Anne Arundel Medical Center
Agency Nursing Staff Orientation Packet

Updated 12/15
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I. WELCOME TO ANNE ARUNDEL MEDICAL CENTER

The information in this booklet is designed to help orient you to the standards and routines that apply to most of the nursing units at AAMC. Standards for specialty areas vary. Please consult the clinical educator or clinical director for questions. Nurses at AAMC maintain primary responsibly for the care of our patients and are expected to comply with AAMC’s standards of care, policies and procedures.

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

B. Parking and Map
Park in Garage A, 4th level. Parking stickers are not distributed to agency staff.

C. Important phone numbers and web sites:
- Central Staffing Office (staffing issues) 443-481-1760
- Hospital Operator 443-481-1000
- Administrative Coordinator (admin issues after hours) 443-481-5509
- Human Resources 443-481-1950
- AAMC Web site www.aahs.org
- AAMC Nursing web site www.aahs.org/aamcnursing
- AAMC Nursing Blog www.aahs.org/nursingblog

D. AAMC Mission, Vision, Values and Philosophy
Mission: To enhance the health of the people we serve
Vision 2020: Living Healthier Together
Learn more here about our values and our organization here.
II. PRACTICE, JOB DESCRIPTION AND COMPETENCIES

A. Practice

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

B. Clocking in and out

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

C. Job description and competencies

Click the policy to review: HR8.8.02 Process for orientation of agency and contractual staff

Job Description Review:

POSITION TITLE: AGENCY/CONTRACT NURSE

FLSA STATUS: NONEXEMPT

DEPARTMENT TITLE: GENERIC

SUPERVISOR’S TITLE: NURSE MANAGER/DIRECTOR

POSITION: 504

JOB GRADE: 00

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

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

KNOWLEDGE/EXPERIENCE: Current licensure as a registered nurse by the Maryland Board of Nursing.

WORKING CONDITIONS/PHYSICAL REQUIREMENTS: Medium work: Exerting up to 50 pounds of force occasionally, and/or up to 20 pounds of force frequently, and/or up to 20 pounds of force constantly to move objects. The above is intended to describe the general content of and requirements for the performance of this job. It is not to be construed as an exhaustive statement of duties, responsibilities or requirements. (Date reviewed: 01/06/04)
BEHAVIORAL COMPETENCIES  (Performance Key: 3 = Excellent, 2 = Good, 1 = Fair)

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

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

3. Continuous Self-Improvement
   The demonstrated commitment to identify opportunities, invest time, and participate in activities resulting in a personal and professional development.

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

5. Problem Solving/Decision Making
   The demonstrated ability to identify issues and opportunities, collect appropriate information, effectively process information and make timely and effective decisions to improve outcomes.

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

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

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

PROFESSIONAL/TECHNICAL COMPETENCIES /ESSENTIAL FUNCTIONS  (Performance Key: 3 = Excellent, 2 = Good, 1 = Fair)

Clinical Decision Making/Judgment

1. Demonstrates clinical nursing knowledge and skill in the specialization of the unit.

2. Demonstrates the ability to apply the nursing process effectively in the care of culturally diverse patients and families.

3. Demonstrates the ability to utilize all applicable laws, policies, standards, guidelines and evidence-based practice in provision of patient/family care.

4. Organizes and reprioritizes patient care activities based on subtle and overt and/or environmental changes.

5. Consistently and thoroughly assesses patients to collect data and identify learning needs according to established standards and policies.

6. Utilizes a systematic, continuous and complete analysis of assessment data to develop individualized problem lists for assigned patients.

7. Develops and individualizes a plan of care for each patient in accordance with established standards, appropriate prioritization of problems/needs, and mutually agreed upon goals.

8. Efficiently implements the patient’s plan of care in accordance with applicable standards, policies, procedures and guidelines.

9. Demonstrates proficiency in medication administration, pain management and other unit or initiative specific skills.

10. Continuously evaluates the effectiveness of the plan(s) of care, making revisions and recommendations based on analysis of patient responses to interventions.
Nurse-Patient Family Relationships

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

___ 2. Demonstrates the ability to apply knowledge of growth and development across the life span to the care of patients.

___ 3. Provides direct patient care to patients and families in a culturally, developmentally and ethically appropriate manner.

___ 4. Plans of care address the physical, psychosocial, spiritual and learning needs of the patient/family.

D. Documented competencies

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

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

**Oncology Unit**
- Chemotherapy infusion
- Epidural/Intrathecal Catheters

**Progressive Care Unit**
- Vascular patient population
- Peritoneal Dialysis

**Mother/Baby Unit**
- Infant Security
- Neonatal Infant Pain Scale

**Pediatric Unit**
- Pediatric – Blood Administration
- Infant Infusion Pump
- IVIG Administration
III. GENERAL ORIENTATION

A. Confidentiality and patient rights

In 2002, a national program was launched to urge patients to take a role in preventing health care errors by becoming active, involved, and informed participants on the health care team. All inpatients receive a “Speak Up” brochure and can report concerns via the hotline, Web site, or by writing in the brochure. If a patient gives you a concern in writing, send it via interoffice mail to “Speak Up”. Staff should try to address any patient concerns as soon as possible with the patient, manager, physician, or patient advocate.

Teach your patients to speak up if they have questions or concerns; Pay attention to the care you are receiving; Educate yourself about diagnosis, medications, treatment and plan; Ask family or friend to be your advocate; Know your meds – what and why; Use a health care facility that is evaluated against current patient safety standards; Participate in all decisions about your treatment.

Click the policy to review:
HR 8.2.05 - Confidentiality Agreement
ERR3.1.03 - Patients rights and responsibilities

B. Patient Safety

Click the policies to review:
GNP14.6.04 - Double identifiers of patient information
GNP14.6.01 - Pre-procedure verification process for preventing wrong site, wrong protocol, wrong person surgery
MED16.1.25 - Medication reconciliation
NAP12.1.13 - Verbal orders from privileged medical staff
NAP12.1.15 - Handoff Report

C. Incident Reporting/4PTS Hotline

All reportable incidents should be reported to the 4PTS hotline (x4787). Examples include but are not limited to: patient falls; medication errors or near misses; specimen labeling errors; missed order for treatment, medication; narcotic discrepancy; removal of a patient’s ID bracelet; significant delays in treatments or disposition.

Click policy to review:
ADM1.1.62 - AAMC Incident reports

D. Patient and Family Centered Care

What is Patient and Family Centered Care (PFCC)? Working with patients and families—instead of doing to and for them. That is Patient- and Family-Centered care. Why is collaborating with patients and families so important? Health care providers are the “experts” in the medical field, while our patients and their families are “experts” on the patient. PFCC defines caregivers as everyone and anyone that has the ability to affect the patient care experience.

What does PFCC look like at AAMC? It is everyone across the hospital caring in a manner that incorporates the four core concepts of PFCC: Dignity and Respect, Information Sharing, Participation and Collaboration. Every patient and family member is treated in a manner that maintains their dignity and respects their preferences. Every patient and family is given timely, useful and accurate information in order to make decisions about their care and level of participation. Every patient and family is welcome to participate with the health care team on a level that is comfortable for them. Patients and families work in collaboration with the health care team to make decisions locally about the care of their loved or globally to help create hospital wide policies, practices and programs.
Our visiting policy welcomes families 24 hours a day, as the patient and/or family wishes. We are also working to bring patients and families as advisors to workgroups, committees and taskforces to add their unique perspective and aid in the decision making process. Collaboration at the hospital-wide level is one of the core concepts of PFCC and we are seeking patient and family advisors.

**E. Behavior Restraints/Seclusion**  
Click to review: GNP14.6.17 - Restraints/Seclusion

**F: Safe Patient Handling and Lifting**  
Click to review: GNP14.6.16 - Safe patient handling and lifting

**G: Fall Prevention**  
Click to review: NAP12.1.21 - Adult inpatient fall prevention and management program

**H: Cultural Sensitivity**

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

Culture - the behaviors and beliefs characteristic of a particular social, ethnic, or age group. Includes the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Diversity - differences in race, ethnicity, culture, language, age, gender, sexual orientation

Cultural Competence
- The ability to understand, appreciate and interact with persons from cultures and/or belief systems other than one’s own
- Understanding one’s own views and those of the patient while putting aside any biases, stereotypes, and/or judgments
- Having a basic knowledge of cultures, beliefs, customs other than your own

Barriers to Cultural Competence
- Equal Treatment Model
- Cultural conflict
- Ethnocentrism

Have I ‘ASKED’ Myself The Right Questions?
- Awareness: Am I aware of my biases and prejudices towards other cultural groups, as well as racism and other “isms” in healthcare?
- Skill: Do I have the skill of conducting a cultural assessment in a sensitive manner?
- Knowledge: Am I knowledgeable about the worldviews of different cultural and ethnic groups, as well as knowledge in the field of biocultural ecology?
- Encounters: Do I seek out face-to-face and other types of interactions with individuals who are different from myself?
- Desire: Do I really “want to” become culturally competent?

The ANA Position Statement is summarized here:
- Knowledge of cultural diversity is vital at all levels of nursing
- Cultural groups often utilize traditional health care providers, identified and respected within the group.
- Concepts of illness, wellness, and treatment modalities evolve from a cultural perspective or world view and are part
of the total cultural belief system.

- Recognizing cultural diversity, integrating cultural knowledge, and acting, when possible, in a culturally appropriate manner enables nurses to be more effective in initiating nursing assessments and serving as client advocates.

Resources at AAMC to communicate with non-English speaking clients:

- MARTII unit - this mobile unit with TV works like Skyle, hundreds of languages are available. Some languages have visual and audio while some only have audio -- the company will tell you when you call.
- Spanish-speaking interpreters - Clatanoff and ACP have interpreters from 8a-10p, 7 days a week.
- Sign-language interpreters available by request. Notify HOC or CPOC.
- Language Line - telephone with two receivers provides instant interpretation in hundreds of languages. Available on every unit. Follow instructions on the telephone to access.
- AAMC is committed to ensuring all staff has the knowledge and training necessary to care for culturally diverse patients (Healthstream assignments annually, educational offerings through Cultural Diversity Initiative Group). Cultural assessment is performed on admission, including dietary preferences, medications taken at home (herbal or vitamins), tests/procedures prohibited by culture, religious preference, primary language/language spoke at home, etc.
- Cultural Competence is emphasized. Nurses must have the knowledge and skills necessary to care for persons of all backgrounds/cultures and must have the desire to do so, while also being able to set aside any stereotypes or biases. Be respectful at all times, even if you do not agree with the patients beliefs or practices.

Language Assistant (Interpreter Services) - It is a fundamental standard of care that all patients and their families are able to fully participate in their plan of care by providing them with culturally and linguistically appropriate services. A need to improve upon how we identify and support patients and families who need interpretation services has been recognized. New processes have been developed to help up serve patients who need interpreter services.

Key updates to the Interpreter policy:

1. When notified that language assistance is needed Staff member must call Patient Advocacy Department/Interpreter Services at ext. 3801,
2. The In-Person Interpreter will now document interactions in the medical record
3. The following communication tools are NO LONGER to be used: Telecommunications Device for the Deaf, Interpretation by family and friends.

A Communication Barrier care plan and a Teaching plan have been added to ALEC.

- Patient will be identified as needing interpretation services at the time of pre-registration.
- If a patient requires some form of interpretation service, a BPA will fire alerting the care team and a Communication Barrier Care plan and Teaching plan will automatically be added in ALEC.
- The nurse will need to individualize the goals and intervention for the patient, implement the interventions in the care plan and document on the goals.

I. SBAR/Bedside Handoff

SBAR (Situation, Background, Assessment, Recommendation) is the report communication tool used at AAMC during bedside shift report. Click here to see the video.

Critical elements of bedside shift report:

1. Open the patient’s medical record with the computer/WOW in the room
2. Introduction
3. Verbal SBAR report with family
4. Focused physical assessment
5. Patient goal for the day
Benefits for Patients: Acknowledges patients as partners, builds trust in the care process, increases teamwork and reassures patient, actively encourages patient and family engagement, gives patient and family an opportunity to ask questions, information shared helps with transitions to home.

Benefits for Nurses: Improved: accuracy about the patient’s condition, accountability, time management, patient safety.

Addressing HIPAA concerns: Health information can be disclosed for treatment and payment. HIPAA acknowledges incidental disclosures may occur. Not a HIPAA violation as long as the nurse takes reasonable safeguards to protect privacy and only discloses or uses the minimum necessary information.

J: Infant Security

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

**Code Pink**

- Suspected or actual infant/child abduction
- Clatanoff Pavilion is secured – access into/out of building is restricted
- Security Personnel and County Police provide direction
- All staff in the Clatanoff Pavilion are to remain on site until cleared by county police
- Staff in hospital are expected to stop and question all individuals with infants, children and bags
- Carefully plans the abduction, visits site several times before event
- Asks detailed questions about procedures and layout
- Obtains uniform, lab coat or other staff attire
- Waits for an opportunity: visible in hallway for as little as 4 seconds
- May be known to parents (Abductor of older child is often an estranged parent/family member)
- Race/skin color of abductor almost always matches the infants

**Abductor profile:**

- Almost always female, usually early 20’s, typically overweight
- Gainfully employed
- Recent pregnancy loss not revealed to partner
- Fakes one or more pregnancies
- Relies on manipulation and lying as coping mechanisms
- Nesting behavior consistent with expectant parent (announces the pregnancy)

**Safety Measures:** All staff must be aware of the risk and prevention measures and be alert to visitor behaviors. Women’s & Children’s staff receive additional training.

**Staff Education:** All hospital personnel are required to wear color photo ID badges. Women’s & Children’s hospital and medical staff wear color coded (red stripe) “Authorized Baby Care Giver”

**Transportation:** Mother always escorted by a Women’s & Children’s RN or Tech when discharged

- Infants are transported: by bassinet; carried by mother while she is riding in a wheelchair/stretcher; in car seat carrier; NEVER carried in arms outside of patient’s room
- Children are transported by: wheelchair or stretcher; Jeep or Wagon

**Prevention**

- Educate families and staff
- Know abductor profile
- Know acceptable modes of transportation
- Identify unusual behaviors
- Know your role in a Code Pink
• Control access to restricted areas: Do not allow unauthorized personnel to ride restricted elevators or enter restricted doors when you pass through; escort people to their destination
• ASK QUESTIONS: “Excuse me, I’m_____ from the_____ Department. We are very concerned about Patient Security at AAMC. Do you have a Visitor Pass? Who are you visiting, please? Please walk with me to Security to get the proper identification.”

K: Abuse and Domestic Violence

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

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

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

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

Referrals to the AAMC Abuse & DV Program
• Page A/DV through the Hospital Operator 443-481-1000, after paging A/DV send a consult;
• For noncritical issues contact A/DV at 443-481-1209.

Domestic Violence (Adult Partner Abuse)
• 30% of female homicides are committed by intimate partners
• DV is leading cause of death of both pregnant women and women who are 1 year post delivery or pregnancy termination
• 25-45% of battered women were battered while pregnant
• Reporting Laws: In MD, there is no mandatory reporting unless assault is with a deadly weapon or moving vessel.

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

Vulnerable Adult/Elder Abuse
• Older adults may be subjected to a pattern of abusive behavior
• Abuse may be committed by a family member or by someone with whom they have an intimate relationship (may also be caregiver).
• Vulnerable adults (such as physically or mentally disabled individuals) may be at risk for abuse.
• Reporting Laws: Mandatory report to Department of Social Services, Adult Protective Services
# L: Age Specific Care

Each age group has different communication, comfort, and safety needs. How these needs are met depends, in part, on the age of the patient and your understanding of their needs.

<table>
<thead>
<tr>
<th>Communication</th>
<th>Comfort</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>Keep warm &amp; dry, avoid bright lights</td>
<td>Pt may feel safer when cuddled</td>
</tr>
<tr>
<td></td>
<td>Allow for usual feeding schedule</td>
<td>Provide non-flammable toys and safe environment</td>
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<tr>
<td></td>
<td>Allow caregiver nearby</td>
<td>Avoid choking hazards</td>
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<tr>
<td></td>
<td>Allow patient to keep comfort objects</td>
<td>Transport using size-appropriate means</td>
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<td></td>
<td>Meet physical needs promptly</td>
<td></td>
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<tr>
<td>Toddler</td>
<td>Provide warmth</td>
<td>Do not leave unsupervised. Pt often does not recognize danger.</td>
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<td></td>
<td>Allow pt to keep favorite comfort objects</td>
<td>Keep side rails up</td>
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<tr>
<td></td>
<td>Establish routine of care and keep continuity</td>
<td>Provide non-flammable toys</td>
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<tr>
<td></td>
<td>Consolidate care to provide rest</td>
<td>Avoid choking hazards</td>
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<tr>
<td></td>
<td>Encourage use of playroom</td>
<td>Limit separation from caregiver</td>
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<tr>
<td>Pre-school</td>
<td>Allow pt to talk and verbalize fears</td>
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<tr>
<td></td>
<td>Do not separate from comfort objects</td>
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<tr>
<td></td>
<td>If frightened, may accept explanations/exams given on “teddy” or favorite toy</td>
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<td></td>
<td>Praise attempts to cooperate</td>
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<tr>
<td>School-Aged</td>
<td>Allow security objects.</td>
<td>Curious</td>
</tr>
<tr>
<td></td>
<td>Be subtle in encouraging child to take comfort object with him</td>
<td>Able to accept limits</td>
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<tr>
<td></td>
<td>May need parent</td>
<td>Review rules and parameters of safety</td>
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<tr>
<td></td>
<td>Use calm, unhurried approach</td>
<td>Provide safe environment</td>
</tr>
<tr>
<td></td>
<td>Allow child some input on decisions</td>
<td>May transport in wheelchair</td>
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<tr>
<td></td>
<td>Reassure that it is okay to cry</td>
<td></td>
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<tr>
<td>Adolescents</td>
<td>Maintain privacy. May be very modest</td>
<td>Can recognize danger</td>
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<tr>
<td></td>
<td>Allow patient to choose whether or not caretaker is present</td>
<td>Inform pt of hospital/department rules</td>
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<td></td>
<td>Take time for explanations</td>
<td>Transport as an adult</td>
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<td></td>
<td></td>
<td>Provide safe environment</td>
</tr>
<tr>
<td>Young Adult/Early Middle Age</td>
<td>Maintain adult privileges- decision making, privacy, routine of personal habits</td>
<td>Keep needed items within reach- including walking and hearing aids</td>
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<tr>
<td></td>
<td>Offer assistance with personal care</td>
<td></td>
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<td></td>
<td>Inform of available amenities/services</td>
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<td></td>
<td>Inform of hospital/department policies (ex. smoking, visitors)</td>
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<tr>
<td>Late Middle Age/Late Adult</td>
<td>Same as “Young Adult/Early Middle Age”</td>
<td>Fall precautions, if appropriate</td>
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<tr>
<td></td>
<td>Do not rush pt</td>
<td></td>
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<td></td>
<td>Ask family to bring in familiar items from home</td>
<td>Keep needed items within reach, including walking aids</td>
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<td></td>
<td>Tell confused pt who you are, where they are, and what time of day it is every time you meet them.</td>
<td>Weak or confused pts may need special safety measures</td>
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<td></td>
<td>May need repeated offers of assistance for personal care needs</td>
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<tr>
<td></td>
<td>Keep pt warm</td>
<td>Do not rush pt. Reaction time is slower</td>
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<tr>
<td></td>
<td>Follow home routine as closely as possible</td>
<td>Help pt to and from bathroom if necessary</td>
</tr>
</tbody>
</table>
M: Infection Control

Healthcare-associated infections affect 2 million patients in the US each year and are responsible for 80,000 deaths per year. Transmission of health care-associated pathogens most often occurs via the contaminated hands of health care workers. The Centers for Disease Control and Prevention (CDC) and other health care-related organizations believe that cleaning your hands before and after having contact with patients is one of the most important measures for preventing the spread of bacteria in health care settings.

Wash hands with soap and water if:
- your hands are visibly soiled (dirty)
- hands are visibly contaminated with blood or body fluids
- before eating
- after using the rest room

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

When should you use an alcohol-based handrub? If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based handrub for routinely cleaning your hands:
- before having direct contact with patients
- after having direct contact with a patient’s skin
- after touching equipment or furniture near the patient
- after removing gloves

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

Artificial Nails Policy: Nails need to be intact and short, no more than ⅜” in length. Polished nails are acceptable only if nail polish is clear and intact. Artificial nails are not allowed for those administering patient care or patient-related care.

N: Sound-Alike-Look-Alike (SALA) Medications

JCAHO National patient Safety Goal #3 Requires AAMC to develop and maintain a list of medications that can be confused and potentially leading to errors. Our list is developed from both JCAHO’s suggestions AND medication error reports from 4PTS calls. In addition, the corresponding actions taken by AAMC to prevent these errors are listed. The detailed AAMC list of SALA medications is available as an attachment to the policy on the Intranet.
Joint Commission-required Intranet policies to guide use and interpretation for standing orders and multiple narcotic orders

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

**Range Orders:** Range orders are permitted when deemed essential to the care of the patient by the MD—
- Both “time” and “dose” ranges are allowed, however time ranges are redundant and should be discouraged.

Interpretation of range orders is outlined as follows:

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

If the initial, or subsequent, dose is inadequate the time the peak effect is anticipated, one additional dose may be given.

- The additional dose cannot exceed the difference between the first dose given and the largest dose in the interval AND the time before giving another dose begins at the administration of the additional dose

For example: “Morphine 1-2 mg IV q 3 hours PRN pain” would be given as 1 mg for the first dose. If the patient still rates pain unacceptable within 30 minutes of the first dose, an additional dose of 1 mg may be given. The next dose may be given 3 hours after the additional dose. Since 1 mg was shown to be ineffective initially, the next dose could be 2 mg.

**Multiple Narcotic Orders:** In place to prevent excessive multiple narcotic administration which may lead to an adverse drug reaction
- States that only one short-acting narcotic may used at a time.

MD orders must give specific directions to the nurse as to when to choose one drug over another. For example:

Morphine 2 mg q 3 hours PRN pain, may give percocet-5 2 tabs po q 4 hours PRN pain when taking PO Morphine 2 mg q 3 hours for severe pain, Percocet -5 1 tab q 4 hours for moderate pain

A narcotic option may not be given until the end of the time span for the last short-acting narcotic given (e.g. in the examples above, the patient cannot get Percocet until 3 hours following the last morphine dose)

- Short-acting narcotics may be given for breakthrough pain when patient is on a long-acting narcotic

Multiple short-acting meds may be ordered with a long acting narcotic if done according to the previous guideline
- Long-acting narcotics should be limited to only one medication which should be adjusted by the MD for optimal pain control. Multiple long-acting narcotics may only be used on patients who are admitted already on multiple long-acting narcotics.
**O: Medication Administration/Double Identifiers**

The identification wristband will include the patient’s name, assigned account number and bar code. The patient’s name and account number will serve as the double identifiers when providing care, treatment and services by all caregivers. 

**Click policy to review:** MED16.1.01 - Medication administration.

**P: Pain Management**

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

Acceptable examples:
- Morphine 2mg IV q2hrs prn pain while NPO
- Percocet 5mg 1-2 tabs po q4hrs prn pain when tolerating PO
- Percocet 10/325 1-2 tabs po q4hrs prn pain
- Dilaudid 6mg po q3hrs prn pain if Percocet ineffective and discontinue Percocet thereafter.

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

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

**Reassessment & Documentation of Pain**

- When a prn analgesic is administered, you are required to reassess and document your reassessment within 1 hour.
- Consideration of the onset, duration and peak effectiveness should be considered when timing your reassessment of pain.
- Make every effort to reassess and document pain within 30 minutes for IV analgesics and within 60 minutes for PO analgesics.
- The documentation of the reassessment of pain is audited every month and reported to the unit directors.

**Dilaudid**

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

**PCA by Proxy**

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

**Patient / Family / SO Education**

- Pain management education must be documented in the Interdisciplinary Patient Education Record (IPER).
- The following documentation is REQUIRED for every patient: 
  - The “risks for pain” – this is now a look up option in the IPER in the pain management section
  - Pain scale
  - Pain management plan
Q: Code Carts
Defibrillator/ pacer check is performed and documented daily. Code cart checklist is checked daily. All outer locks on the adult code carts, broselow carts and NICU carts should be the same color. A cart that has different colored locks on the outside or has a lock missing or broken may not contain all the needed supplies.

R: Emergency Response, Code Blue and Rapid Response
As part of our commitment to a culture of safety, anyone (patients, family, employees, visitors and volunteers) can call the Rapid Response Team for help. The team can be activated by dialing 1111.

Emergency Response by campus location on campus is as follows:
- Code Blue and Rapid Response Team (Both teams -1111): Hospital, Clatanoff, Edwards Pavilions and Donner Pavilion Radiation Oncology Inpatients only
- EMS (911) and Security (6911): Wayson, Donner, Health Sciences and Sajak Pavilions, including all outpatient regulated space and all campus parking areas. Outpatient regulated space can still call the Hospital Operations Coordinator at 5909 if they need additional assistance to bridge the gap waiting for EMS arrival

There are still special situations for neonates in the Bay Area Midwifery and Outpatient Infusion Center – Click policy to review: GNP14.6.15 - Emergency response teams (code blue, rapid response, and 911 calls)

AEDs are located at the elevators in our office buildings and garages.

Patients who have a DNR or “do not resuscitate” designation and are undergoing a procedure will have an opportunity to discuss with their provider whether they wish this designation to remain intact during and after the procedure.

If the Rapid Response Team or the Code Blue Team is activated, the Unit Clinical Director, Hospital Operations Coordinator or Clatanoff Pavilion Administrative Coordinator will follow-up with the patient and/or family within 24 hours of the event. This will give the patient and/or family an opportunity to ask questions or voice concerns.

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

<table>
<thead>
<tr>
<th>Code Blue</th>
<th>Rapid Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria for Activation</td>
<td></td>
</tr>
<tr>
<td>Immediate response – goal to defibrillate as needed within 2 minutes of call for:</td>
<td>Responds within 10 minutes to adults for these reasons:</td>
</tr>
<tr>
<td>• Respiratory or cardiac arrest</td>
<td>• Any worrisome signs or symptoms</td>
</tr>
<tr>
<td></td>
<td>• ACUTE change in heart rate (&lt;40 or &gt;130 beats/min)</td>
</tr>
<tr>
<td></td>
<td>• ACUTE change in systolic BP (&lt;90 mmHg)</td>
</tr>
<tr>
<td></td>
<td>• ACUTE change in respiratory rate (&lt;8 or &gt;28 breaths/min)</td>
</tr>
<tr>
<td></td>
<td>• ACUTE change in oxygen saturation (&lt;90% despite O2)</td>
</tr>
<tr>
<td></td>
<td>• ACUTE change in LOC</td>
</tr>
<tr>
<td></td>
<td>• ACUTE Bleeding</td>
</tr>
<tr>
<td></td>
<td>• ACUTE Neurological Change/ Stroke</td>
</tr>
<tr>
<td></td>
<td>• Dysrhythmias</td>
</tr>
<tr>
<td></td>
<td>• Rapid Deterioration</td>
</tr>
<tr>
<td></td>
<td>• Seizures</td>
</tr>
<tr>
<td>Primary Responders</td>
<td>CCU’s Care Team Coordinator (CTC)</td>
</tr>
<tr>
<td>• Physician: intensivist, ED physician, Pediatric Hospitalist, Neonatologist, NNP</td>
<td>• Respiratory Therapist</td>
</tr>
<tr>
<td>• Critical Care RN, ED RN</td>
<td></td>
</tr>
<tr>
<td>• Respiratory Therapist</td>
<td></td>
</tr>
<tr>
<td>• Administrative Coordinator</td>
<td></td>
</tr>
<tr>
<td>• Primary RN/LPN/CTC/PC</td>
<td></td>
</tr>
<tr>
<td>• Unit based tech / escort</td>
<td></td>
</tr>
</tbody>
</table>

S: Advance Directives Click policy to review: ERR3.1.02 - Advance directives

T: Peak Census Click policy to review: NAP12.1.12 - Peak census
U. Corporate Compliance

What is Compliance?
- “The willingness to follow or consent to another’s wishes” - Webster
- Not a new concept
- Who do we comply with at AAHS?
  - Federal Government
  - State Government
  - Other Regulatory Agencies

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

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

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

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

Reports can be made anonymously!
IV. ENVIRONMENT OF CARE/SAFETY MANAGEMENT/EMERGENCY OPERATIONS PLAN

AAMC MEDICAL PARK
SYSTEM FAILURE & BASIC STAFF RESPONSE
(See department policies & procedures for additional details)

<table>
<thead>
<tr>
<th>Failure of:</th>
<th>What to Expect</th>
<th>Who to Contact</th>
<th>Responsibility of User:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Systems</td>
<td>System down.</td>
<td>Information Systems</td>
<td>Use backup manual/paper system</td>
</tr>
<tr>
<td>Normal Electrical Power Failure</td>
<td>Many lights are out. Only RED plug or RED face plate outlets work on emergency power.</td>
<td>Engineering Respiratory Care Services</td>
<td>Ensures that life support systems are on emergency power (red outlets). Ventilate patients by hand as necessary. Don’t start new cases. Use flashlights. Manually regulate IV if necessary.</td>
</tr>
<tr>
<td>Elevators Out of Service</td>
<td>All vertical movement will have to be by stairwells.</td>
<td>Engineering</td>
<td>Review fire &amp; evacuation plans.</td>
</tr>
<tr>
<td>Elevator stopped between floors</td>
<td>Elevator alarm bell sounding.</td>
<td>Engineering</td>
<td>Keep verbal contact with personnel still in elevator and let them know help is on the way.</td>
</tr>
<tr>
<td>Fire Alarm System</td>
<td>No fire alarms or sprinklers.</td>
<td>Engineering</td>
<td>Institute Fire Watch; minimize fire hazards; use phone or runners to report fire.</td>
</tr>
<tr>
<td>Medical Gasses</td>
<td>Gas alarms, O2, N2, Xylene Oxide (NO)</td>
<td>Engineering Respiratory Care and Security</td>
<td>Hand ventilate patients; transfer patients if necessary; use portable O2, and other gases; call for additional portable cylinders.</td>
</tr>
<tr>
<td>Medical Vacuum</td>
<td>No Vacuum, vacuum system fails &amp; in alarm.</td>
<td>Engineering</td>
<td>Call Central Service for portable vacuum; obtain portable vacuum from crash cart; finish cases in progress; don’t start new cases.</td>
</tr>
<tr>
<td>Natural Gas; Failure or Leak</td>
<td>Odor no flames or burners, etc.</td>
<td>Engineering</td>
<td>Contact Engineering to assist in opening windows to ventilate; turn off gas equipment; don’t use any spark producing devices; electric motors, switches, etc.</td>
</tr>
<tr>
<td>Nurse Call System (Attended Mode)</td>
<td>No patient contact. Room light over door not working; Nurse Station console not working</td>
<td>Biomedical Engineering Nursing Supervisor</td>
<td>Use bedside patient telephone if available; move patients; use bells; assign a roving RN to check patients.</td>
</tr>
<tr>
<td>Nurse Call System (Unattended Mode)</td>
<td>Not receiving patient calls on cordless phone, not receiving code alerts on pager</td>
<td>Biomedical Engineering Nursing Supervisor</td>
<td>Inform staff to switch to Attended Mode; assign staff member to monitor master console at nurse’s station.</td>
</tr>
<tr>
<td>Patient Care Equipment/System</td>
<td>Equipment/system does not function properly.</td>
<td>Biomedical Engineering</td>
<td>Replace &amp; tag defective equipment.</td>
</tr>
<tr>
<td>Sewer Stoppage</td>
<td>Drains backing up.</td>
<td>Engineering</td>
<td>Do not flush toilets, do not use sinks. Install plastic bags in toilets.</td>
</tr>
<tr>
<td>Steam Failure</td>
<td>Sterilizers inoperative.</td>
<td>Engineering</td>
<td>Conserve sterile materials. Call Central Sterile Processing at main campus (x1035) to coordinate sterile supply requirements.</td>
</tr>
<tr>
<td>Telephones</td>
<td>No phone service.</td>
<td>Communications</td>
<td>Use overhead paging, pay phones, emergency truck phones, cell phones; use runners as needed.</td>
</tr>
<tr>
<td>Water</td>
<td>Sinks &amp; toilets inoperative.</td>
<td>Engineering</td>
<td>Institute Fire Watch; conserve water, use bottled water for drinking; be sure to turn off water in sinks; use RED bags in toilet.</td>
</tr>
<tr>
<td>Water Non-Potable</td>
<td>Tap water unsafe to drink.</td>
<td>Engineering Dietary, and all Managers</td>
<td>Place “Non-Potable Water - Do Not Drink” signs at all drinking fountains and wash basins.</td>
</tr>
<tr>
<td>Ventilation</td>
<td>No ventilation; no heating or cooling.</td>
<td>Engineering</td>
<td>Contact Engineering to assist in opening windows (Institute Fire Watch) or obtain blankets if needed. Restrict use of odorous/hazardous materials.</td>
</tr>
</tbody>
</table>

**Phone Numbers**

- Biomedical Engineering: 4750
- Environmental Svcs: 6160
- Dietary: 6830
- Information Systems Engineering: 4727
- Materials Mgmt: 4957
- Security STAT: 6611
- Communications: 3115
- Oncology Center: 5840
- Emergency Management Center: 5700
- Mr. Firestone: 6911
- Off-Site Emergency: 911

**SYSTEM FAILURE SHEET**
FIRE OR SMOKE IN YOUR AREA
(CODE RED: MR. FIRESTONE)

1. Do not shout "FIRE!" Adhere to the following procedure:

2. R·A·C·E
   
   R - Remove all individuals from the vicinity of fire. Close door to room.
   
   A - Activate the alarm:
      
      1. Pull the lever on the nearest red fire alarm box. **Know the location of all pull boxes in your area.**
      
      2. Pick up the telephone and dial Security at 6911. State "CODE RED: Mr. Firestone", location of fire, your name and type of fire. (trash, electrical, chemical)
      
      3. Ask security to repeat back what you told them.
   
   C - Confine - Close all doors and check to see that fire exits are clear.
   
   E - Extinguish - Obtain a fire extinguisher and attempt to extinguish the fire. **Know the location of the fire extinguishers in your work area.**

3. Assist fire response team and fire department.

4. Department Evacuation Plan:
   
   A. Exit building via fire exits. Know the location of fire stairway exits and the proper direction of evacuation from your work locations. See EOC 4.5.02 on the Intranet.
   
   B. Elevators may be used to evacuate non-ambulatory patients if elevator or elevator lobby is not the scene of the fire.

CODE RED - MR. FIRESTONE
CARDIAC/RESP ARREST (CODE BLUE)

1. ACTIVATE THE CODE BLUE EMERGENCY RESPONSE SYSTEM.
   A. For In-Patients
      1. Push Emergency Call Button (if available on unit)
      THEN
      2. Pick up phone and dial 1111 and announce “Code Blue, patient, location, patient’s name & physician’s name”.
      3. If room has two-way intercom unit, you may speak directly with hospital operator – hands free

2. BEGIN CPR - only if you have been trained. Use ambu bag or open emergency air way kit located on wall in room. (NO MOUTH TO MOUTH RESUSCITATION.)
   A. Send for crash cart and monitor/defibrillator.
   B. Flatten bed.
   C. Put a backboard under the patient.
   D. CPR (2 man CPR: 2 ventilations to 15 compressions)

3. WHEN CRASH CART AND MONITOR/DEFIBRILLATOR ARRIVES:
   A. Attach cardiac monitor to patient. Turn on recorder.
   B. Assure a patient IV is in progress.

4. WHEN CODE TEAM ARRIVES:
   A. Have the patient’s chart available.
   B. Assist code team.
ENG. DEPT. UTILITY/TELEPHONE OUTAGES

C. To activate the use of the emergency phone line during a power failure, lift the telephone handset (this will give you dial tone from the Central Verizon Office). Then dial the desired 443 = 2-digit number you are trying to reach.

D. You will NOT need to dial 9 before dialing 443 + 7-digit number. You must also begin dialing immediately or you will lose dial tone after four (4) seconds.
EMERGENCY INCIDENT PLAN

Upon hearing CODE YELLOW “Emergency Incident Plan now in effect” over the overhead paging system, employees will:

1. Immediately report to their department manager/supervisor.
2. Incident Commander and HICS Section Chiefs (Logistics, Planning, Finance and Operations) report to Command Center, located in the Rotary Room, 1st floor Clatanoff Pavilion, and carryout appropriate incident response.
3. All directors or designees will report their departmental status, including staff availability, to the HICS (Hospital Incident Command System).
4. See Hospital Emergency Operations Plan, policy EOC4.4.01 found on the Intranet for department specific instructions and duties.
5. Limit use of telephones.
6. All questions from the media should be directed to the HICS on ext. 1414 or Public Relations on ext. 4700.
RIGHT-TO-KNOW LAW/MATERIAL
SAFETY DATA SHEETS (SDS)

1. The purpose of the law is to create a safer and healthier workplace by providing employees with information about the chemicals that they use in their work areas.

2. The SDS sheets describe the hazards and technical information of the chemicals that an employee uses on the job.

3. To obtain a SDS, call the 3E Company at 1-800-451-8346 to get the SDS faxed to you. In the event the telephone land line is down, the alternate way to receive the SDS would be by using a cellular phone to call 3E and request the information be emailed to you. Please look for the yellow and black stickers on your phone or the yellow and black poster that is posted in your area. Information needed by 3E when requesting a SDS is:
   A. Product name or chemical description
   B. Manufacturer name
   C. UPC code (if available)
   D. Tell them the nearest fax number to you

4. Employees have these basic rights under the RIGHT-TO-KNOW LAW:
   A. The right to know information about the chemicals they work with in their work areas.
   B. Access to the chemical list and SDS within five working days of request by employee (Immediately if an emergency).
   C. One copy of the requested information about a chemical (the SDS) or the means to make a copy.
   D. If the SDS is not provided, an employee may refuse to work with the chemical.

5. If more information is needed, check with your supervisor or manager and Administrative Policy EOC 4.3.01

6. Department heads are responsible to ensure that all chemicals in use in their departments are added and subtracted from the facility’s computerized chemical list.
BOMB THREAT

Notification of Threat
A. If a bomb threat is received via telephone call:
   1. Get bomb threat checklist from the Emergency Flip Chart and get as much
      information about the caller as possible.
   2. Keep the caller on the telephone as long as possible - DELAY - ask caller to repeat.
   3. If a co-worker is nearby, they should contact Security immediately by dialing 6911,
      and give all pertinent data.
   4. The Security Office will contact the Anne Arundel County Police Department, the Fire
      Department, and Administration.
B. See Bomb Threat Policy EOC 4.2.02 on the intranet.

BOMB THREAT CHECKLIST

Date of Call ___________________________ Exact time of call ___________________________

Exact words of caller ________________________________________________________________

QUESTIONS TO ASK:
1. When is bomb going to explode? ____________________________________________
2. Where is the bomb? _________________________________________________________
3. What does it look like? ______________________________________________________
4. What kind of bomb is it? ____________________________________________________
5. What will cause it to explode? _______________________________________________
6. Did you place the bomb? ____________________________________________________
7. Why? ___________________________________________________________________
8. Where are you calling from? _________________________________________________
9. What is your address? ______________________________________________________
10. What is your name? ________________________________________________________

CALLER’S VOICE (please circle)

Calm  Disguised  Nasal  Angry  Broken
Stutter  Slow  Sincere  Lisp  Rapid
Giggle  Deep  Crying  Squeaky  Excited
Stressed  Accent  Loud  Slurred  Normal

If voice is familiar, whom did it sound like? _________________________________________
Were there any background noises? _______________________________________________

Remarks: ________________________________________________________________________

Person receiving call: ___________________________ Date: ___________________________

Report call immediately to: ________________________________________________ (Refer to bomb incident plan)

CODE GOLD - BOMB THREAT
OSHA/BIOHAZARDOUS WASTE MANAGEMENT/
INFECTION CONTROL

1. **Standard Precautions** will be consistently practiced by employees when dealing with patients. All patients are potentially infectious. Use appropriate personal protective equipment (gloves, gown, and mask) to prevent skin and mucous membrane exposure to blood and other body fluids. Wear masks and protective eye wear or face shields during procedures that are likely to generate droplets or aerosolization of body fluids. **All PPE must be removed** upon exiting a patient room or procedural area.

2. Utilize transmission-based isolation precautions (airborne, droplet, contact isolation) for presence or suspicion of those organisms that require enhanced protection. Appropriate signage must be posted on the patient’s door and left posted until environmental services removes the sign following isolation cleaning at discharge.

3. Call engineering at ext. 4777 to conduct a “smoke test” prior to use of any negative pressure room for **airborne** isolation patients.

4. N-95 respirators are to be worn while caring for airborne isolation patients and may be worn only by those fit tested to wear them (employees). Fit testing is conducted **annually** per OSHA guidelines for those likely to enter airborne isolation.

5. Perform hand hygiene –washing hands and/or use of alcohol-based handrub--thoroughly before and after contact with patients and body fluids, as well as the patient environment. Soap and water should be used when hands are visibly soiled, before eating, after using the restroom and for handrub patients in Contact C (e.g., *Clostridium difficile*) isolation.

6. Take care to prevent injuries when using needles, scalpels, and other sharp instruments. Dispose of all SHARPS in appropriate containers.

8. Impervious protective garb must be worn when working with biohazard materials or chemicals.

9. Biohazardous waste is to be placed into a leak-proof BIOHAZARD bag.

10. Employee exposures must be reported to the employee’s supervisor and Employee Health (x1965) and treated immediately as directed.

11. **NO EATING OR DRINKING** in areas where potential exposure to blood and other infectious material takes place or where potential contamination of surfaces may occur (OSHA Bloodborne Pathogen Standard).

12. For detailed information, refer to the Infection Control intranet policies. For replacement isolation signage, refer to the Infection Control intranet site.
### SPILL RESPONSE CATEGORIES:
(CODE ORANGE)

#### Category "A" Outside Assistance Required – Highly Toxic, Volatile, Large Volume (1 liter or greater), Unidentified or High Risk Chemical

| High Risk Chemicals |  |
|---------------------|---------------------|---------------------|
| Acetic Acid         | Benzoic Acid        | Hydrochloric Acid   |
| Acetone             | Calcium gluconate   | Oxalic Acid         |
| Ammonium Hydroxide  | Carbon Tetrachloride| Perchloric Acid     |
| Ammonium Molybdate  | Citric Acid         | Potassium Thiocyanate|
| Ammonium Sulfate    | Formaldehyde        | Sodium Nitroprusside|

Evacuate/isolate spill area; warn others; assist those who may need help.

Provide medical treatment for those exposed, if necessary.

Requests SDS to be faxed from 3E Company, 1-800-451-8346. Provide SDS to fire department spill team upon arrival.

Contact Communications by calling 1111 for Code Orange. Provide the following information: Location of spill/release and chemical name, if known. Communications will contact the fire department for spills in this category.

#### Category "B" No Outside Assistance Required – Non-volatile, Low Toxicity, Small Volume (under 500 ml.)

Evacuate/isolate spill area; warn others; assist those who may need help.

Provide medical treatment for those exposed, if necessary.

Request SDS to be faxed (email if fax is not working) from 3E Company 1-800-451-8346.

Wear appropriate personal protection as defined by the SDS.

Perform cleanup according to SDS or departmental spill procedures.

Place all materials and waste from cleanup into yellow spill bucket; secure lid and label as to contents.

Attach copy of SDS to yellow bucket with scotch tape and contact the Hazmat Officer (ext 4274) to arrange disposal.

#### Category "C" No Outside Assistance Required – Infectious Waste

Evacuate/isolate spill area; warn others; assist those who may need help.

Provide medical treatment for those exposed, if necessary.

Do not ventilate area.

Wear protective clothing, eye protection, and gloves.

Cover spill with a paper towel/absorbent material to avoid splashing and to contain spill.

Pour solution of Virex 256 (available from environmental services) on covered spill and let stand for 10 minutes contact time.

Wipe up with paper towels or other absorbent material and dispose in regular trash.

#### Category "D" No Outside Assistance Required – Radioactive Material Release

Radiology or Nuclear Medicine technicians utilizing this material have been trained to respond to this type of spill/release.

#### Category "E" No Outside Assistance Required – Chemotherapy Material Release

Cleanup of chemotherapy material release will be the responsibility of the department where the material is utilized.
EMPLOYEE INJURIES

1. Complete the Employee Incident/Injury Report (commonly called “Green Sheet“)

2. Notify department manager or area supervisor immediately after event, to complete the Supervisor's Investigation Report.

3. Go to the Employee Health Office for treatment or the Emergency Room if the health office is closed and the injury is serious enough to require immediate treatment. (Let your supervisor help you make the decision).

4. Always notify the Employee Health Office, ext. 1965, of injuries and report to the office as soon as possible,(next business day if EHO is closed), for assessment and to complete additional necessary worker’s compensation forms.

5. EXPOSURE TO BLOOD/BODY FLUIDS (Includes needle sticks or splashes to open skin, mucous membranes or eyes.

   A. Wash area of splash immediately and/or flush eyes well.

   B. Follow the above procedures (steps 1 through 4) for reporting employee injuries.

   C. Always record the name and medical record number of source patient.

   D. Contact supervisor immediately so testing of the source patient can be done before discharge. Four Gold Top tubes are to be collected from the source and brought to EHO or, if after hours or on the weekend, to the blood bank.

6. If seen in the Emergency Room after any type or severity of injury, always follow up by reporting to the Employee Health Office on the next business day.

7. Supervisors should complete Supervisor's Investigation Report at time of accident and forward it immediately to the Employee Health Office.
SECURITY MANAGEMENT PROGRAM
SECURITY RESPONSE

1. **Security Notification**: Dial ext. 6999.

2. **Emergency Response**: Dial 6911 for Security "STAT"; give location and circumstances requiring an emergency response.

3. **Customer Service**: Contact Security on ext. 1430 or 6999 for customer service needs.


5. **Repository of Patient Valuables**: To provide secure, temporary storage for patient valuables.

6. **Investigation Reports**: Safety and Security will document situations on AAMC premises which involve property loss, trespassing, assault or unusual circumstances.

7. **Transportation**: Should a patient require the need for emergency transportation, Security will coordinate and arrange transportation by the most economical taxi available.

8. **You are the first to activate the silent alarms to alert Medical Center Security staff that a life threatening situation exists in the Gift Shop, Emergency Department, Pharmacy, Cashier or other sensitive areas.**
INFANT ABDUCTION

The staff member discovering the missing child will:

1. Contact Security by calling 6911, and
2. Inform the C.P.A.C. (Clatanoff Pavilion Administrative Coordinator) and the A.C. (Administrative Coordinator)
3. All staff must be on high alert. Monitor the exit doors, stop and question individuals with children, infants or carrying bags capable of concealing an infant.

Security will:

1. Overhead page “CODE PINK”
2. Notify the Anne Arundel County Police Department
3. Report STAT to the units
4. Lock down the unit, and
5. Direct the operator to activate the Code Pink contact procedure.
RAPID RESPONSE ACTIVATION PROCEDURES

Criteria for Activating the Rapid Response Team

- You are worried about your patient
- Call even if you are not sure!
- Acute change in heart rate < 40 or > 130 beats/minute
- Acute change is systolic BP < 90 mmHg
- Acute change in RR < 8 or > 28 breaths/minute
- Acute change in saturation < 90% despite O₂
- Acute change in LOC

How to Activate the Team:

- The nurse caring for the patient dials extension 1111 and informs the hospital operation to activate the RRT (except in NICU and Peds)
- The patient’s attending physician may be paged at this time
- NICU and Peds patients are managed within their own units

EMERGENCY RESPONSE ACTIVATION PROCEDURES

The Emergency Response Team is activated in the event of a sudden illness involving an outpatient, visitor, and/or employee of or to AAMC.

How to Activate the Team:

- The ERT is activated by dialing the Operator at ext. 1111 (you are required to provide the specific location of the incident)
- The Operator will activate either the Rapid Response Team or the ERT depending on the circumstances.
- The responding ERT personnel will make an initial determination of the clinical condition of the subject, and recommend and/or administer the appropriate level of treatment.
- The ED is responsible for the maintenance of the ERT Bag. The ERT Bag is to be stored in a central location within the ED.
- Restocking – The ERT Bag is to be restocked immediately following an incident.
COPING WITH - AN ACTIVE SHOOTER SITUATION

- Be aware of your environment and any possible dangers
- Take note of the two nearest exits in any facility you visit
- If you are in an office, stay there and secure the door
- Attempt to take the active shooter down as a last resort

PROFILE - OF AN ACTIVE SHOOTER

An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area, typically through the use of firearms.

CHARACTERISTICS - OF AN ACTIVE SHOOTER SITUATION

- Victims are selected at random
- The event is unpredictable and evolves quickly
- Law enforcement is usually required to end an active shooter situation

Contact your building management or human resources department for more information and training on active shooter response in your workplace.

HOW TO RESPOND - WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

1. EVACUATE
   - Have an escape route and plan in mind
   - Leave your belongings behind
   - Keep your hands visible

2. HIDE OUT
   - Hide in an area out of the shooter’s view
   - Block entry to your hiding place and lock the doors
   - Silence your cell phone and/or pager

3. TAKE ACTION
   - As a last resort and only when your life is in imminent danger
   - Attempt to incapacitate the shooter
   - Act with physical aggression and throw items at the active shooter

HOW TO RESPOND - WHEN LAW ENFORCEMENT ARRIVES

- Remain calm and follow instructions
- Put down any items in your hands (i.e., bags, jackets)
- Raise hands and spread fingers
- Keep hands visible at all times
- Avoid quick movements toward officers such as holding on to them for safety
- Avoid pointing, screaming or yelling
- Do not stop to ask officers

INFORMATION - YOU SHOULD PROVIDE TO LAW ENFORCMENT OR 6911 OPERATOR

- Location of the active shooter
- Number of shooters
- Physical description of shooters
- Number and type of weapons held by shooters
- Number of potential victims at the location

Call 6911 when it safe to do so
You have reached the end of the agency nurse orientation packet. Please complete the orientation checklist and return to appropriate personnel.

“Access to the policies is for the sole purpose of fulfilling the clinical work assignment at AAMC. The policies are the sole property of Anne Arundel Health System and may not be released, forwarded, shared, viewed or re-disclosed to any other individual without written permission from the hospital administration risk management office.”