Dependant Adult Abuse Reporting (Appendix A) and sign the form acknowledging that you have read and understand both.

Mandatory Reporting – Substance Abuse

*RCH Policy 178/178A says that all RCH employees are obligated to report any suspicious behavior of another employee’s condition which would impair their ability to perform their duties or which may cause a hazard to the safety and well-being of others. Do you know what those signs are?*

Signs Associated with Substance Abuse

Substance abuse (alcohol or drugs) is nondiscriminatory in nature; anyone may become addicted. Learn to recognize signs of substance abuse. These indicators can help in early identification of potential substance abuse problems and allow the employee to be referred to a qualified professional.

Behavior and Appearance - sudden changes in behavior
- Appearance deteriorates. May come to work looking sleepy, unkempt, unshaven, or dressed inappropriately (e.g., long-sleeved shirts in the summer, sunglasses indoors).
• Quality of work is inconsistent, work pace is slower than usual or sporadic. Makes more mistakes, sudden inability to fulfill complex assignments or meet deadlines. Safety issues arise – carelessness in operation and maintenance of potentially hazardous materials or dangerous equipment. May be involved in off-the-job accidents.

• Mood swings - signs of irritability, impatience, depression, excessive talkativeness, moodiness, arguing with co-workers or insubordination toward supervisors.

• Other performance-related signs include: excessive sick leave or tardiness, frequent early departures, extended breaks, excessive time on the phone, patterns of absenteeism (Mondays, Fridays, before or after holidays, etc.

Physical signs may include:

• Red, runny eyes and nose, dry throat, glassy eyes
• Decreased coordination – lack of dexterity
• Loss of appetite
• Increased breathing rate
• Sweating
• Muscle tremors
• Increased body/facial hair
• Decreased ability to concentrate
• Forgetfulness
• Severe itching

• Paranoia; suspicious toward others
• Speech problems (slurred, incoherent)
• Sleeping problems
• Needle marks on the skin
• Dilated or contracted pupils
• Vomiting
• Severe diarrhea
• Unexplained weight loss or gain
• Poor judgment
2014 National Patient Safety Goals

1. **Improve the accuracy of patient identification.**
   - Use of Two Patient Identifiers
   - Eliminating Transfusion Errors

2. **Improve the effectiveness of communication among caregivers.**
   - Timely Reporting of Critical Tests and Critical Results

3. **Improve the safety of using medications.**
   - Labeling Medications
   - Reducing Harm from Anticoagulation Therapy

4. **Improve the safety of clinical alarms systems.**
   - Improve the safety of clinical alarm

5. **Reduce the risk of health care-associated infections**
   - Comply with either the current CDC or WHO hand hygiene guidelines
   - Implement evidenced-based practices to prevent health care-associated infections due to:
     - Multidrug-Resistant Organism Infections in acute care hospitals
     - Central Line-Associated Blood Stream Infections
     - Surgical Site Infections
     - Indwelling catheter-associated urinary tract infections

6. **The hospital identifies safety risks inherent in its patient population.**
   - Identifying Individuals at Risk for Suicide

7. **Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery**
   - Conducting a Pre-Procedure Verification Process
   - Marking the Procedure Site
   - A Time-Out is performed before the procedure
Patient Rights and Responsibilities

Hospital Policy Statement
It is our policy to support a patient’s right to accept or refuse medical treatment and to participate in health care decision-making. We encourage patients to communicate their health care preferences. We have formal policies to ensure that your wishes about treatment will be followed and we do not condition the provision of care or otherwise discriminate against anyone based on whether or not you have executed an advance directive.

The hospital and medical staff have adopted the following list of patient rights. This list is posted in each patient care area, and is available in Spanish.

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.

7. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.

10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients’ rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

12. Confidential treatment of all communications and records pertaining to your and stay in the hospital. Basic information may be released to the public, unless specifically prohibited in writing by you. Written permission shall be obtained before medical records are made available to anyone not directly concerned with your care, except as otherwise may be required or permitted by law. You will receive a separate “Notice of Privacy Practices” that explains your privacy rights in detail and how we may use and disclose your protected health information.

13. Access information contained in your records within a reasonable time frame, except in certain circumstances specified by law.

14. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective services and advocacy services including notifying government agencies of neglect or abuse.

15. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

16. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

17. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.

18. Know which hospital rules and policies apply to your conduct while a patient.
19. Designate visitors of your choosing, if you have decision-making capacity, whether or not
the visitor is related by blood or marriage, unless:
  ● No visitors are allowed
  ● The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
  ● You have told the health facility staff that you no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

20. Have your wishes considered, if you lack decision-making capacity, for the purposes of
determining who may visit. The method of that consideration will be disclosed in the
hospital policy on visitation. At a minimum, the hospital shall include any persons living in
your household.

21. Examine and receive an explanation of the hospital’s bill regardless of the source of
payment.

22. Exercise these rights without regard to sex, age, disability, medical condition, economic
status, educational background, race, color, religion, ancestry, national origin, sexual
orientation or marital status or the source of payment for care.

23. Voice your complaints. Most concerns can be satisfactorily addressed at this level. Ask to
speak to the nurse in charge or the Director of the unit. If you cannot resolve your issues on
the unit, you may speak to someone else in Nursing Administration extension 3430.

24. File a grievance. If you are still dissatisfied with your care and want to file a grievance
with this hospital, you may do so by writing or by calling:

   Riverside Community Hospital
   Attn: Administration
   4445 Magnolia Avenue
   Riverside, California 92501
   (951) 788-3430.

The grievance committee will review each grievance and provide you with a written
response within 21 days. The response will contain the name of a person to contact at the
hospital, the steps taken to investigate the grievance, the results of the grievance process,
and the date of completion of the grievance policy process. If you are a Medicare patient and
have concerns regarding quality of care or premature discharge, you may call the Quality
Improvement Organization (QIO), Health Services Advisory Group, at 1-866-800-8749.
TTD Hearing Impaired 1-800-881-5980 www.hsag.com
File a complaint with the California Department of Public Health (CDPH) regardless of whether you use the hospital’s grievance process. The CDPH’s phone number and address is:

625 E. Carnegie Drive
Suite 280
San Bernardino, CA 92408
(909) 388-7170 or toll free (888) 354-9203

You may also report concerns with The Joint Commission (TJC) by either calling 1-800-994-6610 or emailing complaint@jcaho.org

Patient Responsibilities

1. Provision of Information

A patient has the responsibility to provide, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health. The patient has the responsibility of reporting unexpected changes in his condition to the responsible practitioner. A patient is responsible for reporting whether he clearly comprehends a contemplated course and what is expected of him.

2. Compliance Instructions

A patient is responsible for the following the treatment plan recommended by the Practitioner primarily responsible for the care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care, implement the responsible practitioner’s orders, and enforce the applicable hospital rules and regulation. The patient is responsible for keeping appointments and, when unable to do so for any reason, for notifying the responsible practitioner or the hospital.

3. Refusal of Treatment

The patient is responsible for his actions if he refuses treatment or does not follow the practitioner instructions.

4. Hospital Charges

The patient is responsible for assuring that the financial obligations of his health care are fulfilled as promptly as possible.

5. Hospital Rules and Regulations

The patient is responsible for following hospital rules and regulations affecting patient care and conduct, including complying with our non-smoking policy.

6. Respect and Consideration

The patient is responsible for being considerate of the rights of other patients and hospital personnel and for assisting in the control of noise and the number of visitors. The patient is responsible for being respectful of the property of other persons and the hospital.
Advanced Directives

Patient Self Determination Act 1990

An Advance Directive (AD) is a document that allows a person to:

- Give instructions about his or her healthcare
- Appoint another person (agent) to make healthcare decisions when he/she no longer can.
- Give specific instructions about care and treatments without naming an agent.

All patients admitted must be asked if they have an Advance Directive and given the option to complete one. If they do not have one, he or she must be offered written material to explain this legal right.

Organ Donation

OneLegacy is the transplant donor network utilized to determine medical suitability for organ donation. If, after review, OneLegacy considers the case acceptable the opportunity of donation will be extended to the family. Experience has shown that families are not opposed to the inquiry, but often are grateful to provide some benefit from their tragedy.

Interpreters

RCH has:
- Language Service Associates (LSA) is a service that provides interpreters (by phone) for almost all languages and dialects. The LSA Line should be used for informed consents and in-depth assessments, treatment options and discharge instructions.
- There are dual handset phones available to avoid passing the handset back and forth.
- LSA also has sign-language services for the hearing impaired via laptop computer.

ALWAYS USE AN INTERPRETER FOR ANY CLINICAL SIGNIFICANT DISCUSSION.

Special considerations in selecting an interpreter:
- Don’t assume anyone who can interpret is appropriate.
- Same sex/age/gender as the patient is preferred.
- Family members tend to censor what is said to shield the patient.
- Young children should not be used.
- Speak directly to the patient, not the interpreter.
Falling Stars Program

Riverside Community Hospital has a FALLING STARS Program. Each patient is assessed for risk of falls. If the patient is judged to have a risk for falls (due to medication, weakness, memory etc.), a bed alarm is used and they are part of the "Falling Stars" program. A magnetic star will be placed on the door frame of the patient’s room. The Star has an A, B, or A/B, indicating which patient(s) should be carefully observed. Bed “A” is always closest to the door. In addition, a YELLOW armband indicates a “High Risk for Falls”. Yellow slippers will be placed on the patient to identify them as a high risk of fall. If you see someone that has been identified as a “High Risk for Falls” walking without assistance, please get the nurse or any available help for the patient to prevent a fall.

Suicide Precautions (Policy IND 14)

Suicide precautions must be instituted for patient who has threatened and/or tried to commit suicide. If admitted to Med-Surgical, must have constant 24-hr. observation by a staff member or a sitter, until psychiatrist/physician orders a transfer to an appropriate facility or documents that patient is no longer a threat to self or others. While on unit keep all sharp objects out of patient’s room. Request paper containers and plastic silverware. If the patient becomes combative or uncontrollable, Code Gray (imminent danger) should be called. At MD request a member of the hospital staff, certified by the County of Riverside may evaluate a patient for placement on an involuntary psychiatric hold (5150).

Infant Abandonment

A California Senate bill enables mothers to drop off unwanted newborns to an RN in a hospital Emergency Department without risk of criminal charges. An infant identification packet is given to the mother. The infant becomes a ward of Child Protective Services and the mother has 14 days in which to reclaim the baby. She must have the infant identification packet with her.

Restraints

Definition: Anything that restricts motion (that is not easily removable by the patient) may be considered a restraint: soft restraints, mittens, arm splints (used at RCH).

The standard of care at Riverside Community Hospital is NOT to use restraints. This means we try everything possible to avoid the use of restraints. If restraints must be used, they are removed as soon as possible.

If you go by a room or into a room where a patient is restrained, be aware that we have a special duty to protect a patient who is unable to protect himself. There are also special regulations that apply to a patient who is restrained:

- Continued monitoring and assessments
- Restraints must be removed 2 hours to ensure a patient’s needs for toileting, turning, fluids, nutrition needs have been met.
- Must be protected from other patients or visitors in the area
- Restraint must have a quick release mechanism, so in case of emergency, the patient can be evacuated quickly and easily.
Look to see if they are in a normal and safe position in bed or in a chair. Patients have been known to slide down in bed or in the chair and suffocate.

Let the nurse know if the patient’s breathing seems funny or noisy, or hands or feet are turning blue or skin is torn.

Greet the patient and respect the patient as an individual. The patient still has rights, including the right to privacy and keeping the environment clean and safe.

Do not take a restraint off unless you have notified the nurse or there is imminent threat of danger.

Caring for patients is what we do. It is everyone’s responsibility to ensure our patients are not at risk of injury or harm.

If a restrained patient is in another area for testing or procedures, the patient must be observed minimally every 15 minutes and safety checks documented on the restraint flow sheet (check with the patient’s nurse).

Everyone entering or walking by a room of a restrained patient has a responsibility to ensure that the patient remains safe. Look in and notify the nurse if the patient is restless or wants something. Be sure the patient is not tangled or pulling against the restraint.

RCH Policy & Procedures

You can access RCH policies via an icon on computers with internet access, via the Riverside Community Hospital Intranet.

**POLICY: HR 157 & 157a Attendance**

**Attendance Policy (HR 157)**

**Applies to:**

All employees of Riverside Community Hospital.

**II. Policy Statement:**

The attendance policy establishes guidelines that promote fair and consistent application of basic attendance standards. Each employee is expected to adhere to established work schedules and to arrive at and report to work in a timely manner. Excessive absenteeism and/or tardiness may have an adverse effect on an employee’s performance appraisal rating, transfer requests, and/or promotional opportunities, and may result in disciplinary action up to and including termination.

**III. Procedure:**

A. Employees must arrive for work prepared to begin work at their scheduled start time and report to their workstations immediately upon recording their time in Kronos or the Kronos log. Any time away from their individual workstations during work time must be reported by employees according to established departmental practice or procedure. Unless otherwise stated, an occurrence counts against an employee attendance record, for the purposes of discipline, for one year. Discipline remains in an employee file for one year, except in the case of a final written warning or suspension, which shall remain in the employee file for 2 years.
B. In event of absence, employees must notify the charge nurse, manager, or shift coordinator of any intended absence by phone at least 2 hours prior to the start of their scheduled shift.

1. E-mail notification is not acceptable and is not considered notice for the purposes of this policy.
2. The employee must call in each day of an absence and speak directly to the charge, shift coordinator, supervisor, manager, or department director unless the entire period of the absence has already been communicated with the department director.
3. Failure to provide appropriate notice may result in the absence being considered unexcused and unpaid, and may result in disciplinary action, up to and including termination.
4. If an employee fails to report to work for two (2) consecutive scheduled work shifts without notifying their immediate supervisor (“no call/no show”), it shall be considered a voluntary resignation without notice.
5. Department directors will require employees who are absent for three days or more and/or with chronic attendance problems, to obtain a physician’s statement prior to their return to work.
6. Employees who report for work without proper equipment or in improper attire will be considered tardy and may not be permitted to work that day.
7. Employees who report for work in a condition deemed unfit for work, whether for illness or any other reason, may be considered tardy and will not be allowed to work.
8. Approved time off and/or departmental flextime does not constitute an occurrence.
9. Absences must be recorded through Kronos.
10. Absences of five or more consecutive days are considered as a Leave of Absence and the employee must submit a Leave of Absence form, available in Human Resources.

C. Occurrences—Definition and Accrual Rate

1. **Absence occurrence**: An unscheduled absence from work on one or more consecutively scheduled workdays. All unscheduled absences due to illness, doctor’s appointments, etc. are considered occurrences under the guidelines. Pre-approved PTO/Flex Time is not considered an occurrence, nor is time taken off which is covered by the FMLA or CFRA. Excessive absenteeism is defined as three or more occurrences or unscheduled absences in a rolling three (3) month period, or six occurrences in a twelve (12) month period.

   (1 Unscheduled Absence = 1 Occurrence)

2. **Tardiness**: Arriving late or early shall be grounds for discipline if the following occur:
   a. Clocking in more than 6 minutes late or clocking out more than 6 minutes early three or more times in a rolling three month period or 4 times in a twelve month period;
   b. clocking in and/or returning late from meal and break periods.

   (2 Tardies = 1 Occurrence).

3. **Incomplete Shift**: Leaving work prior to completion of scheduled shift, even where the absence is scheduled, may be counted as an absence. Being sent home due to hospital convenience, or released with the approval of a manager will not be considered an occurrence.

   (1 Incomplete Shifts = 1 Occurrence)

4. **Missed Punch**: An hourly employee who neglects to punch in or out for their shift or meal break has committed a missed punch violation. Entry in the Kronos log of the missed punch is required, but will not count as a punch with regard to the enforcement of this policy, except where authorized by the employee’s supervisor.

   (2 Missed Punches in a rolling 30 day period = 1 Occurrence)

5. **Abandoning Work Station/Assignment**:—Employees found to be away from their work areas without permission, and found in other areas of the premises (including but not limited to, the cafeteria, a break room, coffee shop, in a parking lot) when clocked in and not on an excused break, will be found in violation of this policy and subject to discipline, up to and including termination, for any such occurrence.

   (1 Abandonment = 2 Occurrences)

D. Attendance Violation Disciplinary Action Steps

1. **Verbal Counseling**: A director, manager, or supervisor will, conduct a verbal counseling following any combination of unscheduled absences, tardies, abandonment, and/or missed punches which together or separately constitute reason for discipline, within a rolling 3 – month
period. Such employee counseling is not required and any such meeting will be documented by the
department manager for his/her own records.

2. **Written Warning - Disciplinary Action Form:** The 3rd Occurrence of any combination of
unscheduled absences, tardiness, abandonment, and/or missed punches within a rolling 3-month period will
result in formal written warning. Employees with four tardies in a year shall also receive a written warning.

3. **Final Written Warning:** The 4th Occurrence of unscheduled absences, tardiness, and/or missed
punches within will result in a final written warning.

4. **Suspension:** The 5th Occurrence of absences, tardiness, abandonment, and/or missed punches
following the issuance of a final written warning will result in a 3 day suspension without pay.

5. **Termination:** The 6th Occurrence of any absences, tardiness, abandonment, and/or missed punches
will be cause for immediate termination.

E. Repeated disciplinary action for attendance violations and/or failure to report to work following denial of time-off
request(s) will result in progressive disciplinary action up to and including termination.

F. **ATTENDANCE ENFORCEMENT:** This policy is a "no-fault" policy in that, except where otherwise noted; all
attendance occurrences are included when determining the need for disciplinary action. Exceptions to the "no-fault"
principle are as noted:

1. Absences or tardiness caused/necessitated or covered by enforcement of the Family Medical Leave Act
(FMLA) of 1993, Uniformed Services Employment and Reemployment Rights Act (USERRA), or of the
California Family Rights Act (CFRA) are not considered violations of this policy.

2. Absences and/or tardiness caused by bereavement leave, jury duty, subpoenaed court appearances, and those
directly caused by a worker's compensation injury are not considered when enforcing this policy.

IV. **Exceptions/Clinical Alerts:**

V. **Documentation:**

VI. **References:**

POLICY: HR 174 Dress Code

I. Applies to:

All Employees of Riverside Community Hospital (RCH), students, interns and volunteers.

II. Policy:

Riverside Community Hospital prides itself on the professional atmosphere it maintains and the favorable image
employees present as representatives of the hospital. Employees are expected to observe good habits of dress,
grooming and personal hygiene in an appropriate manner according to the nature of the job performed and specific
requirements of the assigned department. In addition, this general policy applies to all employees even where dress
code rules are already specified by the department.

Employees who have questions regarding appropriate dress and attire should direct them to their supervisor in advance
to avoid conflicts and potential problems. Any employee who is inappropriately dressed when he or she arrives for
work will be considered unsuitable to commence work and will be sent home. The employee may be asked to return to
work later in the same day in proper attire that conforms to the hospital's standards. Employees who are asked to leave
because of inappropriate dress or attire will not be compensated for any time expended in going home or returning to
work. Employees may also be subject to discipline if they continually disregard the dress code.
III. Additional Information:

1. **GENERAL STANDARDS**
   A. Neat
   B. Clean
   C. Conservatively/modestly dressed
   D. Professional dress where regular contact with public is required

2. **EMPLOYEE IDENTIFICATION BADGE**
   A. RCH employee badge only.
   B. Identification badges are to be worn so they are readily visible (State Law).
   C. No defacing or modification of badges (i.e., pins, stickers).

3. **PINS AND BUTTONS**
   A. Professional school pins may be worn as a part of the uniform.
   B. Administration may authorize wearing of specific pins related to hospital activities (i.e., volunteer pins, etc.).
   C. Promotional buttons/pins/ribbons and other devices bearing messages (political, humorous) may NOT be worn.

4. **GROOMING**
   A. Employees will:
      - Avoid having body odor, residual smoke odor, and bad breath.
      - Practice frequent and thorough hand washing.
      - No wearing of strong cologne, perfume and/or after-shave, etc.

5. **FACIAL HAIR**
   A. Facial hair must be:
   B. Short
   C. Neat
   D. Clean
   E. Well trimmed*.
   F. Covered while working in specific areas, i.e., Operating Room, Nutritional Services.

   *While the hospital does not prohibit male employees having properly groomed beards and mustaches in general, OSHA does require employees in direct patient contact to be fit tested for a respirator mask to prevent the transmission of TB. These respirators cannot be properly fitted with facial hair and therefore facial hair is prohibited for these occupations.

6. **HAIR**
   A. Hair must be:
   B. Clean
   C. Controlled (i.e., not falling over eyes, immediate work area, onto patients).
   D. Covered with specific hair covering while working in specific areas, i.e., Operating Room, Nutritional Services.
   E. No unnatural colors.

7. **FINGERNAILS**
   A. Must be clean.
   B. Well trimmed and moderately short.
   C. If nail polish is used, it must be a muted tone and in good repair.
   D. HR 209 Fingernail and Hygiene Policy: Artificial fingernails or extenders will not be permitted for those employees in positions that involve direct contact with patients which includes:
      - All Category One employees (example: Nursing, Respiratory Therapy, Lab, Environmental Services)
      - Those who handle or reprocess equipment or instruments (like SPD)
      - Food service workers who directly handle food
      - Any contract employee who performs one of the above functions.
      - Anyone who prepares Pharmacy sterile products.
      - Category Two employees who may have indirect contact with patient supplies or equipment.
8. ATTIRE

A. Footwear
- Essential elements of footwear worn at RCH:
  (a) Safety
  (b) Comfort
  (c) Appearance
- Shoes must be:
  (a) Clean, well polished, and in good repair.
  (b) If clogs are worn, back strap for safety is required in patient care areas.
- Unacceptable footwear:
  (a) Thongs
  (b) Sandals/open toe shoes cannot be worn in patient care areas.
  (c) Hiking boots (exception: where required for safety).

B. Clothing (Scrubs, uniforms, business attire, etc.)
- Clothing must be:
  (a) Neat.
  (b) Clean.
  (c) Well pressed.
  (d) Modest.
  (e) Sufficient length
  (f) Sufficient fabric weight.
- Non-acceptable clothing includes:
  (a) The bare look, i.e., bare midriff, "see-through" or low cut necklines, spaghetti strap sundresses, recreational shorts or skorts.
  (b) Bib overalls.
  (c) Jeans.
  (d) Faded material.
  (e) Gym attire.
- Men's clothing must include:
  (a) Dress or sport shirt with collar (T-shirts, without a collar, are not permitted*).
  (b) Slacks
  (c) Necktie and coordinated coat or jacket where appropriate.
  (d) Uniforms

*Note: At director discretion, clinical employees may wear hospital sponsored t-shirts that are in good condition, under scrub jacket and lab jackets. EVS employees may wear t-shirts under their uniformed jacket. Night shift personnel that do not have any patient or family contact may also wear the hospital sponsored t-shirts. These are examples of exceptions to the policy. There may be others, but they must be approved by the division VP. Otherwise, unless the hospital designates a special day, such as employee BBQ's or other special events, T-shirts are not considered appropriate attire, when worn alone, or for general office and non-uniformed clinical settings.

- Women's clothing must be professional looking, i.e.:
  (a) Dress
  (b) Suit
  (c) Tailored pants
  (d) Uniforms
- The following are NOT appropriate while on duty.
  (a) Leggings.

C. Uniforms
- Hospital issued uniforms, laundered by RCH, are not to be worn to and from work.
- Uniforms supplied by the hospital but laundered by the employee may be worn to and from work.
- Department uniform questions should be directed to the Department Director.
- Scrubs are unacceptable for business/non-patient care departments.
9. JEWELRY/ACCESSORIES
   A. The wearing of excessive jewelry while on duty is discouraged.
   B. Acceptable jewelry:
      - Wedding Set/one other small ring.
      - Limit of 3 pierced earrings per lobe.
      - Earring should be no more than one inch in diameter or length.
      - Bracelets and dangling earrings are not allowed in patient care areas.
      - Decorative pin/broach (exception in patient care areas).
      - Medic-alerts and wristwatches are not considered jewelry.
      - All accessories must be limited to those items which provide simple, conservative, professional appearance.

10. BODY PIERCING
    No other facial or visible body jewelry is permitted; refer to I. Jewelry/Accessories, 2b above.

11. TATTOOS
    Tattoos must be covered and not visible.

12. CASUAL FRIDAY
    For those departments that routinely wear professional office apparel a more casual business appearance is allowed on Fridays.

**POLICY: GA 14 Smoking Policy**

I. **Applies to:**
   All personnel, contractors, physicians, visitors and departments of Riverside Community Hospital.

II. **Policy Statement:**
    Riverside Community Hospital is a no-smoking facility. Riverside Community Hospital is committed to providing an environment for restoring and maintaining the health of our patients and setting an example for the community. Smoking is both a fire and health hazard (California Health and Safety Code 1286).

III. **Procedure:**
    A. Smoking is prohibited within any structure or area of the Hospital campus. This includes all buildings in the main hospital, including the parking facilities, garage, automobiles, elevators, driveways, walkways and any Hospital controlled buildings.
    B. “No Smoking” signs are posted at entrances into the hospital.
    C. Smoking is not allowed in any area of the Hospital and Medical Campus.
       1. Patients shall not be permitted to smoke. Alternate solutions to the desire to smoke shall be pursued through Nursing (e.g., request for Nicotine patch from M.D.).
       2. Patients may not leave patient care units to smoke. Should patients do so despite interventions (notify nursing unit, speak to patient, notify M.D.). Patients should be considered to have left AMA. (See AMA policy.)
    D. Enforcement
       1. All personnel are responsible for providing courteous enforcement of this policy.
       2. Employee discipline will be pursued as deemed appropriate for violations of this policy.
    E. Education
       1. All inpatients are given smoking cessation information in their Admission packets. This information includes community resources including phone numbers of National Quitlines in their area, the effects of smoking on the physical body, medications that could help in withdrawal, and the effects of second hand smoke on children.
       2. Employees are given educational materials at every New Employee Orientation. They are also informed that this is a non smoking facility. Resources are available.
       3. Building contractors and sub-contractors will receive cessation of smoking information during their orientation. This will be done before a project begins.

IV. **Exceptions/Clinical Alerts:** N/A
VI. References:
California Health & Safety Code 1286
The Joint Commission Standards

POLICY: EH 200 Influenza Vaccination and Post Exposure Follow-up

Influenza Vaccination and Post Exposure Follow-Up (EH 200)

I. Applies to:
All personnel, departments, and entities of Riverside Community Hospital including Contracted employees and Auxiliary volunteers. This also includes Licensed Independent Practitioners having close patient contact.

II. Policy:
Influenza vaccination is the primary method for preventing the spread of influenza. The CDC’s Advisory Committee on Immunization Practices has recommended that health care workers be immunized to prevent the spread of this virus. Because the virus can be shed for 24-48 hours prior to influenza symptoms showing, there is the potential to reduce further hospitalizations and physician visits and also reducing death among high risk persons.
Any staff member or volunteer that is exposed to a patient that is positive for influenza should be educated on the signs/symptoms, and the incubation period. If not previously vaccinated, then influenza vaccine will be offered. Post-exposure prophylaxis will be given on a case-by-case basis after consultation with the Infectious Disease Chairman of the Treatment and Surveillance Committee.

III. Procedure:
A. All staff will be notified via Meditech Mox, email, and flyers throughout the hospital that the annual influenza vaccination program is being initiated. This typically occurs at the end of September with vaccinations starting as RCH receives its annual supply of vaccine.

B. All staff will be screened for the ability to receive the vaccine, i.e. allergies or contraindications.

C. All RCH personnel and volunteers will be required to either be vaccinated or declare in writing that he/she has declined vaccination. The vaccinations will be offered during the annual flu season which typically occurs between September and April. The vaccinations will be offered as vaccine is available.

D. Department Directors will be notified of staff that has not been vaccinated, and disciplinary Action will be taken if staff do not complete the consent or declination form.

E. Staff that have received the vaccine at another facility or outside clinic need to Complete the consent Or declination form.

F. Staff receiving vaccine will be given the injection intramuscularly in the deltoid muscle of the right or left arm.

G. Staff should be educated on the signs/symptoms of allergic reaction. If any allergic reaction should occur, then the staff will be screened in Employee Health first, and then referred to either the Industrial Clinic or the Emergency Room depending on severity.

H. If exposed to a positive influenza patient, the employee needs to notify Infection Control or Employee Health or the Administrative Liaison for further follow-up to determine if an actual exposure took place. If there was an unprotected exposure, then the Infection Control Department of Employee Health Department will contact the Treatment and Surveillance Chairman for his recommendation regarding post-exposure prophylaxis.
POLICY: Internet, E-Mail, Cell Phones, & Other Electronic Communications (HR 190)

Applies to:

All Employees, including but not limited to contract services.

II. Policy Statement:

Computerized information and electronic communication systems are one of the Hospital’s most valuable assets. Our guest relations success and the privacy of our patients depend on the proper use of personal cell phones and hospital electronic assets. This policy is designed to protect the Hospital, its personnel, its customers, and its resources from the risks associated with the use of e-mail, the Internet, cell phone and other forms of electronic communication.

A. Hospital electronic communications facilities (internal mail boxes, Meditech, e-mail, cell phones) are intended to be used only for official Hospital business. Occasional use of the of the hospital’s Meditech MOX and Outlook e-mail systems by employees for personal communications or messages of a non-controversial nature is permitted, so long as the communication or message is reasonably limited in scope of it’s distribution. No personal messages shall be broadcast hospital-wide, including solicitation or non-hospital event announcements. No messages shall be sent over the hospital’s Meditech or e-mail system which contains statements which are critical of any individual or of any policy, practice or service of the hospital or its affiliates. Users have the responsibility to use electronic communications in a professional, ethical, and lawful manner. No messages may be sent which violate the Hospital’s Code of Conduct, ACT II Service Standards or any other policy or procedure.

B. Every user has a responsibility to maintain and enhance the Hospital’s public image and to use the Hospital e-mail, access to the Internet and other electronic communications in a productive manner. These electronic communication mechanisms may be subject to discovery in the event of litigation. As with all communications, employees should avoid saying or using anything that might appear inappropriate or might be misconstrued by a reader.

C. Riverside Community Hospital (RCH) encourages the use of the Internet, e-mail and other electronic communications to promote efficient and effective communication in the course of conducting Hospital business. Hospital provided Internet access, e-mail and other electronic communications are Hospital property, and their primary purpose is to facilitate Hospital business. Employees must understand there is no guarantee of privacy regarding e-mail communications or Internet usage.

III. Procedure:

Employees, physicians, consultants, volunteers, and vendors may at some time be required to operate computer equipment or have access to software systems as part of their performance or duties for Riverside Community Hospital.

A. Those charged with this responsibility must understand and follow the Information Security policies in effect throughout the Hospital, as follows:

1. Do not operate or attempt to operate computer equipment without specific authorization from a supervisor.
2. Do not demonstrate the operation of computer equipment to anyone without specific authorization.
3. Maintain assigned passwords that allow access to computer systems and equipment in the strictest confidence. Do not disclose a password to anyone, at any time, for any reason.
4. Access only computer systems, equipment and functions as required the performance of job responsibilities.
5. Contact your Supervisor, the Facility Information Security Officer (FISO), the Director of Information Services, or designee immediately and request a new password(s) if yours is (are) accidentally revealed.
6. Do not record passwords in any manner as this increases the possibility of accidental disclosure.
7. Do not disclose any portion of the Hospital’s computerized system with any unauthorized individuals.  
   a. This includes, but is not limited to, the design, programming techniques, flow charts, source  
      codes, screens, and documentation created by Hospital employees or outside sources.
8. Do not disclose any portion of a patient’s record except to a recipient designated by the patient or to a  
   recipient authorized by the Hospital who has a need to know in order to provide for the continuing care of  
   the patient or to discharge one’s employment or other service obligation to the Hospital.
9. Report any activity that is contrary to the provisions of the Information Security Agreement to your  
   Supervisor, Facility Information Security Officer (FISO), or the Director of Information Services.

B. All employees covered by this policy must sign the Confidentiality & Security Agreement, which may be  
   obtained in Human Resources or the Information Services Department. Failure to comply with the above  
   policies will result in formal disciplinary action up to and including termination from the Hospital in the case  
   of employees, and the termination or cancellation of Agreements in the case of physicians, consultants,  
   volunteers or vendors.

C. Electronic Communications
1. Telephone Use  
   a. The company recognizes that occasionally it is necessary for employees to make or receive personal  
      telephone calls during working hours. The company, however, asks that employees restrict their  
      personal telephone usage to emergency situations. Employees may not charge personal long-distance  
      calls to the company. Excessive personal telephone calls may result in progressive discipline.
2. Personal Electronic Devices  
   a. Personal Electronic Device – Any portable electronic handheld equipment that can be used for the  
      purposes of communication, data management, word processing, wireless Internet access, image  
      capture/recording, sound recording and entertainment. Solely for the purpose of example, such  
      devices may include but are not limited to: Smart technologies (e.g. cell phones, smart phones, etc.);  
      Portable Internet devices (e.g. I-Pod®, I-Pad®, BlackBerry®, Android systems); Handheld  
      entertainment systems (e.g. gaming systems, audio/video players); Recording devices - Digital or  
      analogue audio and/or video captures; Laptop computers, tablets, notebooks, netbooks, etc.; Any  
      other convergent communication technologies.
   b. Unless properly authorized in writing by administration or designee, employees should refrain from  
      the use of any form of personal electronic devices during normal work hours. Employees are  
      Strictly Prohibited from using any recording feature of any personal electronic device while in  
      the hospital, whether for purposes of recording sound or images. These devices may be used during  
      breaks or when employees are at lunch only in non-work and non-patient care areas.
   c. Employees are restricted from using these devices in work areas, including but not limited to all  
      patient care areas or areas containing Protected Health Information as defined by HIPAA, and during  
      work time. Further, employees who are found to have used these devices in violation of this policy  
      will be subject to discipline up to and including termination of employment.
   d. Any Employee found to have used a personal electronic device to record sound or images on hospital  
      premises in contravention of this policy shall be subject to discipline, up to and including  
      termination.
   e. Departmental Policies may vary from this hospital-wide policy only where such policies are more  
      restrictive than the policy and procedure as set forth herein.
3. **E-Mail Use**
   a. Employees who have access to the e-mail system understand that it is for business use only, and are encouraged to minimize the personal use of the system.
   b. Forwarding of ‘chain’ e-mails, jokes, cartoons or any other non-business related material is strictly prohibited.
   c. Employees are required to delete any of these e-mails as they are received. Further, employees are required to notify Information Services should they receive such an e-mail. Where the sender is not known to the employee, said employees should not request the source to remove them from the distribution list as it may place the hospital at unreasonable risk for security breach.
   d. Employees who disregard this policy and continue to receive and/or forward such material, as described herein, will be subject to progressive discipline, up to and including termination.

4. **Electronic communications may NEVER be used in any of the following ways:**
   a. To communicate patient-identifiable information outside the hospital, except when using encryption methods specifically authorized by the Hospital.
   b. Communicating patient-identifiable information inside RCH must be done in compliance with RCH Appropriate Access policies.
   c. To communicate RCH confidential information to those outside of RCH, except when using encryption methods specifically authorized by IS Security.
   d. To harass, intimidate, or threaten another person.
   e. To access or distribute obscene, abusive, libelous, or defamatory material.
   f. To distribute copyrighted materials which are not authorized for reproduction or distribution.
   g. To communicate RCH’s official position on any matter, unless the employee engaging in such communication has been specifically authorized to make such statements on behalf of RCH.
   h. To access another person’s e-mail, if not specifically authorized to do so.
   i. To impersonate another user or mislead a recipient about the user’s identity.
   j. To bypass the system’s security mechanisms.
   k. To distribute chain letters.
   l. To participate in political or religious debate.
   m. To solicit goods and services.
   n. To run a personal business.

   Violation of this policy may result in disciplinary action, up to and including, termination.

**Hospital Safety & Access**

**Public Safety**

- Provides escorts to any part of the campus or parking lots 24 hours a day, 7 days a week.
- Manages Lost and Found. If attempts to find the owner of lost property fail, label the lost item and take to Public Safety. If patient belongings are not picked up by the family within hours of notification, label items with the patient’s name, room number, and date of discharge and send to Public Safety. Do not keep lost items on the unit for weeks or months. It takes a lot less time to check a room prior to discharge than to manage lost items. Public Safety Dept. is not permitted to accept "patient belongings" from the floors without a proper inventory of the belongings bag and identification of who it belonged to (if known); Nursing staff is responsible for inventorying / labeling patient belongings bags prior to sending to Public Safety.
- Public Safety must always be notified when a visitor is involved in an accident or injury on the hospital premises. They will secure the area, take pictures, and ensure witness reports are taken. Visitor falls or injuries must always have an RIR (Risk Identification Report) completed. Do not make any statements or promises that the hospital will pay the bill as each case is unique and will be assessed and followed by Risk Management or Administration.
- Call boxes are located by the parking structure elevators and in parking lots throughout the campus to report emergency situations directly to the operator. Push the button to talk, release it to hear the operator.
- If Public Safety is called to help with a patient, medical and nursing staff, need to direct the safety officer in exactly what needs to be done to manage the patient and medical equipment safely.
Hospital Access

Employee ID badges give you access to the designated employee entrance and other perimeter points of entry based on the individual needs of the employee / job position; they provide access to all floors and most hospital areas. It also is the badge used at the time clocks.

Quick Do's and Don'ts:
- Do wear your badge at all times while in the hospital. Wear it between the collar and waist, picture facing out.
- Do challenge anyone who is found in any patient care area or restricted area without a badge or identification band.
- Do report any violations immediately to the Public Safety Department.
- Do report any lost or misplaced badge to the Public Safety office @ x3329. The badge will be deactivated.
- Don't loan your badge or use your badge to grant access to anyone for any reason. Each badge is programmed differently and may have sensitive area access (Pharmacy, Cashiers, OB, etc) that another individual may not be permitted to enter.
- All patient visitors must sign-in at the front lobby desk and are issued a colored wrist band (colors vary day by day with NO predetermined schedule) and/or a visitor "badge" if they are being sent to a secure area (e.g. Maternal Child). Don't allow visitors to remain on the floor without the appropriate visitor badge and/or wrist band, direct them to the main lobby to wait or to obtain a visitor badge and/or wrist band.
- Don't puncture your badge with pins or decorate your badge in any way. This will damage the internal components of the badge and may affect your ability to access badge readers throughout the hospital.

Visitor Access
RCH has open visiting hours. Children under the age of 14 are discouraged from visiting. When a child visits, the visit should be limited to 10-15 minute intervals and under direct adult supervision, not including the patient. During flu season, special restrictions apply & the Liaison must approve.

Access to the 2nd Floor and 3rd Floor (Pediatrics) is controlled by badge (includes door access, stairwells, and elevators). Visitors, vendors, and contractors are required to check in at the Information Desk in the Main Lobby.

I. General Safety at RCH
1. If an Emergency Code is occurring in one building, do NOT use the elevators in that building. It is OK to use the elevators in other buildings. **Dial 4911 for ALL CODES**: The PBX Operator will announce the “CODE” and the building it is located in.
2. When any CODE has ‘ended’, the “ALL CLEAR” will be announced 3 times by the PBX operator. Normal activities may then be resumed.

<table>
<thead>
<tr>
<th>CODE RED</th>
<th>FIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>◊ RACE (Rescue-Alarm-Confine-Extinguish/Evacuate)</td>
<td></td>
</tr>
<tr>
<td>◆ Rescue (people from imminent danger)</td>
<td></td>
</tr>
<tr>
<td>◆ Alarm (call ext. 4911; pull Fire Alarm Box)</td>
<td></td>
</tr>
<tr>
<td>◆ Confine / Contain (close doors)</td>
<td></td>
</tr>
<tr>
<td>◆ Extinguish / Evacuate (smother; water; fire extinguisher)</td>
<td></td>
</tr>
<tr>
<td>◊ PASS</td>
<td></td>
</tr>
<tr>
<td>◆ Pull the Pin.</td>
<td></td>
</tr>
<tr>
<td>◆ Aim the nozzle</td>
<td></td>
</tr>
<tr>
<td>◆ Squeeze the handle</td>
<td></td>
</tr>
<tr>
<td>◆ Sweep the base of the fire.</td>
<td></td>
</tr>
<tr>
<td>◊ Please take the time to find the Fire Alarm Box in your department.</td>
<td></td>
</tr>
<tr>
<td>◊ Know your closest evacuation route!</td>
<td></td>
</tr>
</tbody>
</table>

Fire Safety: Prevention
- Prevention is the best defense against fire.
- Smoking is the most common cause of fires.
- To help prevent these:
Follow the RCH facility “Smoke Free Campus” Policy
Instruct visitors and patients of the NO smoking policy

To help prevent fires related to the common cause of Electrical malfunction:
- Remove damaged or faulty equipment from service
- Submit malfunctioning equipment for repair

To help prevent fire related to the common cause of Equipment Misuse:
- Do not use any piece of equipment that you have not been trained to use

### Fire Safety Safeguards in the Event of a Fire
- RCH is equipped with fire safety features.
- These features include:
  - Fire alarm systems
  - Fire extinguishers
  - Emergency exit routes and doors
  - Smoke and fire doors and partitions
  - A fire plan
- **REMINDER…**
  - Never block automatic fire doors with gurneys, wheelchairs, or other items. In a CODE RED, these fire doors close automatically for safety.
  - Keep hallways clutter-free
- **Door Tags**
  - HOT PINK DOOR TAGS (stored in the fire hose cabinets) are used to indicate that a room is empty, once tagged; the room should only be opened by the fire dept.
  - RED DOOR TAG is placed on the door of the fire room, after it has been evacuated.

### CODE BLUE
- **Code Blue -Medical Emergency (Cardiac or Respiratory Arrest).**
- The code team – 2 ACLS trained nurses from critical care, a respiratory therapist, and an ER physician respond. Exceptions: ED, NICU, CCL, and OR will handle their own codes unless staff is limited.

### CODE PINK/PURPLE
- Code pink indicates an infant or baby (under 1 year of age) is missing and possibly abducted.
  - RCH Policy says: Infants are always transported off OB in bassinets -they are never carried off the unit in the arm of parents or staff outside of their room.
  - Code Purple indicates a child (over 1 year of age) is missing and possibly abducted. Code Purple + (age) is announced.
  - For both Codes:
    - Report to the charge nurse who will ask staff to monitor exits/stairwells, stop and tactfully question anyone leaving with a baby/child or a suspicious bundle. Staff will also need to check empty rooms or storage areas where an abductor might hide.

### CODE GRAY
- Combative person and dangerous security problem
- All Security and male employees respond to area (show of force).
- Any staff member confronted with or witnessing a combative situation should initiate a Code Gray.

### CODE SILVER
- **Weapon or Hostage**
- Code Silver indicates a person with a weapon and/or a hostage situation. If you see a person brandishing a weapon, seek cover, and warn others.
- Call 4911 and report Code Silver. Give information such as: location, type of weapon, and number of suspects/hostages. The PBX operator will call the local Police Department. The Police Department will be in full control of the situation upon their arrival on the scene.
- **Upon hearing a Code Silver:**
  - **DO NOT** go to the area specified. This is an extremely dangerous situation that should only be handled by trained authorities.
  - Staff should close ALL patient and unit exit doors and take cover behind locked doors if possible.
  - Any staff members in the area specified by Code Silver:
    - Seek Cover/protection and warn others of the situation
    - Try not to panic
    - Stay alert
| **CODE ORANGE** | • Hazardous Spill  
|                | • Code Orange is an accidental release or spill of a hazardous material.  
|                | • Call 4911 and request RCH HazMat assistance. If you hear the PBX operator make the following announcement: “Attention Please” – Code Orange (Location)”:  
|                | ◇ Clear problem area immediately, all those in the immediate area should evacuate to the next smoke compartment. Ensure all door are closed as you exit.  
|                | ◇ Unauthorized staff should stay away from the area.  
|                | ◇ Notify the supervisor who will call the MSDS Contact 3E number (1-800-451-8346) for precautions and clean-up information.  
|                | ◇ ER will be notified and advised whether decontamination procedures are needed.  
|                | ◇ Public Safety will determine if the Riverside Fire Dept. will be called.  
|                | ◇ Facilities engineering will respond to the area.  
| **CODE YELLOW** | • Bomb Threat  
|                | • Code Yellow is paged to inform staff of a bomb threat. If you receive a bomb threat call, do NOT put the caller on hold or transfer the call:  
|                | ◇ Though it may be a hoax, we treat all threats as real.  
|                | ◇ Motion to a co-worker to notify PBX.  
|                | ◇ Keep the caller on the line as long as possible and get as much information as possible.  
|                | ◇ Use the yellow Telephone Bomb Threat Checklist card located in the department’s Emergency Preparedness Manual to help you ask the right questions and document the conversation.  
|                | ◇ If you find something out of the ordinary, do not touch it or move it. Evacuate and close off the area and immediately call 3329 or have PBX contact Public Safety.  
|                | • When a Code Yellow is paged:  
|                | ◇ Close all patient room doors and all fire/smoke compartment doors.  
|                | ◇ Report to your manager for your search assignment.  
|                | ◇ All areas in your department should be scanned for items that are not usually found in your area or for objects that are arranged in a different manner than usual.  
|                | ◇ Look around the room three times:  
|                | ◡ First, start at the floor level and look at parts of the room from the floor to about three feet up.  
|                | ◡ Second, move your eyes to the midpoint of the walls to the ceiling.  
|                | ◡ Third, check the ceiling area, light fixtures, and top shelves.  
|                | ◡ Finally, put a note/marker on the door that the room was searched and notify Public Safety your area is clear.  
| **TRIAGE CODE** | • “Triage” is a process used to sort and classify the sick or injured. When the need exceeds our capacity to care for the sick or injured you may hear “Triage codes” announced by the PBX operator. There are three types of triage codes:  
|                | ◇ **Triage Alert** announces an impending disaster mode for the hospital. Preparations should be made to activate your department’s disaster plan. Report to your supervisor for assignment.  
|                | ◇ **Triage External** announces a disaster has occurred and the hospital expects a large number of casualties to come through Emergency.  
|                | ◇ **Triage Internal** announces a disaster that has occurred inside the hospital (fire, flood, etc.) and people are needed to respond to a designated floor or department.  
|                | • When a Code Triage is paged:  
|                | ◇ All direct patient care services departments will continue to provide the highest level of service possible. Managers will complete an Inventory Labor Pool slip and determine which staff can be directed to assist with the disaster.  
|                | ◇ All other services will focus efforts towards direct inpatient care needs. Non-essential operations will be discontinued until Triage All Clear is announced.  
|                | ◇ If your supervisor assigns you to report to the People (Labor) Pool, report to the cafeteria unless an announcement states otherwise. Nursing staff should bring a blood pressure cuff and stethoscope.  

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All unused patient movers (wheelchairs and gurneys) should be taken directly to the hallway between ER and Radiology.

Designated team members report to assigned duties.

The Control (Command) Center is located in the Emergency Department lounge (unless otherwise announced). If your department needs additional supplies or equipment during an emergency, you should contact the Command Center at 1911.

II. Emergency Preparedness

1. Hospitals must be prepared to respond to disasters such as:
   A. Natural disasters…earthquakes or hurricanes
   B. Technological disasters…electrical failure
   C. Major transportation disasters…trains, planes
   D. Terrorism…Sept. 11th
   E. Nuclear, biological, chemical & radiological events…anthrax, dirty bombs, etc.

2. To prepare for such disasters, each hospital must:
   A. Identify events that could occur internally or in the area
   B. Be prepared for events that might occur
   C. Develop strategies for dealing with each event and develop an Emergency Operations Plan
   D. Hospitals must have an Emergency Operations Plan that centers on six key elements:
      E. Communication
      F. Resources and assets
      G. Safety and security
      H. Staff responsibilities
      I. Utilities
      J. Clinical activities

3. In Order to be Prepared, Staff Must Be:
   A. Educated on the procedures in the Emergency Operations Plan
   B. Trained and drilled to respond to disasters according to the plan.
   C. Make sure YOU participate in RCH’s disaster drills, and
   D. Read your department Emergency Preparedness Manual

III. Electrical Safety

1. Most equipment in the
2. Healthcare setting is electric.
3. This means there is risk of electric shock from medical equipment.
4. Electric Shock can cause:
   A. Burns
   B. Muscle Spasms
   C. Ventricular fibrillation
   D. Respiratory arrest
   E. Death

5. Remove and report hazards
6. Remove electrical equipment from service if it:
   A. Malfunctions
   B. Shows signs of damage
   C. Shows signs of unusual heating
   D. Produces a burning smell during operation
   E. Shocks staff or patients
   F. All Medical equipment should have a current inspection tag on it, if not, notify BioMed.
7. Use equipment safely.
   A. Learn proper equipment operation before use.
   B. Do not use equipment on which liquid has been spilled or handle with wet hands.
   C. Turn equipment off before plugging in or unplugging.
   D. Maintain, test, and inspect
   E. All medical equipment should be inspected and tested on a regular schedule
   F. Use power cords and outlets properly
   G. Do not use outlets or cords with exposed wiring.
   H. A hot outlet can be an indication of unsafe wiring. Unplug cords from the outlet. Report the hazard.
   I. Do not bend, stretch, or kink, power cords excessively
   J. Do not jerk cords from outlets. Pull on the plug.
   K. Do not staple, tack, or nail power cords to walls or floors. Use tape, if necessary.
   L. Do not rest equipment on power cords.
   M. Use only power cords with three-prong plugs. Never use adapters, two-prong plugs, or broken three-prong plugs.

8. Protect patients
   A. Place electrical equipment at a distance from patients.
   B. Maintain patient areas, keep floors dry at all times.
   C. Do not touch patients and electrical equipment at the same time

IV. Radiation Safety
1. Exposure to radiation can increase the risk of cancer, therefore it is important to protect against exposure.
2. The three key factors for limiting exposure are:
   A. TIME. Minimize the amount of time that you are exposed.
   B. DISTANCE. Maximize your distance from the radiation source.
   C. SHEILDING. Use appropriate shielding to absorb the energy of radioactive particles.
3. The goal is to keep radiation exposure As Low As Reasonably Achievable (ALARA).
4. Nuclear Medicine
   A. When a patient is injected with a radioactive isotope, Nuclear Medicine will place a sticker on the patient’s chart noting:
      ● Name of isotope
      ● Dose of isotope
      ● Date of decay
      ● Nuclear Medicine
   B. Nuclear Medicine will also place a door tag on the patient’s door which states:
      (a) Environmental Services do not remove trash/linen from room until
      (b) Date: __________________
      (c) Time: __________________

V. Magnetic Resonance Imaging MRI Safety
1. An MRI system is not an inherent biological hazard.
2. However, hazards can arise when certain items enter the MRI systems:
   A. Ferromagnetic objects are attracted to the magnet at the center for the MRI system. They can become dangerous projectiles (“the projectile effect”).
B. Electronic devices that enter the magnetic field of the MRI system can malfunction due to interference.
C. Metal implants or wires can conduct electrical currents resulting in burns.

3. MRI safety is largely a matter of ensuring that potentially hazardous items stay outside the magnetic field. Therefore:
   A. Control access to the magnetic field
   B. Remove metallic objects from clothing and pockets before entering the magnetic field.
   C. Thoroughly screen patients prior to MRI. Ensure that patients do not have MRI-unsafe implants or embedded objects.
   D. Properly position patient for MRI so that electronically conductive loops are not formed. This will prevent burns.

VI. Ergonomics
1. Ergonomics means designing work equipment and tasks to fit the “natural law” of the human body.
2. Good ergonomic practices can lead to fewer work-related injuries.
3. Ergonomic best practices are:
   A. Avoid fixed or awkward postures.
   B. Avoid lifting without using proper devices or lift equipment.
   C. Avoid highly repetitive tasks, if possible.
   D. Provide support for your limbs.
   E. Use proper posture and body mechanics when sitting, standing, or lifting.
   F. Avoid reaching, twisting, and bending.
   G. Respond promptly to aches and pains to prevent slight injuries from becoming severe or debilitating.

VII. Back Safety
1. Healthcare is a high-risk setting for back pain and injury.
2. Healthcare workers who lift and move patients are at especially high risk for injury.
3. Injury may be prevented through:
   A. Proper care and operation of the spine
   B. Proper posture
   C. Regular exercise
   D. Back Safety & Proper Posture
   E. Maintain proper posture and head alignment.
   F. Ears over shoulders, shoulders over hips.
   G. Maintain slight curves of the neck and back
4. Maintain the three curves of the spine while:
   A. Sleeping
   B. Standing
   C. Sitting
   D. Lifting a static load vertically
   E. Lifting or transferring a patient
   F. Lifting & Transferring Patients
5. Healthcare staff who lift and transfer patients are repeatedly exposed to the three major risk factors for injury during physical task:
   A. Awkward posture
Manual patient handling often involves awkward postures. For example, bending and reaching while lifting or lowering creates an awkward position.

B. Force
- Force refers to how hard the muscles have to work. A lot of force is required to lift patients who typically weigh 100 pounds or more.

C. Repetition
- This risk factor refers to performing the same motion or series of motions over and over again. Nurses and aides might perform dozens of lifts and transfers in a single shift. They might perform thousands of lifts over a lifetime of nursing.

6. Lifting & Transferring Patients
   A. Slide objects as close as possible before lifting
   B. Test before lifting; ask for help if heavy
   C. Tighten stomach muscles without holding breath
   D. Use smooth movements; do not jerk.
   E. Distribute load evenly
   F. Do not bend, use your legs to lift
   G. Do not twist at the waist
   H. To minimize or eliminate manual lifting, use devices to help with patient lifts and transfers.
     - Available devices include:
       (a) Motorized lifts - ARJO
       (b) Non-motorized transfer devices such as, transfer boards, maxislide, etc.
       (c) Step up on a stool to reach surfaces that are too high to reach without arching your back.
   I. Bend at the knees and hold the object close to the body
   J. Use 2 people to lift or move heavy or bulky objects
   K. Push instead of Pull

VIII. Slips, Trips, & Falls: Prevention
1. Slips, trips, and falls in the workplace cause injuries and deaths every year.
2. To help prevent Slips, Trips, & Falls:
   A. Keep floors clean and dry
   B. Increase the friction of floors with abrasive coatings, non-skid strips, or rubber mats.
   C. Secure rugs with skid-resistant backing.
   D. Choose slip-resistant shoes.
   E. Post safety signs around slip hazards (icy sidewalks, wet floors, etc.
   F. Keep your feet flat and slightly spread apart.
   G. Point your toes slightly outward.
   H. Keep your center of balance under you.
   I. Make wide turns at corners.
   J. Keep your arms at your sides
   K. This gives additional balance.
   L. It keeps your arms available for support if you fall.
3. Most falls in the workplace are foot-level falls. In a foot-level fall, a person slips or trips on a walking or standing surface. This results in a short-fall.
4. Falls from a height carrier a higher risk for injury. These include:
   A. Stairs
   B. Keep staircases clean and well lit.
   C. Staircase should have sturdy handrails on both sides
D. Maintain your center of balance when stepping.
E. Ladders
F. Use a ladder of the proper height

5. **FALLING STARS Program.**
   A. Each patient is assessed for risk of falls.
   B. If the patient is judged to have a risk for falls (due to medication, weakness, memory etc.), a bed alarm is used and they are part of the "Falling Stars" program.
   - A magnetic star will be placed on the door frame of the patient’s room.
     - (a) The Star has an A, B, or A/B, indicating which patient(s) should be carefully observed. Bed “A” is always closest to the door.
   - In addition, a YELLOW armband indicates a “High Risk for Falls”
   - Yellow slippers will be placed on the patient to identify them as a high risk of fall.
   C. If you see someone that has been identified as a “High Risk for Falls” walking without assistance, please get the nurse or any available help for the patient to prevent a fall.

IX. **Latex Allergy: Screening & Diagnosis**
   1. Latex allergy means sensitivity to contact with certain protein in latex.
   2. Latex allergy is becoming more and more common. Most reactions to latex are mild. But some can be life threatening.
   3. Screen questions provide good tools for identifying patients at risk for latex allergy. This can help prevent future problems.
   4. Review the questions: (If you or a patient answers “yes” to one or more of these questions, the patient may be at risk for latex allergy.)

<table>
<thead>
<tr>
<th><strong>LATEX ALLERGY SCREENING QUESTIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery</strong></td>
</tr>
<tr>
<td>Have you ever had an unexplained problem during surgery?</td>
</tr>
<tr>
<td><strong>Dental Exams</strong></td>
</tr>
<tr>
<td>Have you ever experienced breathing problems during a dental exam?</td>
</tr>
<tr>
<td><strong>Balloons</strong></td>
</tr>
<tr>
<td>Have you ever experienced swelling or wheezing when blowing up balloons?</td>
</tr>
<tr>
<td><strong>Food Allergies</strong></td>
</tr>
<tr>
<td>Are you allergic to any foods, especially bananas, avocados, or kiwis?</td>
</tr>
<tr>
<td><strong>Medical Exam/ Condoms</strong></td>
</tr>
<tr>
<td>Have you ever developed a rash or discomfort after having a medical exam or using a condom?</td>
</tr>
<tr>
<td><strong>Allergy/ Skin Problems</strong></td>
</tr>
<tr>
<td>Do you have a history of allergy or skin problems?</td>
</tr>
</tbody>
</table>

5. A careful and thorough latex screening is performed on all patients.
6. Latex Allergy: Management
7. Healthcare workers are at elevated risk for latex allergy.
8. If you or your patient are allergic to latex:
   - The patient should inform the nurse and you should inform your supervisor or employer.
   - RCH provides many latex-free products are possible.
X. Security & Workplace Violence
1. Workplace violence is any violence committed in a work place setting.
2. To help keep your workplace safe from violence:
   A. Recognize aggressive behavior and warning signs of potential violence.
   B. Respond appropriately to the level of aggressive behavior.
   C. Report all unsafe situations immediately.
3. Warning Signs of Workplace Violence:
   A. All threatening comments or behaviors should be taken seriously – never dismiss them as “harmless” or “just blowing off steam”. We take a proactive stance to prevent violence. Report the following:
   B. Direct or verbal threats of harm
   C. Intimidation of others by words or actions
   D. Refusing to follow policies
   E. Carrying a concealed weapon or flashing a weapon to test reactions
   F. Hypersensitivity or extreme suspiciousness
   G. Often verbalizes hope for something to happen to the other person against whom the employee has a grudge
   H. Expression of extreme desperation over recent problems
   I. Intentional disregard for the safety of others
   J. Destruction of property
4. When Violence Erupts…
   A. Call for help. Page CODE GRAY if necessary or call the PBX Operator to have security stand by. A show of force may curb angry/violent behavior.
   B. Move bystanders to a safe location.
   C. Use physical restraint as a last resort.
   D. Wait for police to deal with weapons.
5. Harassment Free Workplace
   A. Harassment Policy HR 155 applies to all hospital agents, including employees, medical staff, and contract services. The policy prohibits unlawful harassment in any form, including verbal, physical and visual harassment.
   B. RCH is committed to a work environment that is free of discrimination and maintains a strict policy which prohibits all forms of unlawful harassment, including sexual harassment, harassment based on race, color, religion, national origin, or age.
   C. Harassment may occur regardless of whether the behavior was intended to harass: unwelcome sexual advances, verbal or physical conduct of a sexual or otherwise offensive nature, any behaviors that create a hostile or offensive work environment - it can be in the form of jokes, innuendoes, printed materials, emails.

XI. Safety Hotline Ext: 3383
1. Report any safety issues or concerns to your manager or liaison. If the issue is not resolved, use the Safety Hotline (3383) to report any safety issue or concern. Patient’s families and physicians are also encouraged to use the hotline. You may identify yourself or leave the message anonymously. Safety issues may also be reported directly to the California Dept. of Health Services and/or then to The Joint Commission: (800) 994-6610 or to jointcommission.org
XII. Mandatory Reporting
1. Elder/Dependent abuse, Domestic Violence, and Child Abuse
   A. Abuse is defined as the intentional maltreatment of an individual which may cause injury (either physical or psychological) and includes: Mental abuse, physical abuse, sexual abuse, neglect, abandonment, fiduciary (finances), isolation, and domestic violence (assault or abuse by a family member).
   B. If you are a health care professional and have knowledge of/or reasonably suspect abuse/neglect, you must (by law) report abuse to the proper authorities to be investigated:
   C. Child abuse - report to Child Protective Services/Child Abuse Hotline before child leaves the hospital.
   D. Elder/Dependent abuse (any hospitalized patient 18 years or older) – report to County Adult Protective Services, Long-term Care Ombudsman, or Police.
   E. Domestic Violence - report to local law enforcement by telephone and in writing, while the patient is in the hospital. Also report any possible abuse incident to Social Services Department.
   F. If you need information on recognizing signs and symptoms of abuse, there is a learning module entitled “Recognizing and Reporting Abuse Across the Life Span” in the nursing library.

2. Substance Abuse
   A. RCH Policy 178/178A says that all RCH employees are obligated to report any suspicious behavior of another employee’s condition which would impair their ability to perform their duties or which may cause a hazard to the safety and well-being of others. Do you know what those signs are?

XIII. Hazardous Materials
1. Chemical products and medical gases are necessary in health care. When handled incorrectly they can burn, explode, cause tissue damage, or lead to acute or chronic health hazards.
2. To protect workers from exposure to hazardous chemicals, the following groups of people have hazard communication duties:
   A. Manufacturers
   B. Employers
   C. Employees
3. MSDS (Material Safety Data Sheet) Material Safety Data Sheets (M.S.D.S.) provide:
   A. Detailed information on hazardous materials provided by manufacturer
   B. Specific hazardous of a chemical
   C. Hazardous ingredients
   D. Fire, explosive, and reactivity data
   E. Health hazards
   F. Special precautions for handling
   G. Any required Personal Protective Equipment (PPE), such as gloves and eye protection
   H. Proper storage and disposal
4. Your Responsibilities During a Hazardous Spill
   A. Know the hazards of any product you work with.
   B. Read all container labels.
   C. Use any specified Personal Protective Equipment for handling/clean-up (gloves, mask, etc.) or call Environmental Services.
   D. Safely handle, store and dispose of hazardous materials.
E. Immediately notify your Supervisor and Public Safety of any spill or release of a hazardous material.
F. Public Safety will request HazMat assistance, if necessary.
G. Report any hazardous material exposure to your Supervisor and complete an Employee Injury-Exposure Report (on Meditech).
H. Reporting Incidents (RIRs)

XIV. Infection Control
1. Healthcare-Associated Infections (HAI’s)
   A. An infection that develops in the hospital or after treatment is considered a healthcare-associated infection (HAI) if it appears 48 hours after contact with the healthcare system.
   B. HAIs may be caused by bacteria, viruses, fungi, or parasites.
   C. These "germs" may come from:
      - Environmental sources (dust, etc.)
      - Patients
      - Staff members
      - Hospital visitors
   D. Many HAIs are related to invasive procedures, especially:
      - Catheterization
      - IV line placement
   E. The most common type of HAI is urinary tract infection (UTI), associated with indwelling urinary catheters.
      - Therefore:
        (a) High-risk procedures such as catheterization should be performed only when absolutely necessary.
        (b) Catheters should be removed as soon as possible.
        (c) According to SCIP guidelines, a catheter must be removed by Day 2 post-op or the physician must document the continued need in the progress note.
        (d) Instruments and equipment used for invasive procedures should be properly sterilized before use.
   F. Best practices for preventing HAI are related to:
      - Hand hygiene
      - Environmental hygiene/Equipment Cleaning
      - Antibiotic use
      - Standard precautions
      - Bloodborne pathogens
      - Airborne Precautions
      - Contact Precautions
      - Droplet Precautions
      - Personal protective equipment
      - Personal responsibility

2. Hand Hygiene
   A. The single most important factor for preventing the spread of infection is proper hand hygiene.
   B. Hands should be washed or decontaminated before and after each direct patient contact.
   C. Current CDC guidelines recommend the use of:
      - Soap and water for washing visibly soiled hands
● Waterless hand sanitizer is used for Routine Decontamination hands in all clinical situations, even after contact with intact skin or contact with inanimate objects in a patient’s room.

D. When washing with soap and water:
- Remove rings, jewelry, and watches
- Pre-wet hands with water
- Use an appropriate amount of soap
- Rub all surfaces of the hands and wrists for 15 seconds
- Rinse thoroughly under running water
- Dry hands with a disposable towel

E. When decontaminating hands with waterless hand sanitizer:
- Remove jewelry
- Apply the amount of rub recommended by the manufacturer
- Rub all surfaces of the hands and wrists until hands are dry

3. Environmental Hygiene
   A. Best Practices for Environmental Hygiene
      - Maintain a visibly clean environment (no visible dust or soiling)
      - Clean, disinfect, or sterilize medical equipment after each use
      - Dispose safely of clinical waste
      - Launder used and infected linens safely and effectively
      - Follow appropriate guidelines for kitchen and food hygiene
      - Maintain an adequate pest-control program

   B. Equipment Cleaning
      - All clean patient equipment will come up from the Sterile Processing Department (SPD) with a “I’m Clean” tag. Take the tag off prior to patient use.
      - SPD Equipment - includes (but is not limited to) IV pumps, wound vats, CPM machines, SCDs, PCA pumps, Gomco pumps etc.
      - NON-SPD Equipment – includes but not limited to – gurneys, wheelchairs, blood pressure cuffs/machines, thermometers, blood glucose machines, etc.
      - When a piece of equipment is discontinued:
        (a) Nursing is responsible for removing all disposable equipment such as suction tubing, suction canister, IV tubing, etc.
        (b) Nursing is also responsible for placing All reusable patient equipment originating from SPD in the dirty utility room of that unit to be picked up by SPD for cleaning
        (c) Patient equipment coming from an isolation room will be cleaned by nursing staff using germicidal product prior to placing the equipment in the dirty utility room to be picked up by SPD.
        (d) SPD equipment that is excessively and visibly soiled will be placed into a clear bag, placed into the dirty utility room, and SPD will pick up for cleaning. It will not be cleaned by nursing.
        (e) Non SPD equipment - If equipment is taken from room to room (BP machine, glucose meter, E-MAR cart, thermometer, stethoscope), clean with equipment germicidal wipe prior to using it on another patient.
      - If you do NOT see the “Clean” Tag attached to the equipment, it means that the equipment is DIRTY, and has not been cleaned by SPD.
      - If you need to use this equipment, you MUST first clean it, following the correct procedure:
(a) Don gloves
(b) Obtain disinfectant (spray/pour bottle) and washcloth from the designated area of the dirty utility room.
(c) Spray/pour 3ml disinfectant on washcloth, making sure the cloth gets fully saturated.
(d) Using the wet cloth, wipe equipment, making sure all surfaces are wet including the cords.
(e) Allow to remain wet for 1 minute, let air-dry.
(f) Remove and discard gloves.
(g) Perform hand hygiene.
(h) After 1 minute equipment is ready for patient use.
(i) If using bleach wipes, the contact time is 5 minutes.

4. **Antibiotic Use:**
   A. **Antibiotic Resistance**
      - Antibiotics have been used to treat Bacterial illness; however, bacteria are very adaptable and have the ability to change genetically to resist the effects of antibiotics.
      - The more antibiotics are used, the more common resistant strains of bacteria become.
      - Clinically important examples are:
        (a) Methicillin-resistant *Staphylococcus aureus* (MRSA)
        (b) Vancomycin-resistant *Enterococci* (VRE)
        (c) Multidrug-resistant *Mycobacterium tuberculosis* (MDR-TB)
   B. **Impact of Resistance**
      - Antibiotic resistance is a significant health problem and it adversely affects:
        (a) Drug choice
           - Less effective against the bacteria
           - More toxic to the patient
           - More expensive
        (b) Patient health
           - Longer illness
           - Higher medical bills
           - Greater risk of death
        (c) The healthcare system
           - Antibiotic-resistant strains contribute significantly to HAI.
           - More the 70% of all bacteria that cause HAI are found to be resistant to one of more commonly used antibiotics
   C. **Prevention of Resistance**
      - Healthcare professionals must take an active role in preventing the spread of antibiotic resistance
      - Strategies include:
        (a) Preventing illness through vaccination
        (b) Diagnosing & treating infections effectively
        (c) Using antibiotics prudently
        (d) Preventing spread of infection

5. **Bloodborne Pathogens**
   A. Bloodborne diseases are spread from person to person as a result of unprotected exposure to:
      - Infected blood
• Other bodily fluids
• Non-intact skin
• Most body tissue

B. Important bloodborne diseases include:
• HIV infection/AIDS
• Hepatitis B
• Hepatitis C

C. Bloodborne Pathogen Standard
• The Bloodborne Pathogens Standard (BPS) helps protect workers from exposure to HIV and other bloodborne pathogens... The BPS include:
  (a) Cover any worker who might come in contact with blood or other potentially infectious materials (OPIM) as part of his or her job
  (b) Requires employers to take certain steps to help protect these workers
• One of the key parts of BPS is to require the use of **Standard Precautions:**
  (a) Standard Precautions should be used in the care of All patients, regardless of their diagnosis.
• These precautions apply to patient:
  (a) Blood
  (b) Body fluids
  (c) Secretions & excretions (except sweat)
  (d) Non-intact skin
  (e) Mucous membranes

D. Standard Precautions
• Hand washing
• Gloves
• Mask, Eye Protection, Face Shield, Gown
• Patient-Care Equipment and Linens
• Environmental Control
• Bloodborne Pathogens
• Patient Placement

E. Needlestick Prevention
• RCH has a no recapping policy (needles/sharps). If recapping is unavoidable, use the one-handed method to replace the cap.
• Replace or report any needle container that is filled 2/3rds or more, so it can be changed.
• Contaminated needles and other contaminated sharps should not be bent or recapped.
• Shearing or breaking of contaminated needles is prohibited.
• Contaminated sharps should be placed in appropriate containers. These containers must be puncture-resistant, appropriately labeled or color-coded, and leak-proof on the sides and bottom.
• Should you be exposed to blood or other potentially infected materials by needle stick, by sharps injury, or by splashes to mucous membranes (eyes, nose, mouth), report the incident immediately to your supervisor! Best treatment results occur when follow-up care is started within one hour of exposure.

6. **Airborne Precautions:**
A. Background
• Airborne diseases are transmitted from person to person via infectious droplet nuclei.
These tiny particles:
   (a) Are produced when an infected person sneezes, coughs, or talks
   (b) Can remain suspended in the air for long periods of time
   (c) Can travel long distances on air currents
   Transmission occurs when a health person inhales an infectious particle.
   Infection & disease symptoms then may occur.
B. Common organisms isolated in Airborne Precautions
   • Important airborne disease include:
     (a) Chickenpox & Shingles
     (b) Measles
     (c) Tuberculosis (TB)
   • Other disease that may be spread by airborne route include:
     (a) SARS
     (b) Smallpox

C. Summary Table
   • To prevent the transmission of airborne disease in the healthcare setting, Airborne Precautions are used for patients known or suspected to have illnesses transmitted by Airborne Droplet nuclei (small-particle residue, 5 microns or smaller in size).
   • Patient Placement
     (a) Patients are isolated in private rooms with special air ventilation systems. Airborne-diseases require isolation in a room capable of having negative pressure ventilation.
     (b) Place an "airborne precautions" sign on the door.
     (c) When a private room is not available, place the patient in a room with a patient who has active infection or is colonized with the same organism within a similar timeframe (cohorting).
     (d) Consult Infection Prevention & Control for any questions regarding cohorting
   • Respiratory Protection
     (a) Healthcare staff must wear an N95 mask or PAPR whenever entering the patient room with a known or suspected airborne disease.
     (b) Susceptible persons should not enter the room of patients known or suspected to have measles (rubeola) or Varicella (chicken pox).
     (c) Persons immune to measles or Varicella do not need to wear respiratory protection.
   • Patient Transport – Limit patient transport as much as possible, when transporting the patient have them wear a surgical mask.

D. References:
   • TB Exposure Control Plan (IC 401) and Emerging Respiratory Disease Plan (IC 402) for information TB, SARS, and Pandemic Influenza.

7. Contact Precautions:
   A. Background
      • Contact transmission of disease occurs via direct or indirect person-to-person contact (hand-to-skin or skin-to-skin).
      • This form of transmission is the most important & common cause of HAI.
   B. Diseases
      • Examples of contact disease are:
        (a) clostridium difficile (C-Diff)
        (b) Hepatitis A
        (c) E. coli 0157:H7
        (d) Rotavirus
(e) Respiratory syncytial virus infection (RSV)
(f) Impetigo
(g) Conjunctivitis
(h) Viral hemorrhagic infections
(i) Scabies and Lice
(j) Chicken pox and disseminated (full body) shingles
(k) Many others

C. Summary Table
- MRSA guidelines: we no longer isolate patients with history of MRSA, VRE, Acinetobacter or shingles unless they have large wounds that are uncontained by dressings. The Infection Control Policy is on every unit – see Infection Control Manual.
- All patients will be cleaned with CHG (chlorhexidine gluconate) on admission. No rinsing is required. It is required daily in place of the traditional bath. However, if a patient desires a bath or shower, the CHG will be applied after the bath or shower. CHG bathing cloths replace soap for routine daily bathing for all areas below the jawline. Use shampoo caps and hospital supplied cleansing/soap products above the jawline as per IC 201 Patient Bathing. Please do not flush bathing cloths down the toilet.

Patient Placement
(a) Patients are isolated in private rooms or cohorted for C Diff (with active diarrhea)
   Open and draining wounds uncontained by dressings, Salmonella/Shigella, RSV, c-Diff, Scabies/Lice, Hepatitis A.
(b) Consult Infection Prevention & Control for any questions regarding cohorting
(c) Place a "contact precautions" sign on the door. Partially close the door so the sign is visible
(d) Gloves, Gowns, & Hand Antisepsis – Healthcare staff must don a gown and gloves when entering a room on Contact Precautions.

D. Patient Transport – Transport should be limited as possible.

E. Patient Care & Equipment
- Hand Hygiene:
  (a) During patient care, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material or wound drainage).
  (b) Remove gloves inside the room, and immediately decontaminate hands.
- Personal Protective Equipment:
  (a) Wear a gown every time you enter the patient's room. You must wear a gown and gloves whether they are colonized or infected. If the patient is coughing AND you will be in close contact with them, a regular mask will also be appropriate.

- Non-critical equipment should be dedicated to a single patient.
- Equipment should be cleaned and disinfected between patients.

8. Droplet Precautions:
A. Background
- Droplet transmission happens via large respiratory droplets.
- These droplets:
  (a) Are generated during coughing, sneezing, talking, etc.
  (b) Travel a short distance through the air (up to three feet).
  (c) Droplets may land on the mucous membranes of a nearby person’s eyes, nose, and mouth.
(d) Droplets may also contaminate surfaces.
(e) Disease transmission then may occur.

B. Diseases:
- Examples of droplet disease are:
  (a) Bacterial meningitis or meningitis cause unknown,
  (b) Pertussis (whooping cough)
  (c) Pneumonic plague
  (d) Mumps
  (e) Rubella (German Measles)
  (f) Influenza
  (g) Many others

C. Summary Table
- Patient Placement:
  (a) Place patient in a private room
  (b) Place a "droplet precautions" sign on the door.
     (i) Partially close the door so the sign is visible.
  (c) When a private room is not available, place the patient in a room with a patient who
     has an active infection with the same organism but with no other infection
     (cohorting).
  (d) Check with Infection Prevention & Control for cohorting issues
  (e) Wear gloves, gowns, and surgical mask for every entry into the room

- Patient Transport:
  (a) Limit the movement and transport of the patient from the room to essential purposes
      only.
  (b) If transport or movement is necessary, minimize dispersal of droplets by putting a
      regular surgical mask on the patient.

9. **Personal Protective Equipment (PPE):**
   A. Personal protective equipment (PPE) is an important component of infection control. PPE
      helps to prevent the spread of microorganisms both:
      - From patient to healthcare worker
      - From healthcare worker to patient
   B. PPE includes gloves, gowns, mask, eye shields, lead aprons, thyroid shields, etc.
      - Face shields, masks, gloves, and gowns to use any time you suspect there may be a
        potential exposure to body fluids.
        (a) Remember anything that splashes to the eye level will also expose the nose and
            mouth.
        (b) Carry goggles and a mask in your pocket, so you will have them when needed.
      - Lead aprons and thyroid shields any time you suspect there may be a potential exposure
        to radiation.
   C. Every crash cart has a resuscitation bag and cardiac board on the outside of the cart. We
      also have Latex-Free carts for patients allergic to latex.
   D. **DOUBLE BAGGING** of linens is not required unless the leakage is likely.
   E. **TUBERCULOSIS:** If you suspect any patient has symptoms of TB (weight loss,
      unexplained loss of appetite, cough, fatigue, night sweats, fever), notify the charge nurse
      immediately. The Aerosol Transmissible Disease Plan can be found online in the Infection
      Control Manual
   F. **SPECIAL MASKS,** called the N-95 mask, is used for patients with known or suspected TB
      or other organisms that are airborne. If you have been identified as a healthcare provider
who may care for these patients, you must be fit-tested (annually) in order to wear the N-95 mask. This is to ensure it works properly and protects you!

10. RCH Specific Infection Control Policies
   A. Food or drinks may not be taken to the nursing station or to any patient care area.
   B. All refrigerators should have daily log entries to indicate that correct temperatures are maintained for safe food storage. Note: If temperatures do not fall in acceptable ranges, write on the log what was done to correct it!
   C. All stored patient food items should be dated.
   D. Gloves should not be worn in the hallway. When leaving a room, remove gloves and wash your hands.
      - Gloves worn outside a patient room are considered to be contaminated.
   E. Shoe covers should not be worn outside of the operating room (or other work areas) into the general hospital environment. This is hospital policy and an OSHA violation.
      - Shoe covers are used to keep the environment clean. Wearing shoe covers out of the department and back in again potentially "contaminates" the environment! If shoe covers are "soiled" they can transmit infectious material to other departments.
   F. It is everyone's responsibility to maintain a clean, safe environment.
      - Remember to pick up your own trash, clean up your spills, keep your environment clean and uncluttered, and have pride in your hospital.

11. Personal Responsibility
   A. As a healthcare worker, you have personal responsibility for infection control in your facility.
   B. Maintain immunity to vaccine-preventable diseases such as:
      - Hepatitis B
      - Measles
      - Varicella (chickenpox)
      - Rubella
      - Mumps
   C. Report all unprotected exposures, such as accidental needle sticks.
   D. Stay home from work when you are sick.
   E. During influenza season (Oct 1st to March 31st) if you decline influenza vaccination or do not have proof of receiving vaccination you will be required to wear a mask in patient care areas.

XV. Medical Waste
   1. Proper disposal of medical waste is important for many reasons.
      A. First and foremost, it allows for the safe handling of potentially dangerous items. A needle in a trash can result in a person getting a needle stick and developing a deadly disease.
      B. Secondly, disposal of these products is expensive and is often measured by the pound. If all trash is thrown into Biohazardous Waste (red bags) the additional cost of healthcare could rise tens of thousands of dollars. We want to be good stewards of our healthcare resources.
      C. Third, EPA, OSHA, and other government organizations levy fines against hospitals for inappropriate disposal of hazardous waste or personal information.
      D. Finally, it protects our community.
2. **Regular Trash (clear bags)**  
   A. Empty bedpans, urinals, IV bags (block out labels over patient information), dressings, chux diapers, peripads with bodily fluids that are dried or “non-dripping”. Also personal care items such as basins, cups, or toothbrushes.

3. **Biohazardous Waste (red bags)**  
   A. Blood tubing, blood bags, hemovacs, pleurevacs, soaked/dripping dressings, intact glass or plastic bottles with body fluids inside, Foley bags that cannot be completely emptied. All items from biohazardous waste are treated, before going to landfill.

4. **Sharps Waste (designated Sharps container)**  
   A. All sharps, such as needles, scalpels, razor blades, clips, staples, staple removers, scissors, syringes (with less than 2cc of fluid), tubexes, carpujects, trocars, guide wires, biopsy devices and broken glass.

5. **Pharmaceutical waste (white container with blue lid)**  
   A. No needles. Medications must be rendered as unrecognizable or unusable. IV bags/tubing that cannot be emptied, glass vials and broken ampules with meds still inside, partially used (even over the counter meds) in capsule, powders, lotions, creams, and suppositories. Narcotic patches must be folded on self. Controlled substance caps must be crushed prior to disposal. Injectable amounts greater than 2ml. IV fluids of Propofol (Diprivan) and TPN with lipids.
   B. Pharmaceutical waste is incinerated.

6. **Chemotherapy Waste (yellow container – marked special disposal)**  
   A. Everything used to make and administer chemo medication e.g.: tubing, bags, bottles, vials, syringes, gloves, masks, gowns wipes, clean up kits.

7. **Hazardous Pharmacy Waste (black container)**  
   A. Medications that are identified as hazardous to the environment are flagged with a black label and/or are identified in Pyxis/Meditech when dispensing/administering medications. Proper disposal includes pill wrappers, inhalers, contrast bottles, etc.

8. **Confidential Paper Trash (locked bins)**  
   A. Any papers, labels, scratch paper, or documents that contain a patient’s name or any patient information. This even includes a medical record number and any business paperwork confidential to RCH. We pay to have these papers shredded, so don’t throw everything in there, just what should be kept private – that should not go to regular landfill.

9. **Linen hampers (clear bags)**  
   A. All linen regardless of moisture content or type of fluid. Remove all chux and tape prior to placing in linen hamper. Linen does not have to be double-bagged unless it is likely to spill. All linen is treated at the highest level, whether it comes from an isolation or regular room.
# Riverside Community Hospital Waste Stream Summary

<table>
<thead>
<tr>
<th>Confidential Paper Trash (Locked Bins) (Blue Bag—it is shredded)</th>
<th>Regular Waste (Clear Bag) (Down the drain)</th>
<th>Sewer System</th>
<th>Biohazardous Waste (Red Bag)</th>
<th>Sharps Waste (Red Container)</th>
<th>Non-Hazardous Pharmacy Waste (White container w/ Purple lid)</th>
<th>Chemotherapy Waste (Yellow Container)</th>
<th>RCRA Hazardous Pharmacy Waste (Black Container)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any papers, labels, scratch paper, forms, or other documents that have any patient information on them.</td>
<td>• Paper, Trash, Wrappers</td>
<td>• IV’s - Dextrose</td>
<td>• Blood Tubing, Bags</td>
<td>• Return Unopened Unused / Expired Meds to Pharmacy</td>
<td>• Bulk, partial chemo vials, IV soln mixed with chemo</td>
<td>• P-listed drug packaging &amp; containers</td>
<td>• U-listed</td>
</tr>
<tr>
<td>• Any business paperwork confidential to RCH.</td>
<td>• Non bloody Dressings</td>
<td>• Solnc</td>
<td>• Hemovacs, Pleurevacs</td>
<td>• All sharps (except for RCRA)</td>
<td>• All supplies used to make &amp; administer chemo medication</td>
<td>• D-listed t toxic</td>
<td>• Ignitble</td>
</tr>
<tr>
<td>• Confidential patient information is anything that can identify a patient. Examples include, but are not limited to, patient name, address, phone number, date of birth, social security number, and/or medical record number.</td>
<td>• Chux / Diapers / peri-pads</td>
<td>• Sterile Water</td>
<td>• Soaked/Dripping Bloody Dressings</td>
<td>• Needles</td>
<td>• Empty vials &amp; ampules</td>
<td>• Ignitble</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gloves</td>
<td>• Lactated Ring’s - K salts</td>
<td>• Intact Glass or Plastic Bottles with Blood or Other Fluids inside</td>
<td>• Forceps</td>
<td>• Empty syringes &amp; Needles</td>
<td>• Ignitble Aerosols</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disposable respiratory circuits &amp; equipment</td>
<td>• Ca salts</td>
<td>• Suction canisters or suction tubing with Blood or Other Body Fluids inside</td>
<td>• Staple removers</td>
<td>• Empty IV’s</td>
<td>• Presurized Aerosols</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bath basins, cups, toothbrushes, etc (personal care items)</td>
<td>• Empty Irrigation Bottles</td>
<td>• All Disposable Items Soaked or Dripping with Blood or Other Body Fluids</td>
<td>• All supplies used to make &amp; administer chemo medication</td>
<td>• Gowns</td>
<td>• Federal Resource Conservation and Recovery Act</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Empty Irrigation Bottles</td>
<td>Most empty bottles and vials</td>
<td>• Urinary Catheters, Foley or other drainage bags that cannot be completely emptied</td>
<td>• Bio-Hazardous Drugs</td>
<td>• Gloves</td>
<td>*Questions? Please call:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Most empty Ns</td>
<td>• Perivacs that are saturated &amp; dripping</td>
<td></td>
<td>• Trocars, introducers, guide wires, disposable sharps from procedures, specimen or biopsy devices in endoscopy, etc. (Use large volume sharps container if needed)</td>
<td>• Tubing</td>
<td>Infection Control: 3482</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Drugs</td>
<td></td>
<td>• Perivacs that are saturated &amp; dripping</td>
<td></td>
<td>• Wipes</td>
<td>EVS: 3134</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No P-waste containers (RCRA)</td>
<td></td>
<td></td>
<td></td>
<td>• Packaging</td>
<td>Pharmacy: 3484</td>
<td></td>
</tr>
</tbody>
</table>

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Revised 04/2012  IC 101.1/IND 101

RIVERSIDE COMMUNITY HOSPITAL
XVI. Cultural Diversity

1. Rapidly changing ethnic demographics in the U.S. and healthcare systems that are difficult to navigate are forcing hospitals to make sure that their staff members become culturally competent.

2. What does it mean for me?
   A. When delivering care to a patient or their family, the healthcare professional must attend to and respect the cultural needs and beliefs of each individual. This applies to all hospital employees.

3. The first step to cultural competence is to examine your own values and beliefs.
   A. Answer these questions about you and your family:
      - How do you define health?
      - What do you do to maintain & protect your health?
      - What do you do when you experience a noticeable change in your health?
      - Do you diagnose your own health problems?
      - From whom do you seek healthcare?
      - What do you do to restore your health?
      - Do you use over-the-counter medications or herbs?
      - Do you use meditation, prayer, spirituality, religion, or magic in your care?

4. Culture often determines people’s health practices, as well as the way they respond to illness, injury, and pain.

5. A person’s culture affects his or her beliefs about communication, health, and nutrition.

6. In order to provide high-quality care to all of our patients, we must have an understanding of their cultural backgrounds, religious beliefs, and be able to communicate with them.
   A. Determine your patient’s or patient’s families beliefs
      - What is the family’s ethnic background?
      - What is their country of origin?
      - What is their religious belief?
      - What do they do to maintain health?
      - What did their mothers do?
      - What do they do to protect health?
      - What home remedies do they use and what ones did their mother use.

7. In addition to having an understanding of cultural differences, we must provide competent interpretation for our non-English-speaking patients.
   A. RCH utilizes Language Service Associates to obtain professional interpreters for hundreds of languages. Special Phones are available for all nursing departments.
   B. The Language Service Associates phone should be used for informed consents, legal, and in-depth assessments, treatment options, and discharge instructions.
   C. Language Service Associates also has a Sign Language Service (for the hearing impaired) a designated laptop computer is used for interpreting. (available in the PBX or ER).

8. Assessing Health Literacy – patients should always be assessed for their ability to learn and understand health material such as consents, medication use, and any patient teaching.
Infant and Child Safety

9. Abductor Personality
   A. The “typical” abductor is usually female between 12 and 50 years of age. She is frequently overweight, may be nervous, compulsive, appear to be in a hurry and carrying a bundle, a satchel, or large purse.
   B. A woman may abduct an infant to replace the one lost by miscarriage or she may be incapable of childbearing. She may be married and have other children at home.
   C. Seventy percent of the time, the abductor will preplan the abduction; however, the abductor usually does not target a specific baby. In many cases she will visit the nursery prior to the abduction and familiarize herself with the routines and layout of the unit.
   D. Abductors focus on facilities with little or no security.
   E. The abductor may pose as a hospital employee, such as a physician, nurse, volunteer, lab worker, or photographer.
   F. On pediatric units, the abductor usually poses as an aunt or relative of the child.
   G. Most kidnappers wear some type of hospital attire, e.g., scrubs or a lab jacket and maybe a stethoscope. If the abductor was a former employee, a hospital ID badge may even be worn.
   H. After the abductor has identified easy access to an exit, she waits for an opportunity. She will then go into the mother’s room, call the mother by her first name, even call the baby by name as if she knows them and tells the mother she needs to take the baby to the nursery. The reason she gives for taking the baby are varied according to whom the abductor is impersonating. She will use excuses, such as, it’s time:
      - To weigh the baby
      - To draw a lab test
      - For a physical exam
      - To photograph the baby
   I. Abductions also occur when the mother leaves her child unattended in the room to go to the bathroom or take a shower. The abductor is usually off the unit within 4 seconds and on the way out of the hospital with the infant in a matter of a few more seconds.

10. Parent Education
    A. As soon as possible (do not wait until discharge), parents should be taught what to do to safeguard their baby:
        - Check the employee’s ID badge and make sure the photo matches the employee’s face. Nurses in the maternal/child area wear ID badges with a pink frame around the picture. This is a second form of ID.
        - Never leave the baby unsupervised, even to go to the bathroom.
        - Become familiar with the unit routines and the nurse assigned to take care of you and your baby. If in doubt, ask.
        - Relinquish your baby only to a nurse with a photo ID badge with a pink frame.
        - If you become uncertain of a person’s motives, or someone unfamiliar comes into your room and requests your baby, notify your primary nurse. Anyone can put a lab coat on and look like a professional.
        - Infants will only be transported off the unit by bassinets. Anyone carrying a baby will be questioned.
        - RCH utilizes a four-band system: 2 bands for the baby and 1 band each for the mother and a significant other. Only the 2 people wearing these bands will be allowed to take the baby from the nursery.
- As another means of infant identification, an additional set of footprints besides the souvenir set will be taken at the time of birth. It is very important that these are done correctly. Do not press too hard. The ridge marks on the ball of the foot have to be clearly defined.
- When “ROOMING-IN”, request your infant be taken to the nursery whenever you cannot attend to the infant, e.g. when showering, going to the bathroom.

11. Staff Education
   A. Prevention is the best defense against infant abductions.
   B. Anyone who sees a baby being carried in the hall by an unknown person must enforce the policy that infants must be in a crib or bassinette.
   C. Be alert to people who may be wearing partial hospital dress such as a scrub top over street clothes.
   D. Verify identification of anyone requesting to “borrow” scrubs.
   E. Strangers should not be given information about unit routines.
   F. Exits should be in view from the nurse’s station, if possible.
   G. Any exit not in view of a nursing unit should be locked or connected to a security device such as a surveillance camera or alarm.
   H. Look for the unusual, e.g., anyone hanging around the nursery or postpartum unit that has no reason to be there. Visitors should be walking with the patient or a “banded” person, be in the patient’s room, or be in the waiting room. Visitors gathered in the hall need to be directed to the waiting room. People grouped together can be used as a screen to hide an abductor’s movements.
   I. Educate parents about infant safety on admission. More than half of the infants abducted from hospitals since 1983 were taken directly from their mother’s room. Increasing parental awareness is a key factor in the success of an infant safety program.
   J. Parents need to be educated on infant safety not only while in the hospital, but also after they go home. Newspaper articles announcing births and signs posted outside homes alert abductors to a new baby.
   K. All staff working in a maternal/child area (physicians, nurses, volunteers, housekeeping, and lab) should be educated on infant safety and on what to do to prevent abduction.
   L. Become familiar with infant safety policies and procedures.
   M. Supervise babies at all times, especially during visiting hours. Be aware that a disturbance down the hall (or in another part of the hospital) may be a diversion to draw attention away from a baby.
   N. Whenever a maternal-child emergency exit alarms, staff will perform an infant count and report to mother-baby charge RN/Director of Maternal-Child.
   O. Don’t post full names of mothers and babies where visitors can see them. Post the first 2 letters of last name of the infant on the board in nursery.
   P. Examine all large packages leaving the maternity floor.
   Q. Mothers and newborns leave the hospital in wheelchairs accompanied by hospital staff. Immediately report to Public Safety, anyone leaving on foot with an infant/child in hospital pajamas or blankets.
   R. Staff should be in-serviced routinely on RCH’s Policy “Response to Infant/Child Abduction (Code Pink/Code Purple)”. It is important that everyone know his/her role; what to do and who to notify should an abduction or suspected abduction take place.

12. When a Code Pink or Code Purple is called
   A. All staff and volunteers should immediately go into action. Monitor any exits or stairwells in your area and tactfully challenge any person(s) that may be carrying a baby, bundle, bag,
or any item large enough to conceal an infant. Most people, who are told that an infant or child is missing, will gladly open their bag or bundles for you to look inside.

B. Should the person refuse or if you are suspicious, but feel you should not confront the person, ask a co-worker to notify Public Safety and cautiously follow at a safe distance.
   - Take note of:
     Race, sex, age, height, weight, hair color and style, complexion, identifying marks or features, color and type of clothing.
   - Should you see the vehicle, take note of:
     Make, model, color, year, license number, and any special identifying features.

C. Hospital departments are to monitor exits and stairwells, whenever a Code Pink or Code Purple is called. As additional staff becomes available, they should check restrooms, storage rooms, or any other areas an abductor might hide.

13. MyChild System
   A. RCH now has the MyChild Infant Protection System in place to help provide a safe and secure environment for newborn and pediatric patients. The system alerts Nursing Staff and Public Safety when an infant has been transported beyond the designated boundaries of the Nursery, Labor and Delivery, or Pediatrics.

   B. Shortly after birth, an electronic monitoring device is placed on the newborn’s left upper arm. This device will trigger the alarm, when it goes through any of the entrance/exits or elevator containing sensors.

   C. In Pediatrics, the sensor is place on the patient’s arm on admission, and will activate when the child is taken beyond the boundaries of Pediatrics.

   D. An automatic code pink or code purple and location will be announced overhead if the alarm goes off. The newborn tags will also alarm if removed from skin. This infant/child security tag will remain on the infant and children under 13 years of age until discharged from the hospital.
Volunteer Services at Riverside Community Hospital

<table>
<thead>
<tr>
<th>Volunteer</th>
<th>Clinical Care Extender (CCE/COPE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Juniors: Female white pants with Royal Blue Apron</td>
<td>Navy Blue Polo Shirt &amp; Khaki Pants</td>
</tr>
<tr>
<td>o Male black pants white polo shirts</td>
<td></td>
</tr>
<tr>
<td>• Adults: Ladies white pants ceil blue vest or smock</td>
<td></td>
</tr>
<tr>
<td>o Men white pants Royal Blue shirt or polo</td>
<td></td>
</tr>
</tbody>
</table>

**Contact Person:** Lillian Reyes-Maples Ext. 3109

Under the direction of the charge nursing staff or unit secretary, the volunteer will assist the nursing staff with non-nursing duties and provide no hands on comfort care to the patients.

**Volunteer Duties**

1. Discharging patient with exception of obese patients, patients with a cast from the waist down, patients with oxygen.
2. Answering the phones & call lights as needed.
3. Relay patient messages & needs to nursing staff.
4. Assist staff with filing, coping, and clerical tasks.
5. Run errands for staff within the facility.
6. Assist nursing staff to transport patient's belongings.
7. Providing nursing staff with supplies as requested, replacing or restocking as needed.
8. Feeding a patient under the supervision of nursing staff.
9. Visiting with patient (Not as a Sitter).
10. Greeting, directing, and escorting visitors.
11. Assist patient with ordering their meals.
12. Instructing patient on using TV remote control.
13. Providing reading material.
14. Entertain the patient with music, a song, or magic trick.
15. Provide fresh water, beverage, and blankets under the supervision of nursing staff.
16. Other tasks following the facility Policy & Procedures.

**Clinical Care Extender Duties**

1. Assist in the transport of patients as requested by the nurse via gurney, hospital bed, or wheelchair with or without oxygen; except when the patient is cardiac monitored which requires an RN or a pregnant woman which requires a staff member. NEVER transport a patient without the nurse's permission or if you do not feel safe transporting the patient for any reason.
2. Assist in repositioning of patients in bed and in transfers of patients to and from gurneys, wheelchairs, cardiac chairs, and patient beds as instructed by the nurse.
3. Assist the patient to the restroom or with a bedpan or urinal, with the permission of the patient's nurse.
4. Assist the unit secretary with paperwork, answering phones/call lights as needed.
5. Know the location of supplies and replace or restock as necessary.
6. Relay patient request/concerns to nursing staff (for medication, bedpans, questions, etc.).
7. Assist nursing staff to provide patient care including bathing, shaving, brushing teeth, feeding, changing patients and bedpans.
8. Refill water for patients with the nurse's permission.
9. Distribute food trays to patients after receiving permission from the patient's nurse and collect them after the patient is done.
10. Inform patient’s relatives of the patient’s progress of condition ONLY with the permission of the nurse or doctor.
11. Assist hospital staff and physicians as requested.
12. Make rounds on the floors and talk with the patients that would like to talk, addressing their needs.
13. Take discharged patient's charts to medical records.
Clinical Patient Care/Patient Safety Policy Review

I. Patient Identification

1. Use 2 patient identifiers before all tests, procedures, meds, blood administration;
   Patient name and birthdate
   -or-
   Patient name and medical record number

2. Never scan the barcode from patient label when doing blood glucose or giving medications, always scan the patient’s armband (patient safety). If there is a problem scanning, get a new armband from the Meditech label sheet in the patient’s chart.

3. Arm Bands:
   A. Red = Allergy
   B. White = inpatient and outpatient identification
   C. Yellow = High Risk of Falls
   D. Green = Latex Allergy
   E. Blue = temporary when computer is down
   F. Pink = Limb Alert (do not use limb with pink band for injections, BP, etc.
   G. Red Barcoded Blood Band (Securline)

II. Physician Orders and Documentation

1. Documentation is done through the Meditech Electronic medical record for all clinical staff
   A. Areas not converted to Meditech
      A. ER
      B. L&D

2. All physician’s orders are only recorded on approved hospital order sheets

3. No verbal orders accepted unless in a code or when MD is involved in sterile procedure.
   Students are not able to take verbal orders. Students are not able to verify orders or perform 12 and 24 hour chart checks.

4. The nurse should Read back all phone orders (after written on medical record).

5. Faxed order must be re-written on the physician order sheet with the original Fax attached as a permanent copy.

6. LVNs, lab technologists, physical therapists, radiology technologists, and respiratory therapists may take orders from physicians for medications limited to use in their specialty.

7. Range Order Medication orders may have a range in dose (75-100mg) or schedule (2-3 hrs), but not both. Only one variable allowed. An order may be written for 1-2 tabs or 4-6 hours, but not both in the same order.

8. Only Use Approved Abbreviations
   A. Anyone who documents or reviews medical records can easily access the RCH approved abbreviation list - It is in the MOX Library. Highlight ABBREVIATIONS LIST and right arrow in, they are listed alphabetically. Pay close attention to upper and lower case (e.g. PT is Prothrombin Time while pt is the abbreviation for patient. You can even print the lists, just press shift/right control to checkmark all the text files, then P for print.
# Current Do Not Use Abbreviations List

<table>
<thead>
<tr>
<th>Abbreviation/Dose Expression</th>
<th>Intended Meaning</th>
<th>Misinterpretation</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apothecary symbols</td>
<td>Dram Minim</td>
<td>Misunderstood or misread (symbol for dram misread for “3” and minim misread as “ml”).</td>
<td>Use the metric system.</td>
</tr>
<tr>
<td>MS04, MS</td>
<td>Morphine sulfate</td>
<td>Magnesium sulfate</td>
<td>Don’t use this abbreviation.</td>
</tr>
<tr>
<td>U or u</td>
<td>Unit</td>
<td>Read as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as “40” or 4u seen as 44”).</td>
<td>“Unit” has no acceptable abbreviation. Use “unit.”</td>
</tr>
<tr>
<td>IU or iu</td>
<td>International units</td>
<td>Misread as IV (intravenous) or “I” as “1”</td>
<td>Write “International units.”</td>
</tr>
<tr>
<td>Lack of a leading zero before a decimal point (i.e., .1mg)</td>
<td>0.1 mg</td>
<td>Misread as 1 or 11</td>
<td>ALWAYS use a zero before a decimal point.</td>
</tr>
<tr>
<td>Use of a trailing zero after a decimal point (i.e., 1.0mg)</td>
<td>1 mg</td>
<td>Misread as 10.</td>
<td>DO NOT use a trailing zero after a decimal point.</td>
</tr>
<tr>
<td>MgSO4</td>
<td>Magnesium Sulfate</td>
<td>Morphine Sulfate</td>
<td>Don’t use this abbreviation.</td>
</tr>
<tr>
<td>QD, QOD</td>
<td>Every day</td>
<td>Mistaken for each other.</td>
<td>Write daily or every other day.</td>
</tr>
<tr>
<td>µg</td>
<td>For microgram</td>
<td>Misread for mg (milligrams resulting in one thousand-fold dosing overdose.</td>
<td>Write “mcg”</td>
</tr>
<tr>
<td>H.S.</td>
<td>For half-strength or Latin abbreviation for bedtime)</td>
<td>Mistaken for either half-strength or hour of sleep. Q.H.S. mistaken for every hour. All can result in a dosing error.</td>
<td>Write out “half-strength” or “at bedtime.”</td>
</tr>
<tr>
<td>T.I.W.</td>
<td>For three times a week.</td>
<td>Mistaken for three times a day or twice weekly resulting in an overdose.</td>
<td>Write “3 times weekly” or three times weekly”</td>
</tr>
<tr>
<td>S.C. or S.Q.</td>
<td>For subcutaneous</td>
<td>Mistaken as SL for sublingual, or “5 every.”</td>
<td>Write “Sub-Q”, “subQ”, or “subcutaneously”</td>
</tr>
<tr>
<td>D/C</td>
<td>For discharge</td>
<td>Interpreted as discontinue whatever medications follow (typically discharge meds).</td>
<td>Write “discharge”</td>
</tr>
<tr>
<td>c.c.</td>
<td>For cubic centimeter</td>
<td>Mistaken for U (units) when poorly written.</td>
<td>Write “ml” for milliliters.</td>
</tr>
<tr>
<td>A.S., A.D., A.U.</td>
<td>Latin abbreviation for left, right, or both ears</td>
<td>Mistaken for OS, OD, and OU, etc.).</td>
<td>Write: “left ear”, “right ear” or “both ears.”</td>
</tr>
</tbody>
</table>

Do not use these abbreviations or accept them from a physician. Clarification must occur and the proper order must be placed in the chart.
III. White Boards
1. In an effort to increase patient satisfaction and communication, the nurse and student nurse will place their name and relevant information on the white board at the foot of every patient bed. If answering a call light and you are not the caregiver for that patient, the nurse's phone number should be on the whiteboard for easy access.

IV. No-Passing Zones
1. All staff and students are required to stop at a room with a call light on, whether they are the caregiver or not. They should introduce themselves and ask if they can be of assistance. If they cannot help or answer the question, the person should call the nurse on the white board and inform them of the patient’s needs. Then communicate the information to the patient. Our goal is again to increase patient satisfaction and communication, as well as decrease the length of call light responses.

V. AIM for Zero and I-Trace
1. Goal is to decrease central line and IV infection, as well as, decreasing the risk of medication error. Aim for zero requires appropriate documentation of insertion, dressing changes and discontinuation of IV lines in the Meditech system to ensure best practices that decrease catheter associated infections. I-Trace means to trace all IV lines from insertion to source upon admission, transfer, hand off report, and any time necessary to ensure the proper medication is delivered through the correct line.

VI. Hand-Off Communication
1. Occurs when a patient is transferred from one unit/area to another or at end of shift. During “hand offs” there must be an opportunity for active communication between the person who is handing off and the person who is receiving the patient. “Hand-off” or transfer information should include all pertinent information about the patient’s condition, significant history, vital signs, test results, diagnosis and response to treatment. This is completed in Meditech.
2. Staff and students should use the SBAR Tool to give report – see attached SBAR Shift Report Tool.
   1. S = Situation
   2. B = Background
   3. A = Assessment
   4. R = Recommendation
3. The written SBAR report is handed to the next shift. Review any patient care highlights and important information.
4. There is also a SBAR Communication Tool to help organize information before calling the physician.

Critical lab values
5. The nurse caring for the patient will receive a call from the lab within 15 minutes of the critical value.
6. The nurse is then required to notify the responsible physician within 30 minutes with the result. A. There is a chain of command to follow if unable to reach nurse or requesting physician.
VII. **Universal Protocol**
1. Required for all surgeries and invasive procedures (exceptions: venipuncture, urinary catheterization, and NG tube insertion). All other procedures require the protocol which includes:
   A. Pre-Op verification
   B. Marking the operative site by physician
   C. “Time Out” immediately before the procedure

    *Complete the Universal Protocol Pre-Procedure Checklist before every invasive procedure (Policy IND 364)*.

VIII. **Medications and Pharmacy**
1. All medication orders must be scanned to pharmacy for entry.
2. Pharmacy enters all meds and IV orders. There is a 7-day automatic stop date on narcotics, hypnotics, sedatives, and antibiotics, (only if a stop date is not specified by MD).
3. Pyxis System: You must have a code to use the Pyxis medication system. Pharmacy approves all codes. Students do not have access to the Pyxis system. Students should contact their instructor or assigned nurse for assistance.
4. All PRN orders must have a stated purpose for administration, e.g., Compazine 10 mg IM every 6 hours PRN nausea
5. **Medication Reconciliation**
   A. The process of obtaining the most complete and accurate list of each patient’s current home medications (name, dosage, frequency, and route) and obtaining a physician’s order to continue, discontinue, or modify each home medication.
   B. Information from the Institute for Healthcare Improvement states that poor communication of medical information at transition points is responsible for as many as 50% of all medication errors in the hospital and up to 20% of adverse drug events.
   C. Take time to document herbal supplements patients take at home. Some herbs are known to interact with medications, such as St. John’s Wort, which can reduce digoxin and cyclosporine levels.
   D. **Each time** a patient moves from one setting to another, clinicians should compare previous medication orders with new orders and reconcile any differences.
   E. This list is used to provide correct medications for patients anywhere within the healthcare system. Reconciliation involves comparing the patient’s current list of home medications against the physician’s admission, transfer, and/or discharge orders.
   F. All inpatients will have their medications reconciled within 24 hours of admission.
   G. The medication history may be obtained from the patient and/or family members.
   H. The admitting nurse will obtain this information during the admitting process and will input it into Meditech while completing the admission history screens.
   I. The information should be as complete and accurate as possible as this information will be used throughout the patients’ hospitalization.
   J. Upon discharge, along with the discharge orders, you will now obtain a physician’s order to continue or discontinue home meds as listed on the “Medication Admission & Discharge Reconciliation Order Form”.
   K. After making sure all discharge orders are complete and the patient’s home medications reconciled one final time, the patient will sign the chart copy and it will become a permanent part of the medical record.
6. Medication Transfer Order Sheet
   A. Patients who are transferred from one level of care to another (e.g. from Critical Care to a Med-Surg. Unit) need a Medication Transfer Order Sheet printed.
   B. You can find it on the Main Nursing Meditech Menu #32.
   C. Print it off for the MD when the transfer order is written. It lists all the patient’s medications with boxes to indicate if it should be continued, discontinued or modified.
   D. The transferring nurse will review the “Medication Transfer Order Sheet” and list of home medications. Medications which do not have an order to resume or suspend on the “Medication Transfer Order Sheet” will require reconciliation.
   E. The transferring nurse has the responsibility for this and should contact the physician for specific orders.
   F. The transferring nurse is responsible for printing, reconciling, and signing the sheet.
   G. Transfer Medication Orders should be reviewed by the receiving nurse and then faxed to pharmacy for updating the medication profile.
   H. The Medication Transfer Order Sheet becomes a permanent part of the medical record.

7. Always use the “7” Seven Rights when administering medication:
   A. Right medication
   B. Right Dose
   C. Right Route
   D. Right Time
   E. Right Patient
   F. Right Documentation
   G. Right Education

8. High Risk Medications
   A. High risk medications require additional precautions for their delivery.
   B. Some special precautions include:
      A. Prepared by Pharmacy when possible or under direct control of prescribing MD during emergency situations (OR, ED)
         - 2 individuals prepare med and verify order and dose prepared
      B. 2 nurses check med, dose, and patient ID prior to administration and both complete E-MAR screen (or sign MAR during downtime).
      C. Where indicated, drug level or lab level checked prior to administration to ensure nontoxic levels (e.g. digoxin, theophyllin, warfarin and phenytoin).
      D. Chemo agents (parenteral) No verbal or telephone order (written by credentialed MD)
         - Double check by 2 pharmacists and by 2 certified chemo nurses for administration and monitoring.
      E. Coumadin: Dev. system to check INR prior to each dose of Coumadin.
      F. Digoxin: Apical pulse check, if less than 60 per min, hold dose, notify MD
         - Record apical pulse regardless if med given.
      G. Neuromuscular Blocking Agents
         - All have 24-hour stop policy; reordered on daily basis
         - All have precautionary label “Must Be On Assisted Ventilation”
         - Programming for pump must be double checked by 2 licensed professionals familiar with device (on initiation, at change of shift, during dosing changes)
         - Monitor per policy
      I. Concentrated K, Na, Phosphate injections
         - No floor stock except OR-CV.
• Use premixed solutions, following RCH guidelines
• Requires pump
  • Administer via central line (if more than 10% dextrose and/or 5% protein.)
  • Micron filter required
  • Bag hangs no more than 24 hours.
  • Monitored with blood glucose, weights, intake and output.
K. Narcotic PCA pumps Same as Epidural Med
L. IV Heparin
  • Premixed solutions only for floor stock.
  • Venous and arterial solutions stored separately
  • Require pump
M. Insulin All doses double checked by 2 licensed nurses
  • Vials kept separate from heparin
  • Units written out on order and MAR
  • Only regular insulin for IV injections and drips
  • IV drips require pump, prepared by pharmacy and double-checked
  • Patient blood sugar monitored

9. Double Check
   A. SQ heparin, insulin, parenteral chemo, PCA and Epidural pumps require a double check by 2 nurses prior to administration. Do not tell the 2nd nurse what they are checking. Have them communicate to you what they find. This practice helps prevent “confirmation bias” – seeing only what one expects to see.

10. Height, weight and allergies
   A. Pharmacy depends heavily on height, weight, and allergy information, in order to ensure that patients are receiving correct medication and medication doses. By policy, they will NOT send medications until these have been entered in Meditech.
   B. The computer program in pharmacy automatically can give a warning e.g., Dosage Warning: Dose exceeds maximum dose. The computer also gives allergy and cross sensitivity warnings if allergies are entered in the computer e.g. a patient has had an anaphylactic reaction to Cefzil, the warning screen will pop up if Augmentin is ordered (1 allergy found).
   C. Food allergies are also important to document in Meditech. If a patient is allergic to eggs, he or she may also be allergic to lipid products as they contain phospholipids (derived from egg yolk).

11. Expiration Dates
   A. Insulin: is only good for 28 days once opened. Label the vial with date opened and date it will expire.
   B. Multidose vials: Good for 28 days once opened and according to the CDC you must date the vial with the date opened, “discard multidose vials when empty, when suspected or visible contamination occurs, or when the manufacturer’s stated expiration date is reached.”
   C. Sterile water/saline for irrigation: Good for 24 hours once opened. You must date the bottle with the date opened. They contain no preservatives.
   D. IV bags of 50cc or less are good for 15 days after the outer wrap is removed.
   E. IV bags of 100cc or more are good for 30 days after the outer wrap is removed.
   A. The person who opens a multi-pack of IV bags is responsible for labeling all the IV bags with an expiration date. White labels are provided on the units – do not write directly on the bags (ink can leach in through the plastic). If a multi-pack of 50cc IV
bags was opened on 9/7, all of the bags should be labeled with a white label that says:  
EXP 9/21

B. On Sept. 7th, a multi-pack of 100cc IV bags was opened. Any not used immediately 
should be labeled with a white label that says:  EXP 10/6

IX. Scanning Patient Items
1. Point of Use areas are replenished by Sterile Processing & Distribution staff. Only the items 
scanned will be replenished. It is vital that each and every one scans properly!! If items are not 
scanned, the Supply Scan system does not know what’s been used and doesn’t tell supply chain 
that these items need to be replaced.
2. Remember, you must SCAN for IV’s.
3. If your Supply Scan monitors or “scan guns” are not working call I.S. at ext. 4357. for all 
repairs.
   A. Many calls regarding the scan guns not working are because they were not properly 
   returned to their cradles and have lost their charge… make sure you return them and that 
   they are inserted correctly for recharging.
4. You can scan supplies to an empty room! Select the room number… you will hear “room is 
empty”… say “yes”. Scan the supplies to the empty room, then hit “save transaction”. The 
room selected will now go from blue to yellow.
   A. Later, after the patient is admitted to the room, you can go back and select their room 
   (which is highlighted in yellow), and hit “save transaction” again. The supplies will be 
deleted from inventory at that time and transferred to the patient.
5. After you scan an item, remember to push “Save Transaction”. If you don’t, whatever you’ve 
scanned will be lost,
6. If you find that you are out of a particular item
   A. It is usually because the items aren’t being scanned “Scan none, get none.”
   B. The fastest way for you to get what you need is to go to the nearest unit and borrow from 
   them
   A. Push “change department”, enter your department, find your patient, and scan!

X. Blood
1. Numbered stickers from the Securline blood band are placed on the blood sample, blood 
authorization slip, and transfusion record.
2. Must take a copy of the MD order, Signed Consent for Blood Transfusion, and Authorization 
for release of blood products (with two nurses signatures) form to Blood Bank to pick up a unit 
of blood.
3. Bar Coded Transfusion Administration (BCTA) - All blood products must now be scanned into 
the documentation record and the appropriate screens filled out in Meditech.
4. Vital signs for blood transfusions are: Baseline, 15 min. after slowly starting blood, and every 
hour while it’s running.

XI. Physician privileges
1. Verify by calling Medical Staff or checking the computer icon on computer desktop.
XII. **Report Errors and “Near Misses”**

1. It is the responsibility of any licensed professional who prescribes, dispenses, or administers medication to report any medication error or “near misses” via Meditech Risk Management, promptly and accurately.

2. “Near misses” are errors that are identified before they reach the patient or reached the patient but did not cause harm.

3. RCH believes that medication incidents are NOT intentionally caused by individuals, but are usually the result of a “system” that needs to be improved. The goal is to identify and address problems in the system.

   A. “System” problems that you can be aware of and prevent:

<table>
<thead>
<tr>
<th>“System” problems</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional practice (order misinterpretation, order transcription errors)</td>
<td>Read back and Clarify the order</td>
</tr>
<tr>
<td>Drug stocking or delivery problems</td>
<td>Double check and scan what is removed from the AcuDose</td>
</tr>
<tr>
<td>Inadequate patient ID checking</td>
<td>Always scan and check the patient’s 2 identifiers</td>
</tr>
<tr>
<td>Confusing or unclear prescription</td>
<td>Clarify the order</td>
</tr>
<tr>
<td>Confusing or look-alike product labeling</td>
<td>Clarify the order with physician or pharmacy</td>
</tr>
<tr>
<td>Sound-alike drugs (product nomenclature)</td>
<td>Clarify the order with physician or pharmacy and know the goal of your therapy</td>
</tr>
<tr>
<td>Look-alike drugs (product packaging)</td>
<td>Double check and scan what is removed from the AcuDose</td>
</tr>
<tr>
<td>Compounding practices</td>
<td>Pharmacy should mix all meds unless an emergency and then the med should be double checked</td>
</tr>
<tr>
<td>Dispensing practices</td>
<td>Follow policy and practice for RCH</td>
</tr>
<tr>
<td>Inadequate patient monitoring</td>
<td>Follow up with your patient and educate them</td>
</tr>
<tr>
<td>Education – inadequate drug/dosage information</td>
<td>Follow up with your patient and educate them</td>
</tr>
<tr>
<td>Inadequate patient information or medical history</td>
<td>Utilize all approved sources available without violating HIPAA</td>
</tr>
</tbody>
</table>

4. RCH promotes a blame-free CULTURE, which does not focus on individual blame for errors or near misses. We focus on procedures and overall system processes that allow errors to occur. Please report all errors, near misses, and unsafe practices. Complete an RIR (Risk Identification Report) for any unusual events involving a patient or visitor. There is also a Non-Patient Related RIR for a “potential” problem or interdepartmental issues, supply problem, damage to property, staffing concerns, etc.

XIII. Chaplain services are available 24 hours/7days a week via pager 222 or PBX.

XIV. **Rapid Response**

1. **A Rapid Response can be called on any patient having a change in status that requires immediate attention**

2. **Vocera – call Rapid Response Nurse/RT**

3. **Criteria for calling RRT**
   
   A patient is experiencing a change in medical condition that may result in cardiac and / or respiratory arrest; direct caregivers may notify the Rapid Response Team to intervene until the physician is available.
Usual call criteria (but not limited to these reasons):
- Significant change in vital signs
- Altered Level of Consciousness
- Oxygen saturation less than 90 with or without O₂
- Respiratory rate of less than 10 or greater than 28
- Heart rate of less than 50 or change of 20 from baseline
- Heart rate of greater than 120 or change of 20 from baseline
- Change in telemetry pattern for which the RN feels need for assistance
- Systolic BP less than 90 or change of 20 from baseline
- Acute significant bleeding
- New, repeated or prolonged seizures
- Failure of patient to respond to treatment for an acute problem/symptom.
- MEWS score is 5 or greater or a 2 point change from previous recorded measure.

4. Primary Nurse Responsibilities:
A. Get the complete chart and MAR together and bring to the bedside.
B. Notify charge nurse that RRT was activated.
C. The primary nurse is a vital member of the RRT and must remain at the patient’s bedside and assist the RRT team.
D. Using SBAR format be prepared to provide the following information upon arrival of the RRT:
   A. Situation:
      - What prompted the RRT call? (e.g. Acute change in: Resp. status, Cardiac status, Vital signs, Mental Status, other)
   B. Background:
      - Admission diagnosis
      - Allergies
      - Code status
      - Pertinent history, surgeries, procedures
      - Names of physicians caring for the patient
   C. Assessment:
      - Current HR, RR, BP, Temp - IV fluids
      - Pertinent medications
      - Recent diagnostic tests
      - Interventions already attempted and results.
   D. Recommendation/Response:
      - How can the RRT help you?
   E. Primary RN retains responsibility for:
      A. Physician contact.
      B. Assisting the RRT RN in obtaining and administering needed medications and interventions within his/her scope of practice (per protocol)
      C. Overall care of patient.

5. Call the patient's family to notify them of change in patient's condition/status. Rapid Response Team Responsibilities
A. The ICU RN and RT will perform a complete patient assessment.
B. They will collaborate with the patient's nurse to determine the status of the patient and their findings will be promptly reported to the physician for medical orders.
C. Gather information from the primary RN, assess patient, document on RRT record.
D. The RRT RN will perform the initial assessment to include and investigate the SBAR report from patient's primary nurse.
A. Physical Assessment
B. Vital signs
C. Review of chart, Lab values, Diagnostic test results as available
D. Blood glucose
E. Neurological status
F. Cardiac rhythm
G. Pain, Anxiety
H. Fluid status (I & O),
I. Medical history
J. Recent medication history
K. Oxygenation/saturation
L. Communicate w/patients physician - report assessment, interventions, response, and discuss plan of care for any significant intervention.

E. The RRT RT will perform the initial respiratory assessment to include and/or consider:
   A. Breath sounds,
   B. Respiratory pattern and status
   C. Chest assessment
   D. Airway clearance
   E. Recent respiratory history
   F. Apply & monitor O2 sat
   G. Work of breathing
   H. Place oral airway, as needed
   I. Oxygenation, Ventilation
   J. Past respiratory history (last treatment given).
   K. Perform Nasotracheal suction

XV. Core Measures
   1. What are core measures?
      A. They are the use of standardized – or “core” – performance measures in treating an identified illness or core measure set also known as “Hospital Quality Measures” or “Care Measures.”

   2. How many core measure sets are being participated in by RCH and most accredited hospitals?
      A. RCH submits information to (The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS) for multiple core measure sets. They include but are not limited to:
         ● Acute Myocardial Infarction (AMI)
         ● Heart Failure (HF)
         ● Pneumonia (PN)
         ● Surgical Care Improvement Project (SCIP)
         ● Children’s Asthma Care (CAC)
         ● Global Immunizations
         ● Stroke
         ● VTE
         ● Women’s & Children [Early Elective Delivery], Breastfeeding, Pediatric Asthma
         ● ED Measures (inpatients & outpatients)
      B. A hospital’s performance will be measured by its adherence to the core measure guidelines. This means that for each diagnosis, there are sets of evidence-based treatments, diagnostic tests and standards to follow. The facility’s practitioners and nursing staff are
expected to comply with these guidelines.

3. **What are the MDs and nursing staff’s role in core measures?**
   A. Use of order sets by MDs guarantees that all diagnostic and treatment components of each measure set are completed and **documented** at a precise time.
   B. Nursing staff must also ensure that these orders are carried out and **documented** at the right time on the right document (ex. Nurses notes, eMARs, t-system, OR records, etc).
   C. Remember—no documentation means no intervention was done and negative scores are given to set measures.

4. **What does it mean to receive high scores on core measures?**
   A. The goal is 100% in our core measure compliance.
   B. This means that patients with core measure diagnoses were given timely and appropriate care.
   C. Our scores are publicly reported as well as for all hospitals in the surrounding area. The goal of core measures is to have evidence-based care for our patients because it’s the right thing to do!

5. **Acute Myocardial Infarction (AMI)**
   A. **Aspirin** on arrival (*unless contraindicated, document*)
   B. **Aspirin/beta blocker** at discharge (*unless contraindicated, document*)
   C. **ACEI or ARB** for LVSD (*Ejection fraction <40%*)
   D. **Smoking Cessation** Counseling (*smoker within prior 12 months - cigarettes only*)
   E. **PCI** within 90 minutes OR **Fibrinolysis** within 30 minutes
   F. **Statins** at discharge (*unless contraindicated, document*)

6. **Heart Failure (HF)**
   A. Discharge instructions on:
      A. Medications (reconciliations must match)
      B. Activity
      C. Diet
      D. Symptoms Worsening
      E. Weight
      F. Follow-up
   B. LVS function evaluation (ejection fraction)
   C. **ACEI or ARB** for LVSD (*Ejection fraction <40%*)
   D. **Smoking Cessation** Counseling (*smoker within prior 12 months—cigarettes only*)

7. **Pneumonia (PN)**
   A. 1st Dose of **Antibiotic** within 6 Hours
   B. Pneumococcal and/or Influenza **Vaccines**
   C. Blood Cultures Prior to Antibiotics in ED expected. Blood cultures with 24 hrs. of arrival for patients transferred or admitted to ICU
   D. **Smoking Cessation** Counseling (*smoker within prior 12 months—cigarettes only*)
   E. Appropriate Antibiotic selection
      A. Non-ICU admissions
      B. ICU admissions
8. Surgical Care Improvement Project (SCIP)
   A. Appropriate Antibiotic Selection
   B. Antibiotic within 1 Hr before surgery start/incision time (done by anesthesia)
   C. Prophylactic Antibiotic discontinued within 24 Hours After Surgery (CABG within 48 Hours) unless infection is documented
   D. Beta blocker taken prior to admission (document estimated time of last dose taken)
   E. Beta blocker perioperative tx (pre & post-op)
   F. Appropriate perioperative Hair Removal
   G. VTE Prophylaxis order (mechanical/chemical)
      A. VTE Therapy ordered and given within 24 hours of surgery end time
   H. DC Foley cath by POD1 or POD2
   I. Documented postop temp >36C/96.8F 30 mins prior anesthesia to 15 mins post anesthesia
   J. Postoperative blood glucose – cardiac surgery patients; less than or equal to 180 in the time frame of 18-24 hours after anesthesia end time

9. Children’s Asthma Care (CAC)
   A. Relievers for Inpatient Asthma (age 2 years through <18 years).
   B. Systemic Corticosteroids for Inpatient Asthma (age 2 years through <18 years).
   C. Home Management Plan of Care—(HMPC) Document Given to Patient/ Caregiver with a copy in the chart.

10. Global Immunizations
    A. Patients assessed and received pneumococcal vaccine ages 6-64 that are high risk or all patients over 65 years of age.
    B. Patients will be assessed and receive influenza vaccine between September – March.

11. Stroke
    A. VTE prophylaxis by day 2 of admission
    B. Discharge with antithrombotic and statin medication
    C. Patients with atrial fibrillation/flutter will be discharged with anticoagulation medications
    D. Acute Ischemic stroke patients will receive t-PA within 60 minutes of arrival to ED
    E. Patients and/or their caregivers will receive stroke education materials prior to discharge
    F. Stroke patients will be assess for rehabilitation prior to discharge

12. VTE
    A. Patients will receive VTE prophylaxis the day of or day following admission
    B. If no VTE prophylaxis is ordered the reason must be clearly documented in the record
    C. Patients diagnosed with VTE receive anticoagulation overlap therapy (bridge from IV to sub-Q to PO)
    D. Patients discharged from the hospital on warfarin will receive written instructions on medication use, monitoring, adverse drug reactions/interactions
13. Perinatal Care
   A. No elective c-sections
   B. Patients at risk for pre-term delivery at 24 to 34 weeks will receive antenatal steroids prior to delivery
   C. Preventative measures to prevent healthcare associated bloodstream infections in high-risk newborns
   D. Exclusive breast-milk feeding while in the hospital and educating new mothers to encouraging continued exclusive breast-milk feeding upon discharge

14. ED Measures
   A. Transition record
   B. Pain management in long bone fractures
   C. Head CT scan results for stroke interpreted within 45 minutes of arrival

Core Measures Resources:
   A. www.QualityNet.org
   B. www.hospitalcompare.hhs.gov
   C. www.joint commission.org
   D. www.medqic.org
Notice: Presence of Asbestos-Containing Materials in Riverside Community Hospital

The California Health and Safety Code Section 25915 require that we provide you information on the known existence of asbestos-containing building materials in Riverside Community Hospital. The information provided relays our knowledge as to the presence of asbestos-containing materials and our understanding of the threat posed by those materials. Because of the age of Riverside Community Hospital, it is reasonable to assume that certain types of the materials used in its construction are asbestos containing materials. The assumption was proven true by laboratory test of materials taken from the remodeled portion of the building. Contracted firms specially trained in the safe removal and disposal of asbestos containing materials remove those materials. Some laboratory tests have been conducted throughout the hospital to determine the presence of asbestos. However, such materials were in common use when the building was constructed and may exist in the other areas of the hospital. Typically, then asbestos-containing materials are divided into two categories.

**Friable**: Easily broken or crushed. Readily releases fiber into the air

**Non-Friable**: Not easily broken. Does not readily release fiber into the air

Because of the danger of asbestosis or lung cancer come from breathing asbestos fiber, non-friable and encapsulated asbestos post no hazard. Only when asbestos-containing material is disturbed to the extent that the fibers are released that can be inhaled is there a hazard.

While no specific surveys have been conducted to identify asbestos-containing materials throughout the entire hospital, listed below are materials previously found in the Riverside Community Hospital to contain asbestos and are known or suspected to exist in other areas of the hospital.

**Known Asbestos-Containing Materials**

**Pipe Insulation - Friable**

Used to insulate pipe throughout the hospital and is generally visible in basement areas.

This type of asbestos-containing material is encased in cloth or plastic wrap. With casing intact there is no hazard. When the casing is broken the asbestos-containing material appears as a white chalky plaster with fine hairs of fibers projecting from it. The dust from this material should be avoided.

**Sprayed on Insulation – Friable**

Used to fire proof structural steel, metal roof decks, and also as sound insulation.

Having a cottony or spongy, white or gray appearance, this material breaks and crumbles under very little pressure and should therefore be avoided. If work is necessary in an area containing this material, caution should be used not to disturb the insulation.

**Floor Tile – Non-Friable**

Used as a common flooring material and carpeting to the floor. No specific location of its use is known.

Generally 9” X 12” vinyl titles do contain asbestos. These tiles, however do not post an asbestos hazard unless they are sanded or ground to produce dust.

**Roofing Asphalt and Felts – Non-Friable**

Used as common roofing materials. No specific locations of its use are known.

These materials do not pose an asbestos hazard unless ground to produce a dust, as during removal of an old dried roof. Proposed room removals should be preceded by a laboratory test of the materials.

Riverside Community Hospital has taken actions to contain and limit any potential exposure to asbestos; however, it is important that you recognize potential exposure is possible if appropriate safety procedures are not followed. If you have specific questions on the presence of asbestos, you may contact Jose Torres, Directors of Engineering at ext 3140. If you wish to know more about the effects of asbestos, you can contact Riverside County Health Department, Environmental Health Services Division at (951) 358-5050.
Confidentiality and Security Agreement

Note: this form to be used for HCA employees and HCA workforce members.

I understand that the HCA affiliated facility or business entity (the “Company”) for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, “Confidential Information”).

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

General Rules

1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company’s policies.

Protecting Confidential Information

4. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
5. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
6. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
7. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
8. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
9. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

Following Appropriate Access

10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient’s record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

Using Portable Devices and Removable Media

12. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to
do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information
while it is on the media according to Company Information Security Standards.

13. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (e.g., Company
e-mail) may contain Confidential Information and as a result, must be protected. Because of this, I understand and
agree that the Company has the right to:
   a. Require the use of only encryption capable devices.
   b. Prohibit data synchronization to devices that are not encryption capable or do not support the required
      security controls.
   c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic
      locking) on any mobile device that synchronizes company data regardless of it being a Company or
      personally owned device.
   d. Remotely "wipe" any synchronized device that has been lost, stolen or belongs to a terminated
      employee or affiliated partner.
   e. Restrict access to any mobile application that poses a security risk to the Company network.

Doing My Part – Personal Security

14. I understand that I will be assigned a unique identifier (e.g., 3-4 User ID) to track my access and use of
Confidential Information and that the identifier is associated with my personal data provided as part of the initial
and/or periodic credentialing and/or employment verification processes.

15. I will:
   a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
   b. Use only approved licensed software.
   c. Use a device with virus protection software.

16. I will never:
   a. Disclose passwords, PINs, or access codes.
   b. Use tools or techniques to break/exploit security measures.
   c. Connect unauthorized systems or devices to the Company network.

17. I will practice good workstation security measures such as locking up diskettes when not in use, using screen
savers with activated passwords, positioning screens away from public view.

18. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information
Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
   a. my password has been seen, disclosed, or otherwise compromised;
   b. media with Confidential Information stored on it has been lost or stolen;
   c. I suspect a virus infection on any system;
   d. I am aware of any activity that violates this agreement, privacy and security policies; or
   e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information
      or Company systems.

Upon Termination

19. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of
my contract, or my relationship ceases with the Company.

20. Upon termination, I will immediately return any documents or media containing Confidential Information to the
Company.

21. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by
me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions
stated above.

<table>
<thead>
<tr>
<th>Employee/Workforce Member Signature</th>
<th>Facility Name and COID</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7150</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee/Workforce Member Printed Name</th>
<th>Business Entity Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Riverside Community Hospital</td>
</tr>
</tbody>
</table>
EXHIBIT B

PROTECTED HEALTH INFORMATION, CONFIDENTIALITY, AND SECURITY STATEMENT

- Protected Health Information (PHI) includes patient information based on examination, test results, diagnoses, response to treatment, observation, or conversation with the patient. This information is protected and the patient has a right to the confidentiality of his or her patient care information whether this information is in written, electronic, or verbal format. PHI is individually-identifiable information that includes, but is not limited to, patient’s name, account number, birth date, admission and discharge dates, photographs, and health plan beneficiary number.
- Medical records, case histories, medical reports, images, raw test results, and medical dictations from healthcare facilities are used for Student learning activities. Although patient identification is removed, all healthcare information must be protected and treated as confidential.
- Students enrolled in School programs or courses and responsible faculty are given access to patient information. Students are exposed to PHI during their clinical rotations in healthcare facilities.
- Students and responsible employees or agents of School may be issued computer identifications (IDs) and passwords to access PHI.

By initialing each statement, I agree to abide by the following statements:

<table>
<thead>
<tr>
<th>Initial</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Any or all PHI, regardless of medium (paper, verbal, electronic, image or any other), is not to be disclosed or discussed with anyone outside those supervising, sponsoring or directly related to the learning activity.</td>
</tr>
<tr>
<td>2.</td>
<td>Whether at the School or at a clinical site, Students are not to discuss PHI, in general or in detail, in public areas under any circumstances, including hallways, cafeterias, elevators, or any other area where unauthorized people or those who do not have a need-to-know may overhear.</td>
</tr>
<tr>
<td>3.</td>
<td>Unauthorized removal of any part of original medical records is prohibited. Students and faculty may not release or display copies of PHI. Case presentation material will be used in accordance with healthcare facility policies. Copying of the original medical record is strictly prohibited.</td>
</tr>
<tr>
<td>4.</td>
<td>Students and faculty shall not access data on patients for whom they have no responsibilities or a “need-to-know” the content of PHI concerning those patients.</td>
</tr>
<tr>
<td>5.</td>
<td>A computer ID and password are assigned to individual Students and faculty. Students and faculty are responsible and accountable for all work done under the associated access.</td>
</tr>
<tr>
<td>6.</td>
<td>Computer IDs or passwords may not be disclosed to anyone. Students and faculty are prohibited from attempting to learn or use another person’s computer ID or password.</td>
</tr>
<tr>
<td>7.</td>
<td>Students and faculty agree to follow Hospital’s privacy and security policies.</td>
</tr>
<tr>
<td>8.</td>
<td>Breach of patient confidentiality by disregarding the policies governing PHI is grounds for dismissal from the Hospital.</td>
</tr>
</tbody>
</table>
EXHIBIT B

PROTECTED HEALTH INFORMATION, CONFIDENTIALITY, AND SECURITY STATEMENT

- **Need to Know Rule**
  Before looking at a patient’s health information, ask the question “Do I need to know this to do my job?” If the answer is no, STOP! If the answer is yes, use it, but don’t share it with anyone who doesn’t need to know. Even though you may have access to the entire medical record or admitting/billing information, you may only legally look at the information you need to perform your job. The need to know rule applies to every individual in the organization; employees, contractors, students and volunteers. We are all responsible for following the Patient Privacy Policies and Principles.

- **California Privacy Act**
  A state law that works in concert with the federal HIPAA laws and is actually stricter than HIPAA laws. If you violate patient confidentiality and reveal patient information to someone without a “need to know” you can PERSONALLY be fined up to $250,000! California also requires a self-report by the Hospital to both the state and the patient (the federal laws do not) within 5 business days of when it becomes known (The California Privacy Laws SB541 & AB211 became effective 1/1/2009)

- I understand that Federal and State laws govern the confidentiality and security of PHI and that unauthorized disclosure of PHI is a violation of law and may result in civil and criminal penalties.

________________________________________

Signature of Participant

Print Name: ____________________

Date: ________________________________
Agency, Vendor, Student Verification and Attestation

Print Name: _______________________________ Date: ____________________

Company or School: ____________________________________________________

I hereby acknowledge the receipt of this orientation manual. I attest by my signature below that I have read and understand the content, and agree to abide by all policies, procedures, rules and regulations of Riverside Community Hospital. I have been given an opportunity to ask questions and clarify any information. If at a later time I have questions, I understand that I can direct them to my supervisor, charge nurse, manager, director, the education department, or human resources. I understand that all of the departments at Riverside Community Hospital are here to support me in providing outstanding patient care and other services to our patients and their families.

_________________________________________ __________________________
Signature Date
Mandatory Child & Dependant Adult Abuse Reporting Statement

**Mandatory Child Abuse Reporting - California Penal Code Section 11166.5** requires Riverside Community Hospital to provide this statement: any mandated reporter as specified in Section 11165.7, hired on and after January 1, 1985, prior to commencing his or her employment, and as a prerequisite to that employment, shall sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Section 11166 and will comply with those provisions. The statement shall inform the employee that he or she is a mandated reporter and inform the employee of his or her reporting obligations under Section 11166 and of his or her confidentiality rights under subdivision (d) of Section 11167. The employer shall provide a copy of Sections 11165.7, 11166, and 11167 to the employee.

**Mandatory Dependant Adult Abuse - California Welfare and Institutions Code Section 15659** requires Riverside Community Hospital to provide any person who enters into employment on or after January 1, 1995, as a care custodian, clergy member, health practitioner, or with an adult protective services agency or a local law enforcement agency, prior to commencing his or her employment and as a prerequisite to that employment, shall sign a statement on a form that shall be provided by the prospective employer, to the effect that he or she has knowledge of Section 15630 and will comply with its provisions. The employer shall provide a copy of Section 15630 to the employee. The statement shall inform the employee that he or she is a mandated reporter and inform the employee of his or her reporting obligations under Section 15630. The signed statement shall be retained by the Riverside Community Hospital.

I CERTIFY THAT I HAVE RECEIVED A COPY OF CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 15659 AND 15630 IN MY EMPLOYEE ORIENTATION HANDBOOK. I UNDERSTAND AND WILL COMPLY WITH MY OBLIGATIONS UNDER THE DEPENDANT ADULT ABUSE REPORTING LAW.

AND

I CERTIFY THAT I HAVE RECEIVED A COPY OF CALIFORNIA PENAL CODE SECTION 11166.5, 11165.7, 11166, 11167 IN MY EMPLOYEE ORIENTATION HANDBOOK. I UNDERSTAND AND WILL COMPLY WITH MY OBLIGATIONS UNDER THE CHILD ABUSE REPORTING LAW.

____________________________________  __________________
Signature                                      Date

____________________________________
Name