Naval Hospital Camp Pendleton

Joint Commission Survey Readiness Guide October 2025

MIFU oneSOURCE
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Updated October 2025

Table of Contents

Table of Contents

Command Related Information

NHCP
Commander's Guidance

Mission

Serve those who serve(d) and
Generate and Deploy Ready Medical Forces

Vision

To be the hospital of choice for our Marines, Sailors, their families, and beneficiaries.

My command philosophy focuses on three tenets:

- Teamwork – Servant leadership embodies honoring others before self, choosing ethics before profit, and serving with humility. We are part of the Navy/Marine Corps team that takes care of our people, working together to take care of our patients.
- Professionalism – We will demonstrate conduct and attitude in our chosen professions, using our expertise to uphold standards, demonstrate respect, and prioritize continuous learning.
- Honor – We are sailors 24/7/365 and make choices we are proud of each and every day. We respect the trust placed in healthcare providers, prioritizing the well-being of patients, serving with dignity and a commitment to mission readiness and excellence.

High Reliability Organization (HRO)

"High-reliability" describes NHCP's commitment to consistent performance at high levels of safety over long periods of time. A dominant attitude or cultural feature that all high-reliability organizations display is a "COLLECTIVE MINDFULNESS"

High Reliability Organization (HRO)

MHS COMMITMENT TO HIGH RELIABILITY

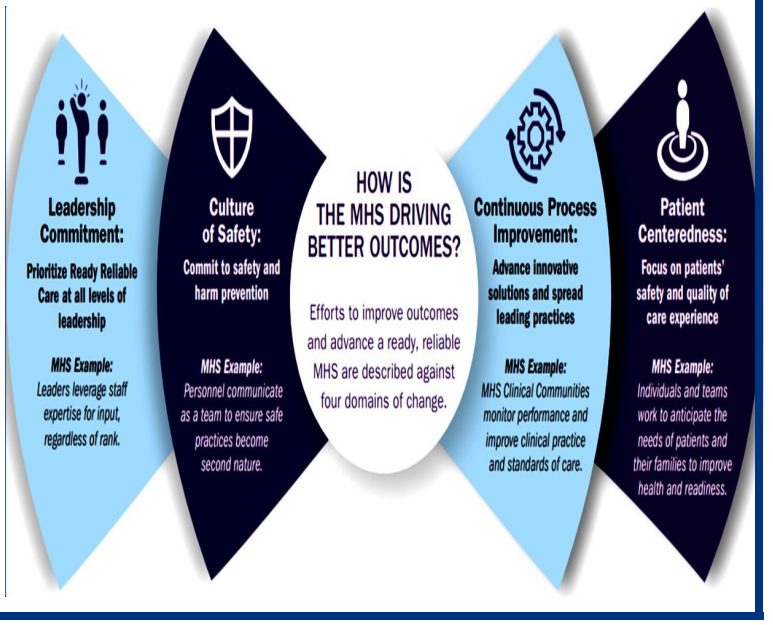
Ready Reliable Care is the commitment to advancing safe, ready, and reliable health care to the 9.6 million MHS beneficiaries.

The patient experience is at the heart of managing risk and regulating operations at every level to advance the MHS toward zero harm.

To achieve its readiness and health mission, the entire organization must adopt reliable behaviors, practices, and processes. Regardless of job function, all staff members shape the reputation of the MHS and its success as a ready, reliable health system.

Continuous process improvements to care and operations demonstrate the MHS' unwavering commitment to readiness and health by ensuring that best practices are being utilized.

The transition to MTF authority accelerates efforts to establish a ready, reliable culture, and to provide consistent, high–quality care to every patient within the MHS.



DHA: Ready Reliable Care

The Joint Commission Survey Overview

Introduction

Every 3 years, The Joint Commission (TJC) conducts triennial accreditation surveys at DHA healthcare facilities unless criteria is met, warranting an earlier visit.

The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

The Joint Commission does this by setting quality standards, evaluating an organization's performance, and providing an interactive educative experience that provides innovative solutions and resources to support continuous improvement.

In addition to clinical surveyors, a team of *Life Safety Code*® Specialists, typically non-clinician surveyors, are on-site for one to five days depending on the size of the organization. Due to the size of our command given the hospital and clinics, our *Life Safety Code*® Specialists will likely be on-site for 3-4 days.

The survey focuses on processes and functions related to safety/ quality of care, treatment, and services using Tracer Methodology. The *Life Safety Code*® Specialists will evaluate NHCP's functions and processes with focus on reviewing compliance with the National Fire Protection Association (NFPA), medical gas system requirements, Life Safety (LS) standards, Environment of Care (EC) standards, and Emergency Management (EM) standards.

The Joint Commission Survey Overview

Tracer Methodology

An evaluation method in which surveyors select patients and use their medical records as roadmaps to move through the organization and follow the experience of the patient through the entire health care process. Surveyors will make requests for the daily census list, operating room schedules, procedure schedules, and other data sources to select patients for individual tracers.

TYPICAL PATIENTS SELECTED FOR TRACERS

√ They have received multiple complex services and usually are close to discharge

√ They crossed different departments/services/programs (Mental Health Clinic→ER→OR→ICU→Med/Surg)

√ They are related to Infection Prevention and Control and/or extensive Medication Management issues

√ ER and Clinic patients who are prescribed antibiotics

√ Patients who are scheduled for a diagnostic imaging examination such as Computerized Tomography (CT)

HOW WILL THE SURVEYORS CONDUCT TRACERS

*Review patient's medical records with staff
*Observe direct patient care
*Observe the medication process
*Observe equipment use
*Interview patients/family
*Observe care planning
*Observe infection control and prevention processes
* Observe the environment of care and safety
* Review competencies, evaluations, and Continued Education (CE's).
* Closed records review of patients for restraints
* Discuss National Patient Safety Goals & Process Improvement projects, related patient care, and services.

What If the Surveyor Asks ME a Question?

DO's

- Greet the surveyor.
- Honestly answer the question(s) you are asked.
- USE phrases like, "Our policy/procedure/process is..." If you don't know the answer to a question, it's OK.

  Be honest and state, "I am not sure, let me find my supervisor for clarification."
- Emphasize that we are always looking for ways to improve our programs. We work as a team!
- Know where to find all required manuals and documents for your department/unit. If online, know how to navigate and access them.

This shows how staff are aware and know how to go about finding information. This may include referencing a policy manual, contacting a supervisor, or calling another department.

DON'T's

- Attempt to hide, ignore, avoid, or run from the surveyors, unless you are involved in a patient's care that would prohibit you from responding!
- Panic, RELAX and TAKE A DEEP BREATH!
- Volunteer unrelated information.
- Let the surveyor make you feel defensive.
- Use phrases that will demonstrate inconsistencies such as, "It should be", "Usually we" or "Most of the time"

These phrases will lead the surveyors to ask more questions.

- NEVER attempt to answer a question by assuming what the documentation was intended to mean; let the record speak for itself.

How to Participate in the Survey

Keep the Conversation Professional

- Ask questions if you do not understand.
- NEVER ARGUE with the surveyors. Be professional and use appropriate language and behavior.

Be Truthful

- If you do not know the answer, say so, and tell the surveyor where or whom you would go to for the answer.
- Remember you may use any resources available to you, such as the intranet, policies, badge information, department resources, or supervisor.

Keep Your Answers Focused and Specific

- Whenever possible, answer in your own words. Keep your answer short and to the point.

Support Your Co-Worker

- If you are present when someone else is being interviewed, feel free to **add any relevant information** without being intrusive.
- Respond to questions with **confidence**—you know the answers better than anyone. Speak freely about all of the great things we do—and there are many!
- **Success is dependent on teamwork.** Excellent patient care is no different. Your communication and interaction with other staff members of the healthcare team is critical to providing excellent care for the patient!

Patient Safety Program

The MISSION of Patient Safety is to promote a culture of safety to eliminate preventable patient harm by engaging, educating, and equipping patient-care teams to institutionalize evidence-based safe practices.

Patient Safety's VISION is to support the military mission by building organizational commitment and capacity to implement and sustain a culture of safety to protect the health of the patients entrusted to our care.

NHCP Executive Leadership and staff are strong supporters of patient safety. The GOAL of the Patient Safety Program is to prevent avoidable harm to patients. This is accomplished by:

- Identifying and reporting adverse events (including Sentinel Events) and near misses
- Reviewing adverse events in a fair and just way. We strive to understand how systems and processes may have contributed to the adverse event instead of just looking at the individual involved in the event
- Disseminating patient safety alerts and lessons learned
- Conducting proactive risk assessments – focusing on prevention!
- Partnering with patients and their families which includes disclosing errors

If we do not provide resolution to adequately prevent or correct problems that can have or have had a serious adverse impact on patients, you may contact The Joint Commission regarding your concerns without fear of disciplinary or punitive action. Further information is available at www.jointcommission.org

Patient Safety Reporting (Event Reporting)

A GOOD CATCH is a problem or error that almost got to the patient, but didn't because you caught it first and corrected it. Think of it as, "*Phew, that was close....*"

What are examples of a Good Catch?

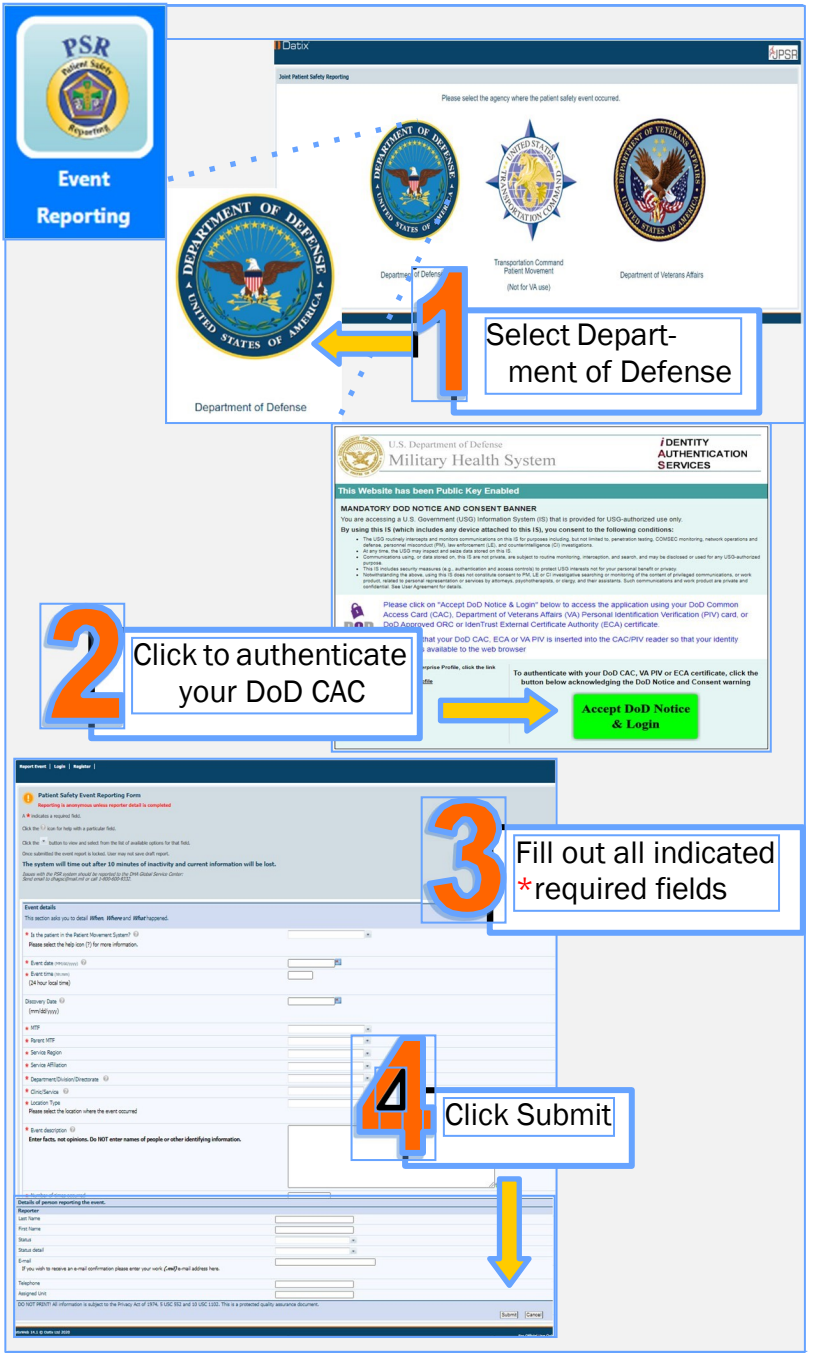
- A medication error that did not reach the patient
- Recognizing trip hazards or other unsafe conditions
- Recognizing a patient's pre-procedural information was not updated or was not accurate before performing a procedure

How do I report a Good Catch?

Good Catches are submitted exactly the same way as Patient Safety Reports in the Joint Patient Safety Reporting System (JPSR). Even though the event did not happen, Patient Safety and Leadership will still examine the process to determine how it almost occurred and if there is any way that the process can be made safer.

In the description of the event, please include the words 'Good Catch'. Additionally, many Good Catches lead to meaningful recognition of staff. By submitting in the JPSR system, there are more opportunities for staff recognition.

Patient Safety Reporting (Event Reporting)



What Types of Incidents Should I Report?

Errors	Near Misses
An unintended act, either by omission or commission, or an act that does not achieve its intended outcomes.	A process variation that did not reach the patient but for which a recurrence carries a significant chance of a serious adverse outcome.
Hazardous Conditions	**Sentinel Events**
Any set of circumstances (unrelated to the patient's condition) which significantly increases the likelihood of a serious adverse outcome.	An unexpected occurrence that results in death or serious injury, or outcome unrelated to the patient's course of illness.

Note: Report needle sticks on a Bloodborne Pathogen Exposure Report form available on the intranet under "Reference Materials". Report staff injuries/illnesses online using a Supervisor's Report of Injury/Illness form through ESAMS under "My Tools".

WHAT HAPPENS TO A PSR AFTER I SUBMIT IT?

1. The Patient Safety Office reviews the event, collects any additional information needed, and assigns a severity score that determines additional review requirements, such as a Root Cause Analysis or reporting to The Joint Commission.
2. Data from event reports are analyzed, collated and shared with leadership and appropriate committees to improve patient safety.
3. Reporting is anonymous but if you would like feedback on the event submitted, you must complete the "Reporter" details section which includes your name and contact information.

Sentinel Events

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

- Death
- Permanent harm
- Severe temporary harm

Employee Responsibilities in a Sentinel Event:

- Immediately notify the Patient Safety/Risk Management Office and your supervisor of a possible Sentinel Event.
- Secure all evidence and documentation about the event (equipment, syringes, IV bags, medication, vials, etc.).
- DO NOT change any settings on equipment.
- Participate in the investigation of the root cause analysis if requested.
- Participate in changes made to systems/processes to reduce the risk of reoccurrence.

Patient Safety Office: (760) 719-3455

Patient Rights/Informed Consent

HOW ARE PATIENTS INFORMED OF THEIR RIGHTS?

- All patient care areas will prominently display the Patient Bill of Rights.
- This bill of rights applies to all patients of all ages. Patients need to know that we respect and protect these rights and that they are entitled to make decisions regarding their care including the decision to accept, refuse, or discontinue treatment.

THE RIGHTS OF THE CAREGIVER

Explains the rights and responsibilities of staff members whose cultural, ethical, or religious beliefs and/or practices conflict with specific aspects of patient care (e.g. sterilization, blood transfusions).

DoDI 6000.14 - DoD Patient Bill of Rights

Informed Consent

Prior to submitting to medical treatment, patients have the right to be informed of the nature of the treatment and procedures, the risks, anticipated benefits, available alternative treatments including probable or expected consequences of a failure to accept treatment. It is the provider's responsibility to discuss this information with the patient in language the patient can understand.

Witness for Informed Consent

- Should be a health care employee of NHCP who is not participating in the procedure/treatment.
- Does not need to be present when the patient signs, but needs to verify the patient's signature and voluntary consent

Informed consent documentation: DoD OF-522

National Patient Safety Goals

National Patient Safety Goals are a series of specific and required actions that prevents frequency of devastating medical errors such as miscommunication among caregivers, unsafe use of infusion pumps, and medication mix-ups.

Goal 1: IMPROVE THE ACCURACY OF PATIENT IDENTIFICATION

Staff Responsibilities:

√ 2 identifiers every time. ALWAYS use the patient's Full Name and full Date of Birth (MMDDYY) . DoD ID number should be used as a third identifier. Match treatment to patient to identify a patient every time you provide a service or treatment. Do NOT skip safety checks.

√ Two staff members must verify (2 patient IDs) when drawing blood for blood products AND before giving blood products. Follow the instruction.

√ LABEL BLOOD AND OTHER SPECIMENS IN THE PRESENCE OF THE PATIENT. Have patient verify labels when able to do so.

√ Use distinct naming for newborn patients. FOLLOW our internal policy.

Goal 2: IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS

Staff Responsibilities:

√ EFFECTIVE communication skills go hand in hand with patient safety.

√ When sharing information, communication should be complete, clear, brief, and timely.

√ Get critical results to provider within 30 minutes (internal policy). Evaluate effectiveness of reporting critical results.

National Patient Safety Goals

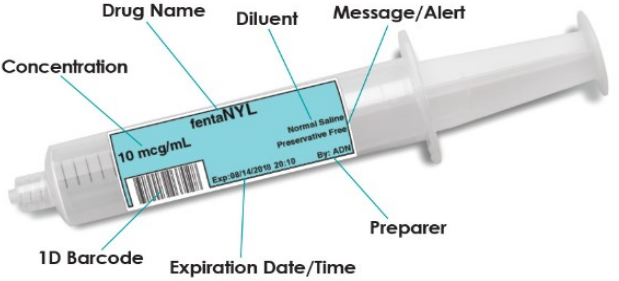
Goal 3: IMPROVE THE SAFETY OF USING MEDICATIONS

Staff Responsibilities:

√ ALWAYS reconcile, record and pass along correct information about a patient's medicines.

√ Make sure the patient knows which medicines to take when they are at home.

L A B E L I N G



√ Before every procedure, ALWAYS label medicines that are out of the original container. Includes syringes, basins, or other containers.

√ Use protocols when administering anticoagulant therapy.

√ International Normalized Ratio (INR) baseline is required prior to beginning Coumadin therapy. Subsequent INRs are obtained for use in monitoring the patient's therapy.

√ Use unit dose, prefilled syringes or premixed infusion bags when giving heparin.

National Patient Safety Goals

Goal 6: REDUCE PATIENT HARM ASSOCIATED WITH CLINICAL ALARM SYSTEMS

Staff Responsibilities:

- √ Clinical alarms alert staff of urgent or potentially adverse patient conditions.
- √ Alarms MUST be audible and offer alerts that are understood and promptly acted on by staff.
- √ Make sure alarms are audible with respect to competing noises in the unit.
- √ Always physically enter the room during an alarm and assess the patient.
- √ Do not turn off or deactivate alarm capabilities.
- √ Ensure regular preventive maintenance and testing is done.

Goal 7: REDUCE THE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS.

Staff Responsibilities:

- √ Each year millions of people acquire an infection while receiving care in a health care organization.
- √ Compliance with hand hygiene guidelines reduce health care acquired infections.
- √ Implement evidence-based practices to prevent infections.
- √ Perform hand hygiene on entry to the patient room/cubicle and on exit.
- √ Perform hand hygiene BEFORE gloving & after removing gloves.

Goal 15: THE HOSPITAL IDENTIFIES SAFETY RISKS INHERENT IN ITS PATIENT POPULATION.

Staff Responsibilities:

- √ LISTEN, ASK, and ACT.
- √ Staff should be AWARE of the signs of and the risk factors associated with suicide.
- √ Suicide risk assessment of the physical environment.

National Patient Safety Goals

Goal 16: **Improve health care equity**

The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients

Staff Responsibilities:

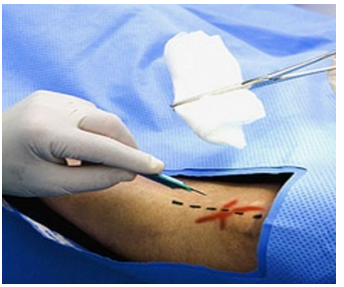
√ We ask because We CARE: When missing or needed, participate in the collection of patient data such as race, preferred language, ethnicity and other social information.

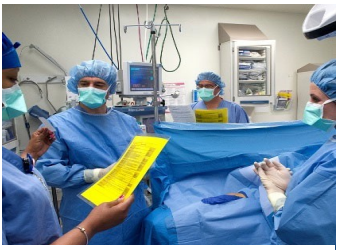
UNIVERSAL PROTOCOL
PREVENT MISTAKES IN SURGERY

*Follow the Universal Protocol Safety Checks—EVERY TIME. The 3 phases of UP applies to all inpatient and outpatient procedures that expose patients to more than minimal risk.

PRE-PROCEDURE VERIFICATION

MARK THE PROCEDURE SITE





TIME OUT PROCEDURE BY THE ENTIRE TEAM

DHN2PACRIM INST 6025.44
SURGICAL AND PROCEDURAL
PATIENT SAFETY PRACTICES

Fall Prevention & Post-Fall Management

All Staff

Have awareness of high-risk fall patients, visitors and the environment of care.

Remain vigilant in identifying those that those that are a high risk of falls by either their age, use of mobility aids, impaired balance/gait AND assist or escort them to their destination in hospital or clinic.

Be able to identify environmental safety hazards and remove he obstacle or notify the appropriate staff .

In Outpatient Setting

Fall risk assessment begins at the **entry point for care.** Easily identifiable fall risk factors include:

- use of ambulatory aides
- unnatural gait
- sight or hearing deficit
- advanced age and/or appearing feeble or weak
- self reports of dizziness or lightheadedness
- known history of falls

Interventions

1. Mobility assistance: physically walking with/ supporting patient
2. Assistive devices: walker, wheelchair
3. Room orientation
4. Modifying physical environment
5. Fall prevention education
6. Placing patient on stationary chair vs exam table
7. Leaving infants/children in car seat, carrier, or stroller until ready for exam

Fall Prevention & Post-Fall Management

In the event a visitor falls, responding staff will:

- –Assess visitor & activate Code Blue if unresponsive
- –If alert and appropriately responsive, offer transfer to the EMD or branch clinic acute treatment room via assistive device for further evaluation
- –Detailed documentation in visitors EHR
- –Complete Patient Safety Report

Inpatient Setting

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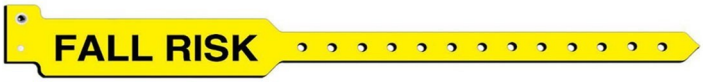


Post Fall Assessment and Evaluation

Un-witnessed inpatient falls require Rapid Response Team (RRT) activation.

Un-witnessed outpatient falls require ED evaluation

Document assessment in MHS Genesis

Consider imaging for patients at high risk for intracranial bleed like patients on anticoagulants, patients with altered mental status prior to the fall, or un-witnessed falls

Complete Patient Safety Report

Performance Improvement (PI), Quality Improvement (QI), Research and Evidence Based Practice (EBP)

Do you have ideas on making improvements
to something in your workcenter?
You might be asking yourself, what kind of project is this
or where do I start?
Lets break it down. Which definition fits.....?

1. EBP: is the process of shared decision-making between practitioner, patient and others significant to them based on research evidence, the patient's experience and preferences, clinical expertise or know-how, and any other available robust sources of information.

Healthcare delivery based on the integration of the best research evidence available combine with clinical expertise, in accordance with the preferences of the patient and family.

Who benefits? Future patients and families, future clinicians, organization

What is the purpose? Improve quality and safety within the local clinical setting by applying evidence in healthcare decisions

What is the scope or interest? Specific unit or patient population within an organization

2. PI/QI : the organizational strategy that formally involves the analysis of process and outcomes data and the application of systematic efforts to improve performance.
The degree to which healthcare services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge.

Who benefits? Current patients & families, current clinicians, organization

What is the purpose? Improve quality or safety of processes or patient experience within the local setting. Evaluate changes in efficiency or flow.

Performance Improvement (PI), Quality Improvement (QI), Research and Evidence Based Practice (EBP)

QI continued

What is the scope or interest? Specific unit or patient population within an organization.

3. Research: Systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

Who benefits? Clinicians, scientific community, subjects (on occasion)

What is the purpose? Contribute to and/or generate new knowledge that can be generalized

What is the scope or interest? Generalize to populations beyond organization

Performance Improvement (PI)

Continuous Process Improvement (CPI)

Naval Hospital Camp Pendleton (NHCP) is committed to the delivery of safe, quality health care, zero preventable patient harm, and the tenets of high reliability organizations (HRO).

As a military institution, our command's critical mission priorities consist of warfighter readiness, medical force generation, and high quality healthcare. NHCP supports PI courses year round and an annual CPI Fair to showcase projects performed by staff & work centers throughout the year.

Robust Process Improvement (RPI)

Methodologies: A variety of methodologies may be utilized towards making improvements at NMCSD depending on the complexity of the project.

BASIC

ADVANCED

Sort-Set in order-Shine-Standardize-Sustain (5S)

- Workplace organization
- May be performed by any staff member

Low Hanging Fruit (LHF)

- Obvious solution is known and takes little effort to implement
- Any staff member may perform

Just Do It (JDI)

- Cause/solution known; minimal resources needed to complete
- Often utilizes a team which may be led by any staff member
- Teams consist of staff members working on the process being improved

Plan-Do-Check-Act (PDCA)

Examines a process utilizing the 4 steps to continuously improve each cycle

Utilizes a team which may be led by any staff member

Teams typically consist of subject matter experts (SMEs)

Rapid Improvement Event (RIE/Lean)

Root cause known/solution unknown

Reduce steps/eliminate waste

May be led by a Green Belt (GB) or Black Belt (BB)

Define-Measure-Analyze-Improve-Control-Validate (DMAICV/Six Sigma)

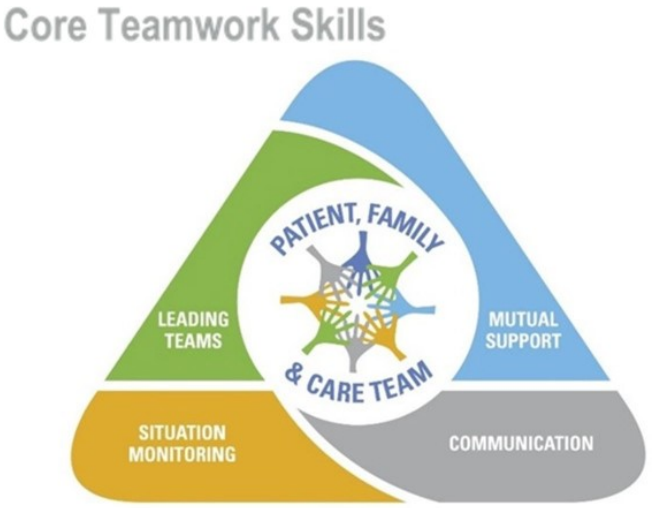
Metric needs improvement but root cause/solution unknown

Reduces variation

May be led by a Black Belt (BB) or Green Belt (GB) with BB mentor

TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety)

An evidence-based framework to optimize team performance across the healthcare delivery system. The core of the TeamSTEPPS® framework is comprised of Four Skills: Leadership Teams, Situation Monitoring, Mutual Support and Communication.



TeamSTEPPS® provides higher quality, safer patient care by producing highly effective medical teams that optimize the use of information, people and resources to achieve the best clinical outcomes for patients; increasing team awareness and clarifying team roles and responsibilities; resolving conflicts and improving information sharing; eliminating barriers to quality & safety.

TeamSTEPPS® is the structure of communication used at Naval Hospital Camp Pendleton

TeamSTEPPS Tools: SBAR & I-PASS

SBAR provides a framework for team members to effectively communicate information to one another. Communicate the following information:

SITUATION

What is going on with the patient?

BACKGROUND

What is the clinical background or context?

ASSESSMENT

What do you think the problem is?

REQUEST/ RECOMMENDATION

What would I recommend?

I-PASS the BATON

BETTER HANDOFFS. SAFER CARE.

I INTRODUCTION Introduce yourself & your role/job (include patient)	**B** BACKGROUND Comorbidities, previous episodes, meds & family history
P PATIENT Identifiers, age, sex, location	**A** ACTIONS Actions taken or required w/rationale
A ASSESSMENT Chief compliant, vital signs, symptoms & diagnosis	**T** TIMING Urgency & prioritization of actions
S SITUATION Current status circumstances, recent changes & responses	**O** OWNERSHIP Who is responsible? (nurse/doctor/family)
S SAFETY Critical lab values reports, allergies, alerts, falls, etc.	**N** NEXT Anticipated changes? Plan? Contingency plan?

Infection Prevention & Control

Located within Quality Management

4th Floor, Patient Admin Wing

What do we do?

Our aim is to prevent and reduce infections of those receiving and providing care at Naval Hospital Camp Pendleton and all outlying clinics.

Infection Preventionist (IP) Nurse- consultant, educate, train, surveillance, collaborate with multidisciplinary teams to keep our patients and staff safe.

During Command Orientation, we review:

§Hand Hygiene program

§Transmission-Based Precautions

§Healthcare Associated Surveillance

§Construction basics

§Bloodborne pathogen exposure

§Environment of Care & How to Clean (MIFU)

§How to access IC resources

§Visitors policy

Do you need to reach an Infection Control RN?

Call 760-719-3185 Quality Management Front Desk

Cleaning visible dirt and debris off surfaces is an essential first step to disinfection and sterilization.

Mixing chemicals can be dangerous. Always follow manufacturer's instructions for use (IFU) for the disinfectant you are using.

Always follow the manufacturer's instructions for use (IFU) for the device you are cleaning.

Cleaning is the removal of visible soil and dirt using a detergent in combination with friction, such as scrubbing.

Disinfection is the process of killing most pathogens on environmental surfaces that can cause illness. Disinfectants are used to combat various organisms.

cleaning
+
disinfection =
decontamination

Infection Control Improvement Opportunities

- Are the hand antiseptic dispensers in your area working and filled?
- Do you have approved disinfectant wipes available?
- Do you know the contact time (time the surface must remain wet) for the disinfectant that you are using?

Instructions for Use (IFU)—oneSource

WHY ARE IFU's IMPORTANT?

- Without the latest IFUs, you increase the risk of Hospital Acquired Infections.
- Eliminate the guesswork and the risk.
- Critical for patient safety.

oneSource is a search tool to find instructions for use. Access the oneSource link by clicking the tile on the NMCSD Intranet through Quick Launch. By typing the instrument's catalog/ model number or keywords, oneSource filters and finds the IFU you are looking for.

NOTE: Not all IFUs are listed in oneSource. Refer to your manufacturer.

MIFU (Manufacturers' Instructions for Use):
How to perform a specific task on the equipment, such as ef-fective cleaning and sterilization processes identified by the manufacturer.

Operators' Manual:
how to safely and appropriately operate the equipment.
Re-verify the correct model when searching for the MIFU and Operators' Manual.

https://search.onesourcedocs.com/login

Login: nhcp
Password: nhcp*24

Wipes & Contact Time

CaviWipes™ HP	CaviWipes™ 2.0	CaviWipes™ Bleach
CaviWipe HP: hydrogen peroxide-based disinfectant wipe offering fast (1 min), broad-spectrum efficacy against bacteria, viruses, and fungi. Ideal for high-touch surfaces and daily cleaning in healthcare settings.	CaviWipe 2.0: An upgraded, multi-surface disinfectant wipe (2 min) designed to offer improved compatibility with surfaces while maintaining broad antimicrobial activity, ideal for use in healthcare settings	CaviWipe Bleach: A bleach-based disinfectant wipe providing powerful germicidal action (3 min) against a wide range of pathogens, including C. difficile, making it suitable for critical areas requiring strict infection control.

Wipes & Contact Time

CONTACT TIME:
SURFACE STAYS WET FOR REQUIRED TIME

Hydrogen Peroxide	Germicidal Bleach	Multi-Surface Alcohol Quat
		
1 MINUTE For General Use	**1 MINUTE** For General Use	**2 MINUTES** For General Use

Do you know the contact time for the wipe you are using?

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

0 Wet hands with water;

1 Apply enough soap to cover all hand surfaces;

2 Rub hands palm to palm;

3 Right palm over left dorsum with interlaced fingers and vice versa;

4 Palm to palm with fingers interlaced;

5 Backs of fingers to opposing palms with fingers interlocked;

6 Rotational rubbing of left thumb clasped in right palm and vice versa;

7 Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8 Rinse hands with water;

9 Dry hands thoroughly with a single use towel;

10 Use towel to turn off faucet;

11 Your hands are now safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

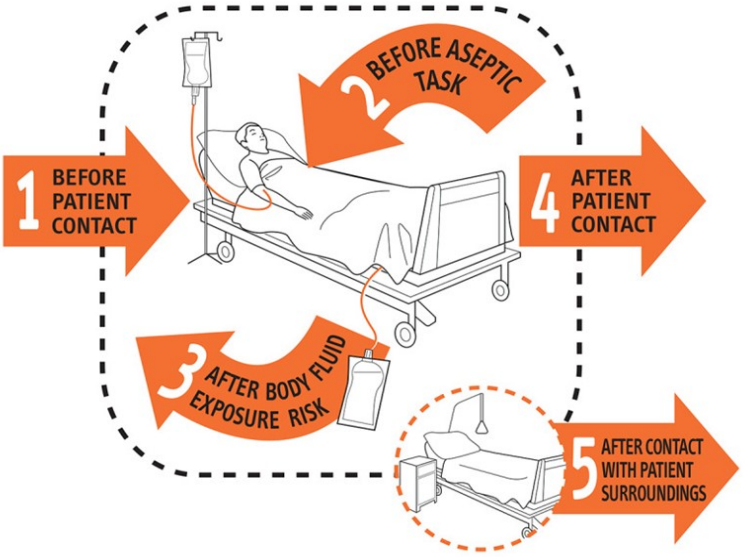
May 2009

When to use alcohol based hand rub as hand antisepsis?
When hands are not visibly soiled and
to reduce bacterial count on hands

1. Put product on hands and rub together
2. Cover all surfaces until hands feel dry
3. This should take around 20 SECONDS

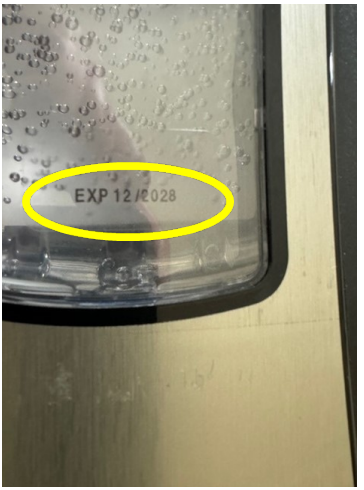
***When working with patients with known or suspected infections from spore-forming bacteria (e.g., Clostridium difficile) hands should be washed to physically remove spores from the surface of contaminated hands

5 Moments of Hand Hygiene



How do I know if the hand sanitizer is expired or not?

Peek through window to observe exp date



Exp date in bold writing 'EXP 12/2028'

Here at Naval Hospital Camp Pendleton, our hand hygiene policy extends beyond the staff who provide direct, face-to-face patient care.

Utilizing evidence based practice, we recognize that there are MANY opportunities to spread infection. Therefore this policy extends beyond patient facing staff for these reasons: the staff that work in dental labs making dentures, staff performing sterilization of reusable medical equipment, staff counting medication in the pharmacy or at a front desk exchanging personal identification cards, pens, clipboards, documents, etc.

Therefore we include all staff working in direct patient care, all types of ancillary support, individuals making or handling food, any individuals touching or making any objects that are given to or going into a patient. ***This policy does not apply to non-clinical administrative staff that do not interact or prepare items for patients.***

Definitions:

Artificial nails: Any type of artificial fingernail treatment aside from regular nail polish. Types include, but are not limited to, gel polish, wraps, acrylics, and dip powders.

√ Jewelry (watches and rings) should be removed prior to hand cleaning.

√ Artificial nails may not be worn by employees who provide direct patient care or who handle or prepare food or medications.

√ Natural nails should not exceed 1/4 inch from the fingertip. Polish may be worn when well manicured and not chipped.

√ When Gloving:

Perform hand hygiene prior to putting on gloves

Wear gloves when in contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur.

Change gloves during patient care if moving from a contaminated body site to a clean body site. Do not use the same gloves for the care of more than one patient.

Standard Precautions

An approach to infection control which treats all body fluids and substances as if they were infectious for Bloodborne Pathogens. Use of standard precautions is determined by nature of the patient interaction and extent of anticipated blood, body fluid, or pathogen exposure. In other words…"*treat all blood and body fluids as potentially infectious materials with appropriate precautions*".

Core Elements of Standard Precautions

√ Use of protective personal equipment (PPE): gloves, gowns, mask, and face shields.

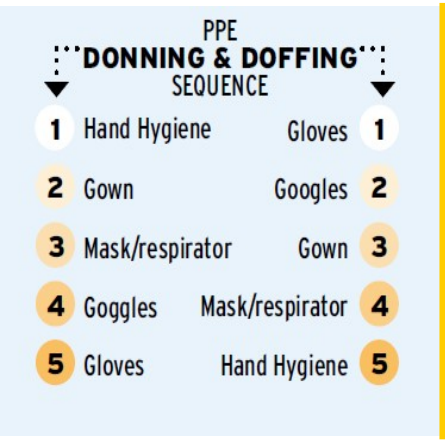
√ Aseptic technique, including appropriate use of skin disinfectants.

√ Personal hygiene practices, particularly hand-washing and hand hygiene, and cough etiquette.

√ Appropriate handling and disposal of sharps and clinical waste.

√ Appropriate reprocessing of reusable equipment and instruments, including appropriate use of disinfectants.

√ Environmental controls, including design and maintenance of premises, cleaning and spills management.



Eyewear = safety glasses with side protectors/goggles/face shields

Basic prescription glasses do NOT protect your eyes from splash, droplets, aerosol, etc.

Don’t feel stuck after needlestick, or splash

PREVENT INJURIES AND SP

Employers: Have
Staff: Spare
Use d
One r

CLEAN IMMEDIATELY.

Skin: Wash
Do no
Eyes, nose, mouth: Flush
Do no

REPORT EXPOSURES TO AN

exposures often require form
promptly to employer (direct

SEEK PROMPT TREATMENT.

providers can assess risk of i

REVIEW THE INCIDENT WIT

reduce the risk in the future.
evaluate different products fo

a sharps, injury.

LASHES.

PPE available.

e a second to wear PPE and wear it properly.

levices with sharps injury protection features.

needle. One syringe. One time.

affected area thoroughly with running water.

ot apply bleach or iodine. Do not squeeze or rub area.

well with water or saline.

ot use soap, antiseptics, or disinfectants.

N EMPLOYER. Follow post-exposure processes. On-the-job al follow-up procedures. Don't delay next steps—report t supervisors, managers).

Discuss the situation leading to the injury so healthcare nfection and treat accordingly.

TH YOUR EMPLOYER. Review what happened to help Determine how the procedure could be improved, and or safer alternatives.

APIC
Association for Professionals in Infection Control and Epidemiology

Infection Prevention & Control
Bloodborne Pathogens

What is Your Risk?

- Do you handle contaminated items or surfaces?
- Do you come in DIRECT CONTACT with blood, mucous membranes, non-intact skin?
- Do you perform vascular access procedures?
- If yes, then you are at risk for exposure to Bloodborne Pathogens.

BLOODBORNE PATHOGEN EXPOSURE PROTOCOL

FLUSH	F— Flush the site/FIRST AID
ALERT	A— Alert supervisor or charge nurse of exposed individual Note: Supervisor initiates reporting requirements
STRAIGHT	S— Report Straight to Emergency Department Triage Area Note: Staff assigned to Naval Health Branch Clinics and outlying clinics may initially report to a physician, nurse practitioner, or physician's assistant to avoid delays in treatment
TIMELY	T— Timely Treatment Goal

At Naval Hospital Camp Pendleton, the Bloodborne Pathogen Exposure Control Plan is updated annually by the Infection Prevention and Control Committee.

This Plan is found on the Command Sharepoint, Quality Mgmt page, under Infection Control. Each Dept Head is highly

When are Privacy Curtains Changed?

1. When visibly soiled or stained and following the discharge of an isolation patient

⇒Call Linen Operations:
⇒760 719-3226 (Operating Hours 0400-1500)
⇒After hours, contact the Housekeeping Supervisor 760 458-1756

2. On a routine schedule per OPMAN

⇒Contact Linen Operations for questions or concerns:
⇒760 719-3226

Need help contacting Housekeeping?
⇒OPMAN/Housekeeping:
⇒760 719-3932/3154
⇒Operations Management DH
⇒760 725-0618

Infection Prevention & Control

Sterility & Peel Packs

STERILITY

Per MIFU—Considered sterile until use *unless*:

♦Moisture ♦Dust ♦Package Integrity

PEEL PACK CONSIDERATIONS

- Expiration date of supplies BEFORE sterilization
- Utilize tip protectors
- Chemical Indicator in EVERY peel pack
- Stored appropriately
  -Not under sink or crowded
  Into storage bin
  - Environmentally controlled conditions
  - Minimize handling
- Adhere to FIFO
  (First In – First Out)
  inventory management

CHECKLIST BEFORE USE

- ❑ Package integrity: No dust, evidence to moisture, package still sealed/not punctured.
- ❑ Type 5 chemical integrator in each peel pack that has changed to indicate successful steam exposure.
- ❑ Load sticker on each peel pack.
- ❑ If any of the above items are missing/compromised, or the peel pack was exposed to an Aerosol Generating Procedure (even if not opened):
  DO NOT USE and return to SPD for reprocessing.

Infection Prevention & Control

Sterility & Peel Packs

CHECKLIST DURING/AFTER USE

A sterilization pouch, or peel pack, is used for lightweight, low-profile instruments or medical devices.

⇒ During Procedure – Wipe instruments/flush lumens with H2O (NOT Saline) to prevent buildup and drying of bioburden.

⇒ Remove disposable sharps or single-use items and dispose of appropriately

Perform the following POU treatment steps inside exam/ patient room OR transport to designated soiled utility room

. Open all hinged instruments and fully disassemble multi-part instruments.
. Wipe instruments and flush lumens with H2O. (NOT Saline)
. Place contaminated instruments in approved biohazard transport container.
. Remove gloves, perform hand hygiene, don clean gloves.
. Apply Prepzyme Forever Wet enzymatic spray directly onto instruments with 5-6 sweeping sprays. (If enzymatic is contraindicated – cover instruments with water-moistened [NOT Saline], single- use, lint- free, absorbent wipe).
. Remove all PPE and perform hand hygiene.
. Close and latch biohazard transport container and transport to decon area of SPD as soon as reasonably possible.

. 

Proper Pre-Cleaning and Transportation of Steel Clinical Instrumentation to SPD

Proper Pre-Cleaning and Transportation of Steel Clinical Instrumentation to SPD

- **Wear PPE**: perform proper hand hygiene/properly don/doff appropriate PPE.
- **Immediately after use**: remove gross debris/wiping them with a damp cloth or using a sterile water rinse.
- **Separate sharp instruments**: handle instruments care fully/ keep delicate instruments separate in red bin.
- **Keep instruments moist**: if immediate cleaning is not possible, keep instruments moist with enzymatic spray or a moist towel to prevent organic material from drying.
- **Prompt transport for reprocessing:** As soon as possible, transport soiled instruments in puncture-resistant labeled biohazard containers with lid secured to SPD Decontamination Rm 2499.

Instruments dropped times 0700 -1100 & 1330 - 1600. Complete with SPD staff Request for Sterilization form. SPD Duty Phone: (760) 696-8027

Supply Storage & Infection Control

- Environment: Clean, Organized, Environment-Controlled
- Store similar items together
- Sterile with sterile
- Clean with clean
- Or segregate with dividers/containers (non-porous)
- Rotate first in, first out
- Store liquids on bottom shelf (or in containers that will hold the volume of the primary container)
- Shelving: 6-8 inches off the floor, 12-18 inches below ceiling (away from vents, sprinklers, lights), 2 inches from outside wall
- Open racks: bottom shelf must have a liner/solid bottom

Do Not Store peel packs or reusable medical equipment supplies in an uneven manner that could penetrate the packaging, thus compromising the sterility of the equipment.

Do Not Store boxes, supplies or equipment on the floor.

Remove supplies from corrugated shipping boxes immediately and dispose. Why, you ask?

Shipping boxes can contain pests

Supply Storage & Infection Control

This supply room is clean, organized, nothing is on the floor and supply items are within the correct distance from ceiling. (18 inches)

Underneath these supply bins is a hard plastic shelf that protects the supplies from back-splash and can be wiped down.

Environmental Health & Safety

Cylinder Status

- Cylinders should be segregated and properly tagged.
- "FULL" and "IN USE" and "EMPTY" O_2 cylinders must be clearly segregated (separate rack, separate area, or separate room)

FULL	IN USE	EMPTY
Sealed	No Seal	No Seal
No Regulator	May have regulator on	No Regulator
Tagged as FULL	Tagged as IN USE	Tagged as EMPTY
		

O_2 Adaptors

O_2 adaptors are for single use/single patient use ONLY.

Fit Testing

Any staff whose duty require entering a room with patients on airborne precautions is required to be enrolled in the Respiratory Protection Program. Contact the Respiratory Protection Program Manager in the Safety Office for more details: (760) 725-1486

IMPORTANT SYMBOLS

Expiration Date

Do not use products or medications past their expiration date.

Develop a process for recognizing when products and medications will expire and what to do if they are close to expiration.

What to do if there is only a month and year for expiration?

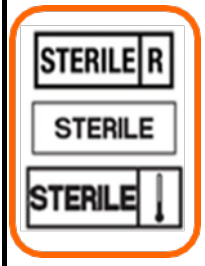
Good until the END of the month

Manufacturer's Date

Indicates when the device/ product medication was manufactured

Single Use

Only use item/product once then dispose of it

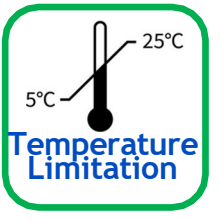


Sterile (Manufacturer's Sterile)

Sterilization destroys all microorganisms on the surface of a product or in a fluid to prevent disease transmission associated with the use of that item. The use of inadequately sterilized critical items represents a high risk of transmitting pathogens

Many ways to sterilize items:

-moist heat (steam), dry heat, radiation, ethylene oxide gas, vaporized hydrogen peroxide



ECG ELECTRODES

Dispose of all ECG Electrodes 30 Days after opening.

Store Open ECG Electrodes in a resealable container labeled with disposal date.

Ultrasound Gel

Sterile and Non-Sterile Ultrasound Gel General Guidance

Background: Outbreaks due to bacterial contamination of ultrasound gel have occurred, and therefore infection mitigation strategies shall be implemented in order to minimize risk associated with its use.

Sterile Ultrasound Gel

- Invasive Procedures where a needle or device passes through tissue.
- Ultrasound examinations or procedures preformed on non-intact skin or near fresh surgical sites.
- All ultrasound examinations preformed on neonates.

Use Single-patient single-use sterile gel packets; discard after one use
Examples: ultrasound-guided peripheral IV insertion, ultrasound guided biopsy, joint injections, needle aspirations.

Non-Sterile Ultrasound Gel

- One opened, **label the bottle with a 28 day expiration** or the manufacture expiration date, whichever comes first.
- Avoid direct contact between the tip of the bottle and any person, instrument or the transducer.
- Can only be used on intact skin
- Do not refill or top off bottles
- **Discard if contamination is suspected or bottle is opened and undated.**

Warming of Ultrasound Gel

⇒ If used, follow MIFU for the warmer
⇒ Do not store gel bottles upside down

Shelf Life and Storage of Aquasonic Ultrasound Transmission Gel info can be found at: https://aquasonicgel.com/blog/shelf-life-and-storage-of-aquasonic-ultrasound-transmission-gel/
POC information for the Infection Prevention and Control team can be fount on the IPC Share Point site: https://nmcsdasintra05.med.ds.osd.mil/sites/cs/qm/IPaC/SitePages/Home.aspx

Pain Management

Pain assessment is completed in primary or specialty care

Pain Assessment Must be Conducted...

- Upon admission to the hospital or each outpatient visit
- After all operative or invasive procedures
- Periodically and/or routinely after procedures associated with pain (e.g. every 5 minutes or 4 hours, if indicated)
- After any significant change in the patient's condition
- Patient's response to therapy (i.e. within 1 hour following any pain intervention)
- Prior to discharge

Pain Assessment, Reassessment, and Documentation

- Identification of pain—how does the patient describe the pain and where does the patient localize the pain
- Assessment & measure of pain—use of pain rating scales for the appropriate age and population
- (examples: children, elderly, cognitively impaired)
- Intensity and quality (character, frequency, location, duration, aggravating and alleviating factors, and symptoms)
- Note vital signs
- Responses to treatment — both pharmacological and non-pharmacological treatments
- Reassessment after treatment and at regular intervals
- Reassessment should focus on the effectiveness of therapy, any side effects caused by therapy, identifying the cause of pain, and developing or modifying the pain therapy plan as appropriate
- Consider consultation with a specialist if treatment fails.
- Written and verbal pain management information will be provided at the time of discharge

Environmental Health & Safety

Eye Wash and Emergency Shower Stations

Eye wash and shower stations must be:

- Unobstructed
- Have protective covers in place
- Tested and logged weekly by the department in which they are located

EYEWASH TEST

- Activate eyewash long enough to flush the line and ensure proper operation (30 second minimum)
- Look for clean and even water streams.
- Document discrepancies in eyewash log and submit work request for repairs.
- Safety Office temperature tests eyewashes annually for 60-100 degree F window.

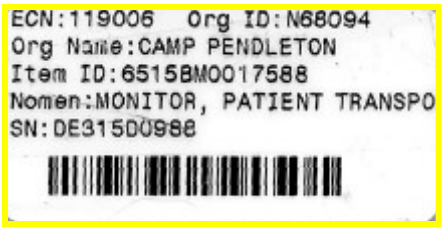
Did you know that…

Positive pressure rooms allow air to flow **OUT** of the room instead of in so that any airborne micro-organisms are kept away from the patient. **Negative pressure rooms** maintain a flow of air **INTO** the room keeping contaminants and pathogens from reaching surrounding areas.

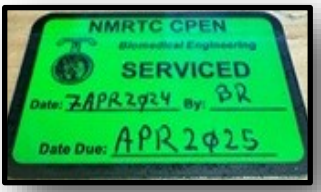
Equipment Safety Check

Is Your Equipment Safe for Patient Care Use?

- **Does your medical equipment have an Equipment Control Number (ECN)? *If missing ECN*, contact** Property Management 725-1610



- **Is your medical equipment's Preventive Maintenance (PM) sticker current?**
- **Verify Date & Due Date are current on PM sticker.**
- ***If expired or missing, contact:***
  Biomedical Division
  760-719-3726



- **Do you have equipment with overdue Preventive Maintenance? How do you take it out of circulation?**
- **Contact BIOMED 719-3726 immediately to have Preventive Maintenance conducted on the equipment. If the equipment cannot be taken out of the work space, coordinate with BIOMED to have a DEFECTIVE sticker with the following information:**

⇒ **Date**
⇒ **Technician Initials**
⇒ **Workorder Number**
⇒ **Description of the problem**
⇒ **Status**

Equipment Safety Check

- **Who do you contact in case of malfunctioning medical equipment?**
  BIOMED 760-3726
  BIOMED DUTY After Hours 442-288-9323
- **How do you take it out of circulation?**
- **How is it marked?**

Submit DMLSS trouble ticket and contact BIOMED immediately to have the equipment inspected. If the equipment cannot be taken out of the work space, coordinate with BIOMED to have a BMET place a DEFECTIVE sticker with the following information:

Date
Technicians Initials
Workorder Number
Description of the Problem
Status

- **Who do you contact if medical equipment failure injures a patient or staff member?**
- **What to do in case of medical equipment failure or injury:**

1. Notify Patient Safety/Risk Management at 532-9377 and BIOMED 760-719-3726.
(BIOMED DUTY After Hours) 442-288-9323

2. Submit PSR and sequester the equipment and keep it removed from service.

3. Do not change any of the configuration settings.

4. Do not allow the vendor access to the equipment.

- **Who do you contact for user training on a piece of new medical equipment?**
  BIOMED or Manufacturer/Vendor Representative via BIOMED 760-719-3726

Emergency Management & CODES

The NHCP Emergency Management Procedures contains action information for command emergency codes.

Are you wearing your Emergency Code Badge?

EMERGENCY CODES

All staff and students at NHCP are responsible for maintaining a safe work environment. It is important to keep yourself informed and aware of the NHCP Main Hospital emergency codes and their appropriate responses. Phone numbers for Emergency Codes are listed on hospital and clinic Emergency Code Badges.

TIP Your Employee Hospital Badge is a valuable resource for the above information.

NHCP Main Hospital Emergency Codes	
PINK	Infant/Child Abduction
GREEN	Combative Person
GRAY	Mass Casualty Event
BLACK	Bomb Threat
ORANGE	Hazardous Material Spill
SILVER	Child/Adult LOST/ELOPED
WHITE	Armed Intruder/ Active Shooter
YELLOW	Utility Failure
MAGENTA	Radiation Event
BLUE	Medical Emergency
PURPLE	OB/Neonatal Emergency
RED	Fire

Emergency Management & CODES

CODE PINK—INFANT/CHILD ABDUCTION

All Clinical Departments are required to have an SOP directing actions in the event of a missing or stolen newborn, infant, or child (up to age 18).

What actions do you take in the event of a missing newborn, infant, or child?

_____

For NHCP inpatient and main hospital :

1. Only staff with a Red Heart on their command ID badges may transport newborn/pediatric patients without parent/guardian.
1. In the event a newborn/infant/child cannot be accounted for, Activate Code Pink by calling: NHCP Command Code Number at 725-1222 Provide a description of the patient and suspected abductor, if known.

3. Block all exits IAW Code Pink procedures..
4. Check all bags and containers large enough to carry an infant. If they attempt to leave the facility, do not put yourself in harm's way - contact Security.

Emergency Management Procedures

CODE SILVER—LOST OR ELOPED ADULT

1. Code Silver is called when an adult or child is lost/ eloped.
2. Perform a rapid search of the local area at NHCP.
3. Dial Command Code Number, 725-1222. Describe the person, where they were last seen, what time they were last seen, their medical condition, and location headed (if known).
4. Security will respond to the scene.

Emergency Management & CODES

CODE GRAY— DISASTER

Emergency Management Procedures

1. Contact the NHCP Command Code Number at 725-1222.
2. Code Gray will be announced along with the nature of the casualty (Ex. incomming wounded)
3. Activate the Hospital Command Center (HCC)
4. Emergency responders report to their assigned locations.

CODE BLACK—BOMB THREAT

Bomb threats usually come in by telephone.

If you receive a bomb threat or any type of threatening phone call, DO NOT HANG-UP!! Listen carefully to the caller and obtain as much information as you can.

ASK... 1) ***When*** *is the bomb going to explode?*
2) ***Where*** *is the bomb located?*
3) ***What*** *kind of bomb is it?*
4) ***What*** *does the bomb look like?*
5) ***What*** *will cause the bomb to explode?*
6) ***Where*** *are you calling from?*
7) ***What*** *is your name? Address?*

- IMMEDIATELY NOTIFY:
  Quarterdeck at 725-1222 and Security at 725-1602
  Your supervisor and standby for further instructions.

- You will be notified by the command/and or your immediate supervisor if you need to evacuate. In that event, use the primary route for your area.

Emergency Management & CODES

- You have the "*Right to Know*" what hazardous materials you work with and/or are exposed to in your area. This includes any material that is labeled flammable, corrosive, poison, or irritant and should be approached with caution.

- Safety Data Sheet (SDS) is a required Fact Sheet on **ALL chemicals** used in your area.
- **ALL containers must be clearly labeled** as to their content and hazards.
- SDS are typically kept in a binder or manual in your area.
- **The SDS Manual in your area is located:**

CODE ORANGE—HAZARDOUS MATERIAL SPILL

What should you do if you have a hazardous spill in your area?

1. If the spill is small (less than 5 gallons) and can be cleaned by qualified personnel on site while not posing a threat to personnel or the environment, Refer to SDS!!
2. If a spill is major, evacuate all personnel and seal off the area as best as possible—call the NHCP Command Code Number at 725-1222 and do not re-enter the area.
3. Obtain SDS sheet if aware of chemical content.

Ref. Materials, Hazardous Drugs or searched online at:

https://chemicalsafety.com/sds-search/

Emergency Management & CODES

CODE STROKE

- Code Stroke is the emergency response mechanism for patients with stroke-like symptoms.

At NHCP:
Activate Code Stroke Team

- Dial 725-1222 from desk phone or (760) 725-1222 from cell phone to activate NHCP Code Stroke team.

CODE PURPLE—OB/NEONATAL EMERGENCY

- Code Purple is the emergency response mechanism for an OB patient emergency.

At NHCP:
Activate CODE PURPLE Team

- Dial 725-1222 from desk phone or (760) 725-1222 from cell phone to activate NHCP Code Purple team.

CODE WHITE

- Code WHITE is the emergency response mechanism for an armed intruder/active shooter.
- **Call 911 immediately**
- When/if able dial the quarterdeck 725-1222 or security 725-1602

Physical Action Plan:

1. **Run/escape - Escape is first priority if possible.**
2. **Hide - If you cant escape, shelter in a locked space.**
3. **Fight - Only fight the intruder as a LAST RESORT!**

Emergency Management & CODES

CODE BLUE—CARDIAC/RESPIRATORY ARREST

1. Initiate **Basic Life Support (BLS)** Measures
2. Call for Help

- **At NHCP:**

  Activate CODE BLUE Team
  - **Dial 725-1222 from desk phone or (760) 725-1222 from a from cell phone to activate NHCP Code Blue Team**
  - Specify adult or pediatric code
  - Give exact location: **Floor, Unit Name, Room**
  - Give the **phone number** you are calling from
  - State **your name**
  - Stay on the phone until told to hang up.

- **At Naval Health Branch Clinics:**

  INITIATE EMS
  - Pick up phone and verify dial tone
  - Dial 991-911 from desk phone or 911 from cell phone
  - Specify adult or pediatric code
  - Give exact location: Building, Floor, Unit Name
  - State your name
  - Give the phone number you are calling from and remain on the phone until you are told to hang up by EMS dispatch

NHCP-PI 6025.06

CODE RED—FIRE PROCEDURES

Inspirations., Healthcare. *Race/Pass Fire Safety Sign*, healthcareinspirations.com/hci_fe03_single_quantity.html?prodid=426.

What do you do in the event of a fire?

_____

Where is the nearest extinguisher and pull box?

_____

In an EVACUATION—where does your dept. muster?

_____

Emergency Management & CODES

RRT—RAPID RESPONSE TEAM

- The RRT program provides early recognition and rapid intervention on hospitalized patients with evidence of deteriorating clinical conditions in an effort to improve outcomes and reduce the possibility of cardiac and/or respiratory arrests.
- The RRT can be activated by **any** staff when **any** element on the RRT call parameter list is met.
- Family members may request that an RRT be initiated.
- The RRT will assess, treat, stabilize, and when needed, transfer the patient to a higher level of care.

At NHCP:
Activate RRT

- **For inpatient RRT, call the quarterdeck emergency line:** (760) 725-1222
- Activates the team via AtHoc message and 1MC.

****All instances of rapid response calls are reviewed for quality assurance in collaboration with the Cardiopulmonary Resuscitation Committee and Quality Management.****

NAVHOSPCAMPENINST 6320.4 Series

H.E.A.R.T.

Hear what the person is saying

Empathize with the person's concern

Acknowledge the patient's concern

Review the details

Take responsibility for follow-through

A Living Will or Advance Directive/DNR

An Advance Directive allows patients to decide how to handle health decisions in the event of a life-threatening condition or terminal illness. Examples of Advance Directives include: A Living Will or Durable Power of Attorney. Witnesses for these documents cannot be hospital employees.

HOW ARE PATIENTS INFORMED OF THEIR RIGHTS REGARDING ADVANCE DIRECTIVES?

Upon admission, same day surgery pre-admission, or at the patient's request, patients who are 18-years of age or older, are given information which includes their rights under California law to accept or refuse medical or surgical treatment and to formulate an advance directive.

If the patient has already executed an advance directive, the patient should provide a copy at the time of admission.

Inpatient staff should document follow-up reminders to family of patients who do not bring a copy of the advance directive upon admission.

DO NOT ATTEMPT RESUSCITATION

In a life-threatening emergency, all inpatients will receive full life-sustaining therapy unless otherwise ordered by a resident physician (PGY-2 or higher), nurse practitioner, physician assistant, or staff physician after discussion with patient/family.

Patient resuscitation options include:

Full Code—Code Blue, Rapid Response Team (RRT)
Continue Life-Prolonging Treatment-No Code Blue
Comfort Measures Only—No Code Blue, No RRT

NAVHOSP CAMPEN INSTRUCTION 6320.92F

Translation Services

For our patients that are hearing impaired or blind:

During daytime hours
contact patient relations (760-725-1436)
After hours contact the CDO (760-685-3537)

For our patients that are non-English speaking:

Language Translation Services
During daytime hours
contact patient relations (760-725-1436)
Or the Quarter Deck (760-725-1288)
After hours contact the CDO (760-685-3537)

- Patients in the outpatient or inpatient area needing assistance with language or translation services due to disability (deaf or/and blind) are entitled to these covered services (Patient Bill of Rights)
- The services may be virtual or in-person, depending on the need
- Additional support person(s) or caregivers in the outpatient or inpatient area needing assistance with language or translation services due to disability (deaf or/and blind) are also entitled to the same services
- Be cautious not to assume all hearing impaired persons use American Sign Language to communicate.
- The service is billed by the minute, it is important to document in a clinical note and report it to the quarter deck to log

NAVHOSPCAMPENINST 6320.100E is our hospitals written guidance for establishing effective communication with our patients and families, located on command Sharepoint.

Healthcare Resolution Program

Office Phone: 760-719-3207
Mobile Phone: 760-846-3209
https://info.health.mil/sites/dadma/hr/pages/home.aspx

Anyone (leadership, quality, providers, patients, family, etc) can directly refer cases to any Healthcare Resolutions Specialist (HRS). Healthcare Resolutions processes are confidential to the extent permitted by law. HRS's do not report individual cases to Quality or leadership without permission of involved parties.

Mission

Promote a culture of High Reliability, by facilitating and providing interventions that emphasize organizational transparency through full disclosure of unanticipated or adverse clinical events, and restore trust and healing through conflict resolution.

Vision

To be the designated neutral cornerstone for resolving clinically-related conflict by capturing every opportunity for engagement and fostering meaningful resolution through a non-legal venue.

The Healthcare Resolutions Program

- Assists organization in timely, compassionate disclosures at time of unanticipated outcomes of care, treatment, and/or services
- Promotes organizational transparency and integrity with full disclosure, recognition of system vulnerabilities, and a commitment to process improvements
- Attempt to resolve complex healthcare issues at the earliest opportunity, in a compassionate, non-judgmental setting with equitable resolutions for patients, providers and organization
- Serves as an early warning mechanism providing feedback regarding emerging issues
- Provides emotional first aid and other support to involved staff through peer support efforts

Healthcare Resolution Program

PROGRAM GUIDING PRINCIPLES

Confidentiality

Your identity is never revealed without your explicit consent

Neutrality and Impartiality

We do not take sides in a dispute and strive to achieve the best possible outcome for all

Independence

Program operates throughout all levels of military medicine and interact with all involved parties

Informality

Non-legal proceedings, non-adversarial, problem solving processes are employed to resolve healthcare issues. Working with Healthcare Resolutions does not limit a person's right to pursue a formal legal process.

Consult for:

- Unanticipated outcomes of care
- Wrong site/wrong patient procedures
- Elevation of care caused by hospital conditions
- Expected or unexpected deaths
- Patient dissatisfaction with treatment outcomes or quality of care
- Poor patient-provider interaction or communication
- Appropriate patient disengagement without abandoning patient care
- Delayed diagnosis
- Medical/medication errors
- Sentinel Events

Staff Knowledge Check

If you do **not** know the answer, avoid making one up. It is ok to say "I do not know" or "I am not sure of that answer but I know who to ask"... You do not have to know everything!!

Where can you find Naval Hospital Camp Pendleton's policies?
Answer: The hospital policies can be found on the intranet site (SharePoint). Look to the far right of the SharePoint home screen under "Common Use Sites". Click the button labeled "Standard Operating Procedures (SOP's)".

What is Naval Hospital Camp Pendleton's Mission?
Answer:
To Serve those that serve(d) and to generate and deploy Ready Medical Forces.

What is Naval Hospital Camp Pendleton's vision?
Answer:
Be the hospital of choice for our Marines, Sailors, their families and beneficiaries.

What is the policy on use of cell phones?
Answer:
Personal cell phones are not to be used within customer service areas. This includes, but is not limited to, inpatient area, patient administration, customer service areas, Human Resource Department, etc.
Personal cell phones may be utilized in lounges, break rooms, or in an emergency situation. VISUAL IMAGERY AUDIO RECORDING DEVICES AND MEDIA POLICY 5291

How are patients informed about their rights and responsibilities?
Answer:
The Patient Bill of Rights and Responsibilities is posted on the SharePoint, internet, and clinical areas of the hospital.

What would you do if your patient was showing signs that they are at risk for suicide?
Answer:
Suicide/safety precautions will be initiated immediately. If outpatient, the correct action is to stay with the patient, notify a provider immediately and escort to the emergency room. If inpatient, stay with the patient, and notify an RN or Physician immediately.

Staff Knowledge Check

What is the hospital policy on photography?
Answer:

Primary Policy: Defense Health Agency Administrative Instruction 6000.02 dated August 5, 2022

• Personal electronic devices are now pervasive, posing an ongoing risk of accidental or intentional breach of privacy and security.

• Images taken from a distance or at a wide angle are permitted without consent only when it is impossible to determine an individual's identity in the image – a determination that must take into account the potential use of facial recognition or other biometric identification – and only when no patient identifiers are captured in the image.

We have a process by which to obtain photos or recordings. They can be made with authorization of the individual and with the correct process and documentation.

Recordings where a patient is identifiable can be made for the following three reasons:

- For the diagnosis and treatment of medical conditions.
- For the purpose of professional education, board certification or licensure.
- For the advancement of science & research.
- Speak to command Legal for questions/concerns.

Staff shall:
- Use government owned or procured recording devices.
- If impracticable or unfeasible to use government procured device, obtain appropriate authorization before using personally owned device.
- Document on DD Form 2870, Authorization of Disclosure of Medical or Dental Information, how the recording will be used.
- Inform leadership of violation where patient/family member/legally authorized representative/visitor violates the policy for appropriate action.

What would you do if MHS Genesis, our electronic health record went down?
Answer:
Paper Downtime forms are available in all patient care areas. Scheduled down times are announced in advance to avoid disruption in care.

Staff Knowledge Check

How do you treat and transport soiled instruments to SPD for reprocessing?

Answer:

- Using proper PPE, and sterile technique if required, remove gross bioburden from the instruments with water.
- All instruments are opened and visible bioburden is removed.
- Instruments are placed open in a red biohazard labeled instrument transport bin.
- Instruments are thoroughly coated with Enzymatic Cleaner (I.e. PreKlenz or Blu 42)
- The lid is secured and instruments are transported to the dirty side of SPD.

How do you obtain accurate guidance on how to clean a piece of equipment?

Answer:

— Refer to the Manufacturer's Instruction For Use (MIFU) online at onesource/docs.com the log in is "nhcp" and password is "nhcp*24".

— Know what bacterial/virus/spore you are cleaning and ensure that amount of contact time is adhered. (C. Diff versus TB versus MRSA)

Does your hospital have a standard list of prohibited abbreviations?

Answer:

Yes. A list of prohibited abbreviations is posted in all medication and vaccine storage areas.

What is staff expected to do if an unauthorized abbreviation is used in a medical record?

Answer:

If you find an abbreviation in the medical record by another member of the patient care team and you do not know what it is, STOP and do not GUESS.

Get clarification by calling the individual who wrote the note or order

Enter a note in the medical record with the correct information before patient care proceeds.

Abbreviations can harm patients.

Staff Knowledge Check

How do you report a workplace violence incident?

Answer: Per our workplace violence policy, all incidents involving workplace violence will be reported via the PSR system in addition to any required security or safety reports. These reports are provided to the workplace violence prevention team for analysis and reporting.

The National Institute of Occupational Safety and Health (NIOSH) defines workplace violence **as ANY assaultive, threatening, or abusive behavior that occurs in the workplace or while on duty**. In other words, any aggressive behavior that causes you to fear in the workplace context.

How do you properly identify a patient before all interactions from bringing a patient to a clinic room to administering medications, treatment, or blood products?

Answer:

Always used 2 patient identifiers, examples are:

- Name
- date of birth

How are critical patient test results communicated? How are they managed and documented?

Answer:

The ordering/responsible provider; if not available, then the registered nurse for the ward or clinic of the ordering physician. After hours or on weekends/holidays, critical values are to be received by the Medical Officer of the Day (MOOD).

The notification process is to take no longer than 30 minutes from the confirmation of result by the testing department to communicating the critical result/value to the ordering provider, Registered Nurse, or MOOD.

Staff Knowledge Check

What do we do to take extra care with patients who take medication to thin their blood?

Answer:

Physicians partner with pharmacists and nurses to reduce the possibility of adverse events associated with anticoagulation therapy by following the hospitals "Reducing Harm from Anticoagulation Therapy Policy."

How does the command ensure that alarms on medical equipment are heard and responded to on time?

Answer:

A hospital alarm management policy is in place to standardize safe alarm system management throughout the hospital.

How do you screen patients for risk of suicide?

Answer:

On admission or during an encounter, patients are screened for risk. If identified as "at risk," consults are placed to social work and psychology for an in-depth assessment.

What would you do if your patient was showing signs of suicide risk?

Answer:

Suicide/safety precautions will be initiated immediately. These precautions include a 24 hour 1: 1 observation of the patient.

What do you do if a patient is suspected of being a victim of abuse?

Answer:

Contact the social work department ASAP at (760) 725-1318. Each department is assigned a specific social worker and he/she or the healthcare provider is responsible for reporting the suspected abuse to appropriate agencies.

What is the purpose of medical reconciliation?

Answer:

This process is intended to reduce the risk medication duplication and adverse reactions that were prescribed in our facility and the drugs/vitamins/therapies the patient was already taking. Patients may access their up to date medical reconciliation on their MHS Genesis patient portal and the patient leaves the facility with a current printout of their prescribed medications.

Staff Knowledge Check

Why do we have to perform pre-procedure verification before invasive procedures?

Answer:

It is another way to check that the correct patient is getting the correct procedure at the correct place on the patient's body. Staff verify they have the correct procedure and site of the patient when the patient is scheduled, assessed, or admitted for procedure. Items that are checked include a signed consent form, H&P, and anesthesia assessment as well as any necessary imaging studies.

What for elements must be included in any timeout before an invasive procedure?

Answer:

- The "Universal Protocol" checklist is used.

Everyone in the room STOPS what they are doing to verify and agree on:

- Patient identity
- Correct site
- Laterality if applicable
- Correct procedure

How is the patient's pain assessed?

Answer:

All patients' pain scores are assessed on initial assessment/ admission using the FACES or numerical rating scale. Reassessments are made after procedures, interventions, or any significant change in the patient's condition.

Where are pain assessments documented?

Answer:

Within the vitals portion of outpatient notes and with vitals assessments during hospitalizations.

What are the 6 rights for medication safety?

- Right medication
- Right dose
- Right time
- Right route
- Right patient
- Right documentation
    - BONUS—Right follow-up after intervention!

Staff Knowledge Check

What options are available to prevent the use of restraints in agitated patients?

Answer:

Providing companionship, diversionary activities, decreasing environmental stimuli, assessing patient for pain, attending to physical needs such as nutrition or hydration, 1-1 care, or verbal redirection.

When are the patient and family education needs determined?

Answer:

Initially at the time of admission or during intake at outpatient clinic appointments.

When is discharge planning initiated?

Answer:

Upon admission and continues throughout the hospital stay.

How do you assure a patient understood what you taught them?

Answer:

Through teach-back. The patient demonstrates the required skills and is able to explain the concepts in their own words. This teaching is documented in the medical record.

How do you assure look-alike and sound-alike medications are not given in error?

Answer:

A look-alike sound-alike (LASA) list is posted in all medication and vaccine storage areas.

Staff Knowledge Check

What are high alert medications?

Answer:

Drugs that bear a heightened risk of causing significant patient harm when they are used in error or are involved in a high percentage of errors/sentinel events. A list of high alert medications (HAM) is
posted in all medication and vaccine storage areas and disseminated to all staff.

Are patients allowed to self-administer medications while admitted to the hospital?

Answer:

Yes. Only medications that cannot easily be obtained by the facility may be allowed to be self-administered. A providers order must be in place prior to use. The inpatient pharmacy must be contacted for disposition on how the medication will be stored and dispensed to the patient. Medications cannot be stored at bedside except in a locked, secure storage device.

Do you have to clean the rubber needle port of a new vial if the flip-cap has just been removed?

Answer:

YES. The vial diaphragm (rubber port) is not sterile. The plastic ls simply a “dust cover.” The diaphragm must be cleaned with 70% isopropyl alcohol or other approved antiseptic swab.

What is the safety data sheet (SDS) and where is it located?

The Safety Data Sheets are provided by the manufacturer of a product. They include important information for each chemical such as: chemical identity, characteristics, health hazards, first aid/ emergency measures and procedures for clean-up and safe handling.

Know where yours is located. SDS is in a known location in each clinic/space.

Staff Knowledge Check

Are multidose vials allowed to be used?

Answer:

Yes. A multidose vial must be clearly marked with a beyond use date of 28 following in use and stored in secure areas away from direct patient care. Vaccines are an exception to this rule. Vaccine beyond use is based off manufacturer's packet insert.

What do you do when an actual or potential adverse event or medication error occurs?

Answer:

- Notify members of the team caring for the patient and the patient's attending physician.
- A PSR will be placed to document this event.

What has your hospital done to reduce the risk of medication incidents?

Answer:

- We limited the number of medication concentrations available on each unit.
- Double check requirements implemented for high alert medications
- All patients are identified using two unique identifiers prior to medication administration.
- A list of do not use abbreviations and symbols are posted in all medication storage areas and disseminated to all providers.
- Look alike and sound alike medications have been identified and a list is posted in medication storage areas and disseminated to all providers

What does not mean to ask a patient what their preferred language is?

Answer:

The preferred language is the language that the patient wants to receive their medical information.

How do you obtain interpreter services?

Answer:

The language services line via the command duty officer (CDO) at the Quarter deck, Patient Relations can assist with coordinating as well.

Staff Knowledge Check

Who can request an ethics consult?

Answer:

Patients, family members, our any caregiver involved in the case.

Does patient have a right to refuse treatment?

Answer:

Yes. Patient and family involved in care decisions is encouraged including the right to refuse care.

What services are available to assist communication with hearing-impaired/deafened?

Answer:

Sign language interpreting service is provided by Deaf Community Services of San Diego (DCS), Monday through Friday 0730-1600. This can be arranged by contacting patient relations at 760-725-1436. After hours, contact the Officer Of the Day (OOD) to arrange services.

If a patient or family member has a complaint, how do you assist them?

Answer:

- Patients may submit an ICE complaint via the intranet.
- camp-pendleton.tricare.mil à click "Contact Us" à click the link under patient relations.
- Patients may share their concerns with the joint commission on line (www.jointcommission.org), via fax(630-792-5636), or via mail.

What is "We Ask Because We Care"?

Answer:

Naval Hospital Camp Pendleton (NHCP) is asking more information about race, ethnicity, preferred language, and other social information. What you share is private and protected by law. It is kept in your medical record.

We ask because this is a way for us to know our patients better. We are asking more detailed questions to help us meet the needs of all of our patients. The patient does not have to answer these questions, it is their choice. We ask because we care about all of our patients.

The answers will give us more data. It gives us more information about our diverse patient population, and will help us to improve the quality of care we give to each patient.

Staff Knowledge Check

Why is collection of patients' race, ethnicity and other demographic information important?

Answer:

Data currently available on patients' race, ethnicity and primary language are limited or inaccurate. This data is critical to documenting our progress in the elimination of disparities in health care and improving the quality of care.

When should you clean your hands?

Answer:

- Before and after contact with patients.
- Before and after wearing gloves.
- After contact with blood, fluids, non-intact skin, or mucous membranes.
- After contact with equipment.
- Before and after eating.
- After using the bathroom.
- After sneezing or coughing.

What is "Informed Consent?"

Answer:

A process that allows the patient or patient's legal representative, full participation in decisions regarding patient care, treatment, and services. It can only occur if there is full understanding of the nature of intervention as well as the risks, benefits, and alternatives.

If a patient or family member has a complaint, how do you assist them?

Answer: Patients have multiple ways to voice complaints or concerns.

- Patients may voice their concerns with the involved department.
- Patients can fill out a patient relations worksheet by requesting a form from the department.
- Patients may submit an ICE complaint via the intranet.
    - camp-pendleton.tricare.mil
    - click "Contact Us"
    - click the link under patient relations.
- Patients may share their concerns with the Joint Commission on line (www.jointcommission.org), via fax (630-792-5636), or via mail.

Staff Knowledge Check

What should you do if your patient has Isolation Precautions such as multiple drug resistant organism (MDRO) infection?

Answer:

Patients with an MDRO should be in a private room in contact precautions.

Gown and gloves should be donned on room entry, regardless of reason or length of time you will be in the room.

As much as possible, equipment is dedicated and remains in the patient room until discharge.

Education on isolation precautions will be documented in the patient's chart and provided to visitors.

How should patient food be handled?

Answer:

- Cover food from the cafeteria on the way to the ward.
- Stored food and separate refrigerator from medications.
- Temperatures must be maintained at all times
- Label any stored food with date and patients name.
- Patient “Left-overs” may not be stored in any refrigerator at any time.

Why do you care about being a “High Reliability Organization (HRO)”?

Answer:

We care about minimizing harm to our patient and achieve optimal outcomes despite working in a complex or risky environment. Our HRO principles are called Ready Reliable Care.

We demonstrate HRO principles by using TeamSTEPPS, daily huddles, continuous process improvement projects, etc.

Joint Commission Prep Checklist

Environment of Care (All Areas):

- Clean, organized, get rid of the clutter.
- No food or drinks in patient care areas (IC manual – Food and Drink in Patient Care Areas)
- Drinks must have a lid and placed in a specific area and in designated "drink area"
- Lock up personal items-book bags, back packs, purses, lunch boxes, etc.
- No paper signs – Place in page protector or laminate
- Bulletin boards organized and current
- Medical records are protected, including electronic and paper
- No names/diagnoses/procedures in public view
- Clean syringes and needles are LOCKED/SECURED
- All items in the halls are on wheels, same side of hallway and temporary
- Check monitoring equipment to verify that all alarms are operational
- Call bells reachable. Pull cords hang freely within 6 inches of the floor. Bathroom key is available for patient rescue.
- Blanket/fluid warmer: Following manufacturer's IFU?
- Bottles marked with expiration date once put in warmer?
- Following fluids manufacturer's temp/fluid expiration date?
- Temp log book maintained and current (all dates filled in)?
- 8" rule (off the floor) met EVERYWHERE. Wire racks with a SOLID bottom to protect supplies.

HAZARDOUS MATERIALS:

- Hazardous materials labeled correctly (original/typed labels with content defined)
- Hazardous materials stored correctly (out of the reach of children)
- Safety Data Sheets (SDS) present in area and accessible to staff—List of all staff (especially new staff) posted in front of book and review date is current (at least annually)
- Authorized User List (AUL) current and reviewed/updated annually -Environmental Aspect Sheet updated?
- Staff knows location of the SDS sheets?

Life Safety (Fire Safety)

Life safety risks vary across different health care settings. These differences are due to the types of services provided, whether patient's remain overnight, and the existence of specific building features.

Fire is a concern for everyone but it is of special concern in hospitals because patients are often unable to move to safety by themselves.

Life Safety (LS) focuses on the importance of a fire-safe environment and buildings, and facility design and related features that help prevent, detect, and suppress fires, considering several options for fire protection, including creating safe areas (smoke compartments) that allow people to remain in their locations and "defend in place," moving people to safe areas within the building, and as a last resort, moving people out of a building.

• Supplies/equipment storage doesn't exceed 18 inches from the bottom of the sprinkler heads. Note: Perimeter wall shelving and storage may extend up to the ceiling when not located directly below a sprinkler (Contact safety for further guidance @ 760.719.4138)

• Medical Gas Cylinder storage:
  "Full" tanks: Sealed cylinders, no regulator, tagged FULL
  "In Use/In Service" tanks: Considered partially full, no seal, regulator may be attached. Tagged IN USE or IN SERVICE
  "Empty" No seal, no regulator, 500 psi or less or not intended to be used again, tagged EMPTY.

- Full, partially full, and empty cylinders shall be stored physically segregated from each other (separate rack, separate area, or separate rooms) and shall have signs to clearly identify the segregation.
- The fire extinguishers are all current (must be checked monthly by Facilities Contractors). If unclear as to last check, contact the Safety Office

Safety Office: 760.719.4138

Joint Commission Prep Checklist

LIFE SAFETY (Fire safety) continued:

- Fire or smoke doors shall never be propped open. Best practice is that no doorstops are visible on the unit, anywhere, at all, ever, at any time.
- No missing or damaged ceiling tiles. No ceiling tiles with un-sealed holes or gaps.
- No (flammable) papers on walls, doors—must be in page protector or laminated. Flammable decorations or paper on walls must be kept to a minimum. Paper should be laminated or in a page protector. No paper or decoration of any type smoke or fire doors.
- All exit signs are illuminated (check them often)---some may not turn on or illuminate
- Staff knows where the nearest fire extinguishers and pull stations are located.
- Staff can explain what they would do in the event of a fire (RACE/ PASS).

Joint Commission Prep Checklist

PHYSICAL SECURITY:

- Staff and Patient personal items are locked/protected from the public
- Staff, volunteers, students, contractors and vendors are wearing NHCP-issued badge above the waist
- Staff know how to challenge and enforce access control to space for piggy-backer(s) or unknown personnel
- All government-issued keys are locked/protected from the public. Keys are inventoried quarterly by the appointed Departmental Key Custodian and inventory is submitted to Key Control Officer
- Any installed Duress Alarms are operational and staff know how to use
- Patient off-limits areas have appropriate signage (e.g. "Restricted Access", etc.)
- Outlying Clinics – exterior doors to facility and internal doors to off-limits areas are kept closed and not propped open

ANTITERRORISM/ACTIVE SHOOTER/INSIDER THREAT:

- Outlying Clinics Only – AT Representative assigned (E-5 or above w/24 months remaining and complete AT Level II Course GS 109.16 via DoD STEPP at https://cdse.usalearning.gov)
- Staff know Active Shooter response methodology (Run, Hide, Fight) and when to when best to use each option; know not to muster; know Primary and Secondary Post-Incident Rally Points to go to once All Clear has been given
- Staff know Immobile Patient considerations during Active Shooter (i.e., either lockdown w/patient (lock area/room doors and/or install door barricade device) – OR – Preserve patient care resources for post-incident and leave (especially if no lockdown options). Tell patient to remain quiet, secure patient room as best able upon exiting.
- Staff know which rooms (if any) are equipped w/barricade devices, where stored, and how to install
- Staff know area's best and worst rooms for locking or barricading
- Outlying Clinics Only – Active Shooter Primary and Secondary Post-Incident Rally Points are identified, incorporated into written procedures, and staff knowledgeable
- Staff know how to report suspicious or insider threat activity

Joint Commission Prep Checklist

LABORATORY:

- What is the cleaning cycle for Phlebotomy trays/Carts?
- How do you transport phlebotomy trays into isolation rooms?
- Do you have a list of critical test results? How do you report them?
- Is there a read back protocol for critical tests results?
- What is the process for obtaining informed consent for blood transfusion?
- How is blood transported to the OR?
- Are any waived tests performed? If so, what tests? Are they defined as definitive or screening? Who is responsible to supervise this activity?

MEDICAL RECORDS:

- Evidence of an Advanced Directive and documented in "LST" section of the EHR
- Was the patient's initial nursing assessment completed and signed by RN within 24 hours of admission
- Was the H&P on the chart within 24 hours of admission, is it > 30 days old (not valid for use), was it updated within 24 hours of admission or procedure and signed by the attending provider
- When appropriate, the patient was educated about personal hygiene and grooming
- Was the education process interdisciplinary
- Need for discharge planning is determined
- Monitoring of a medication's effect includes an assessment of the patient's own perceptions of it's effects
- Documentation is timely, complete, legible, and dated/timed/ authenticated
- Medication reconciliation documented upon admission, transition of care and discharge

Joint Commission Prep Checklist

INFECTION CONTROL:

- What is the contact time for Hydrogen Peroxide wipe, Germicidal Bleach wipes, and Multi-Surface Alcohol wipes? What are they used for?
- How are rooms cleaned?
- How do you know that a room has been cleaned?
- How does the ventilation work in ISOLATION rooms.

  ⇒ How does the staff knows that it's functioning properly.
- Are isolation rooms well marked? Are negative pressure air exchanges for Airborne Infection Isolation Rooms (AIIRs) meet minimum requirements (12 per hour)?
- If your area receives patients with TB (or your staff treats them) you must be fit tested and know how to use the PPE correctly
- Ice machines are clean; no signs of rust, dirt or stains in the tray or on the mechanism, cleaning schedule and maintenance clearly labeled on front
- All appliances are clean.
- No open packages of crackers or food in cupboards without proper wrap
- Clean Linen in public areas remain covered in CLEAN CARTS
- Clean/dirty linen never, ever stored in the same area
- All soiled linen is in bags and the bags not than ¾ full
- Large dirty linen containers protected from public access and has closing lid
- Mattress pads/wheelchair cushions, patient equipment, and all furniture free from adhesive residue, cuts or tears
- Personal protective equipment readily available to staff, especially in areas where hazardous work is occurring
- Biohazard bins/boxes are well labeled, covered, not overflowing, and not readily available to the public
- Are paper towels and soap dispensers stocked and not located within 6" of electrical outlets?
- Dirty rooms have hand hygiene in room, sink preferred.
- Wheelchairs, carts and IV poles clean and staff should be prepared to explain their cleaning process/how they know this fact
- Sharps containers not more than ¾ full. Sharps containers not accessible to children (unattended on the floor or within reach of a child on the bed/chair or crib)

Joint Commission Prep Checklist

MEDICATIONS:

- Can staff identify high alert/look alike sound alike meds?
- Is there special labeling/storage or procedures?
- Only current staff have access to Pyxis?
- Emergency medications are locked at all times
- What meds require a second person verifier?
- What is the second verifier process?
- Narcotics are locked up tight at all times (no breakaway locks on these)?
- Only appropriate personnel have access to the narcotics?
- All narcotics must be wasted appropriately with 2 witnesses?
- All other medications are under control (locked or under constant visual surveillance at **ALL** times)?
- IV bags, vials of anything (i.e., saline) are secured?
- No spiked bags ready to go—once spiked must be hung within 60 minutes?
- No medications are expired?
- *All medications of discharged patients are returned to Pharmacy?
- No disinfectants or cleaners are stored with medications.
- Don't store injectables with topicals on the same shelf .
- Protect syringes, needles from public access.
- Pill crushers and trays are free of debris and clean?

REFRIGERATORS:

- Refrigerators are clean, defrosted
- Thermometers are in ALL refrigerators
- ALL patient nutrition refrigerators have temperature checks done/recorded
- If a refrigerator temperature was out of range, the reason is noted, response noted and temperature rechecked per policy
- All food is labeled and dated; no printed patient labels allowed due to HIPAA. No leftover food stored.
- Medication refrigerators have no food in them
- Juices/Milk/Popsicles must have an expiration date if re moved from the original box-- make sure they are labeled once removed

Medication Management - Multi Dose Vials

Use NEW syringe

Use NEW needle

Apply Aseptic Technique within 28 Days of Opening MDVs

①Scrub the rubber septum with an approved antiseptic swab.

② Allow to dry.

③ Insert a new needle attached to a new syringe for each entry.

MDVs that do not require reconstitution may be used for multiple patients if: Doses are not drawn in "immediate patient treatment areas" including the O.R., procedure rooms, anesthesia/procedure carts, patient rooms, or bays.

Medications reconstituted in an injectable MDV:

- Expires one (1) hour from reconstitution unless prepared and labeled by pharmacy.
- Must be labeled with diluent, concentration, expiration date, and time.

Exceptions to the 28-day expiration of MDVs:

- The manufacturer identifies & extends the expiration date in the product packaging, indicating the manufacturer has conducted testing beyond the minimum required 28 days.
- The manufacturer identifies an expiration date earlier than the 28-day expiration date, in which case the earlier date must be used.
- Currently, vaccines are exempted from this requirement.

The Centers for Disease Control and Prevention (CDC) Immunization Program states that vaccines are to be discarded per the manufacturer's expiration date. The Joint Commission has applied this approach to all vaccines (whether a part of the CDC or state immunization program, or purchased by healthcare facilities) with the understanding that vaccines are stored and handled appropriately.

Medication Management—Injection Safety

What is injection safety?

Injection safety or safe injection practices, is a set of measures taken to perform injections in an optimally safe manner for patients, healthcare personnel, and others.

Source: *https://www.cdc.gov/injectionsafety/providers/ provider_faqs.html*

A SINGLE–DOSE VIAL (SDV) is approved for use on a SINGLE patient for a SINGLE procedure or injection.

SDVs typically lack an antimicrobial preservative. Do not save left over medication from these vials. Harmful bacteria can grow and infect the patient.

DISCARD after every use!

SDVs and MDVs can come in any shape and size. *Do not assume* that a vial is an SDV or MDV based on size or volume of medication.

A MULTIPLE–DOSE VIAL (MDV) is recognized by its FDA-approved label.

Although MDVs can be used for more than one patient when aseptic technique is followed, ideally even MDVs are used for only one patient.

MDVs typically contain an antimicrobial preservative to help limit the growth of bacteria. Preservatives have no effect on blood-borne viruses (i.e. hepatitis B, hepatitis C, HIV).

DISCARD MDVs when the beyond-used date has been reached, when doses are drawn in a patient treatment area, or any time the sterility of the vials are in question!

Medication vials should always be discarded whenever sterility is compromised or questionable.

Medication Management Manual

https://militaryhealth.sharepoint-mil.us/sites/NHCP-GPA-ESC-ecoms-pa

"Banned" **Do not use abbreviations.**

Do Not Use	Potential Problem	Use Instead
"Trailing Zeros" (X.0mg)	Decimal may be misinterpreted or overlooked in handwriting and with the us of carbon or faxed copies result in tenfold overdose	**Never** write a zero by itself after a decimal point **(X mg)**
Lack of Leading Zero(.Xmg)	Decimal may be misinterpreted or overlooked in handwriting and with the use of carbon and faxed copies resulting in tenfold overdose	**Always** use a zero before a decimal **(0.Xmg)**
U or u	Mistaken for zero, four or cc	Write "**unit**"
I.U or IU	Mistaken for I.V. (intravenous) or 10 (ten)	Write **"International Unit"**
µg	Mistaken for "mg" when handwrit-ten, resulting in one thousand-fold dosing overdose	Use "**mcg**" or "**micrograms**"
Q.D., QD, q.d., qd, or Q/D	Mistaken for QID and drug given 4 times daily	Write **"daily"** or **"every day"**
Q.O.D., QOD, q.o.d., or qod	Mistaken for QID or QD	Write **"every other day"**
MgSO4 MS MSO4	Misread as Morphine Sulfate Misread as Magnesium Sulfate	Write **"morphine sulfate"** Write **"magnesium sulfate"**

Naval Hospital
Look-Alike Sound-Alike (

REFERENCES:

1. US Food and Drug Administration (FDA) and Institute for Safe Medication
Recommended Tall Man Letters. ISMP; 2024.
2. Institute for Safe Medication Practices (ISMP). ISMP List of Confused Dru
3. FY 2025 NHCP/NMRTC Patient Safety Reports

DRUG/Confused Drug Name
cloNIDine AND clonazePAM
celecoxib (CeleBREX®) AND/OR citalopram (CeleXA®) AND/OR fosphenytoin (Cerebyx®)
Diazepam AND diltiaZEM
Dicyclomine (Bentyl®) AND DULoxetine (Cymbalta®)
hydrOXYzine AND hydralazine
ePHEDrine AND ePINEPhrine
HYDROmorphone (Dilaudid®) AND Morphine (Duramorph®)
Lantus® and Lente®; Lispro® and Lantus®; Humalog® and Humulin®;Novolog® and Novolin®;Humulin® and Novolin®; Humalog® and Novolog®
oxyCONTIN® (oxycodone-controlled release) AND oxyCODONE (immediate-release)
buPROPion SR AND buPROPion XL
divalproex AND divalproex ER
metoprolol (Lopressor®) AND metoprolol ER (Toprol L®)
tolterodine AND tolterodine (Detrol LA®)
Hepatitis A and Hepatitis B Vaccines (Adult & Pediatric formulations)

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LASA) List and Strategies

n Practices (ISMP). FDA and ISMP Lists of Look-Alike Drug Names with

uug Names. ISMP List of Confused Drug Names; June 2024.

SAFETY STRATEGIES (pairs grouped by common safety strategies)
Indicate standard directions and indication in the SIG section. Pharmacist to verify indication with patient or medical record when not included in SIG.
Store products with look or sound-alike names in different locations in pharmacies, patient care units. If physical relocation of low use items is necessary, use a shelf sticker to help locate the product that has been moved.
Pyxis MedStation provides “Caution more potent than Morphine” warning upon removal of Hydromorphone. Limit patient care areas where Hydromorphone is stocked in non-profiled Pyxis® MedStation® machines. Ensure that health care providers are aware that these products are not inter-changeable.
Limit the variety of insulin products stored in patient care areas. Do not stock U500 insulin outside of pharmacy.
Verify with provider when it is unclear if the immediate release or controlled re-lease is ordered. Verify with provider when oxycodone CR is ordered as “PRN” and/or oxycodone IR is ordered on a scheduled basis. Pyxis MedStation provides warning “Caution long-acting product” warning upon removal of OxyContin.
Default SIGS to indicate BID vs. Daily dosing. Extended-Release Formulations flagged as **ONCE DAILY DOSING**
Store products with look or sound alike names in different areas. Separate adult formulations from pediatric formulations.

Naval Hospital C
HIGH-ALERT MED

DEFINITION: High-alert medications (HAMs) are drugs that bear a heightened risk of causing significan events. Although error may or may not be more common with these medications, the con

REQUIREMENT: The Joint Commission Hospital Accreditation Standards, "The hospital safely manages hig

REFERENCE: Institute for Safe Medication Practices (ISMP). ISMP List of High-Alert Medications for Ac

HIGH ALERT MEDICATION/ DRUG CLASS	SELECTION/ PROCUREMENT	STORAGE	ORDE TRANSC
Unfractionated Heparin, IV (flushe**s exempt**)	Purchase commercially premixed and oral unit dose available products. Standardized heparin continuous infusion concentration	Limit locations and concentrations of heparin stored outside profiled Pyxis® MedStations. Maximize use of profiled Pyxis MedStations.	Do not use "U' fo zero. Spell out th .
Concentrated Electrolytes i.e., potassium chloride concentrations of 2mEq/ml or greater, potassium phosphate vials, sodium chloride concentrations > 0.9%	Premix bags, large volume parenterals, and saline flushes commercially procured. 3% NaCl and 23.4% NaCl commercially procured and stored only in Pharmacy.	Stock all concentrated potassium chloride in Pharmacy.	Standardize and concentrations or Potassium contai available as floor standardized and 20mEq KCl per lit Large volume intr KCl Conc. > 40 m infused only in IC
Insulin	NA	Store in refrigerator and separated by type in labeled bins. *Concentrated insulin U-500 stored in Pharmacy only.	Do not use "U' fo zero. Spell out the word
Methotrexate, Injectable Soln.	Purchase vials for inpatient/ED use only. Pharmacy staff receives and unpack shipment per local SOP	Store in Hazardous Buffer Room in inpatient pharmacy department (excludes premix syringes for outpatient use).	Include weight/he Target dose (mg/ Dose in metric un
Neuromuscular Blocking Agents (NMBA) i.e., succinylcholine, rocuronium, vecuronium	Pharmacy prepared, re-packaged NMDs include a clearly visible warning (e.g., WARNING: PARALYZING AGENT)	Only available in RSI kits, surgical suites, OR, PACU, ER, ICU. Segregated from other medications; Storage bins, pockets or drawers include an Auxiliary label: (WARNING: PARALYZING AGENT)	NMDs are prescr protocol or order outside the OR, F
OXYTOCIN, IV	Purchase commercially premixed products when available	Limit locations outside pharmacy	Standardize and concentrations or
Patient Controlled Analgesia & Epidurals i.e. PCAs, Epidurals	Drugs purchased from different manufacturers when strengths are similar, if possible. Combinations and concentrations of drugs are standardized	Maximize use of profiled Pyxis® MedStations	Standardized Cor Additional orders narcotics/opiates PCA/Epidural are Staff or Anesthes
Pediatric Medications	NA	Limit concentrations available in Pharmacy and Patient Care Areas.	**Inpatient:** include current weight an in orders **Outpatient:** patie weight will be pro ordering provider pharmacist to cal weight based dos
Hepatitis A & Hepatitis B Vaccines	N/A	Separate Adult formulations from Pediatric formulations for both Hepatitis A and Hepatitis B	**N/A**

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ICATIONS (HAMs)

nt patient harm when they are used in error and are involved in a high percentage of errors and/or sentinel sequences of an error are clearly more devastating to patients.
gh-alert and hazardous medications."
ute Care Settings. ISMP; 2024; ISMP Targeted Medication Best Practices for Hospitals 2024-2025.

RING/ CRIBING	PREPARING/ DISPENSING	ADMINISTRATION	MONITORING
r units or trailing e word **"units".**	Per standard heparin Power Plans for both Cardiology and DVT/PE. Heparin added to parenteral solutions only by Pharmacy.	✓ Double-check (UFH): required by second RN (Boluses, dose changes, new bag hung and each shift change); Smart pumps used. ✓	Heparin Drip: Per Protocol/MHS GENESIS Power Plans
limit drug rdered. ning fluids stock are limited to ter. ravenous fluids Eq/1000 mL U.	All intravenous compounding of KCl done in Pharmacy. NaCl fluid orders exceeding 0.9% require pharmacist review and approval.	✓ Double-check required by second RN prior to administration (premix products excluded); Smart pumps used. ***KCL Peripheral line:*** Max Rate: 10 mEq/hour Max Conc. 10 mEq/100 mL ***KCL Central line:*** Max Rate: 20 mEq/hour	Cardiac monitoring required for KCl infusion rates >10 mEq/hour
r units or trailing d **"units"**.	Wards/ER guided by protocol. Standard drip concentration= 1 unit/1ml (100ml bag)	✓ Double check: 2 person verification 1 of which must be an RN and the other may be an HN.	Monitor blood glucose as ordered.
eight for BSA m^2 or mg/kg) its (i.e. mg)	Training required for preparation Use Chemotherapy Bag and Label (instead of High Alert label)	✓ Double-check required by second RN or LP prior to administration ✓ Must complete HD training in RELIAS	Follow local SOP/Protocol
ibed via a set when used PACU, or the ER.	Syringes of NMDs prepared by staff are labeled with the name and concentration/dose of the drug, and the expiration date and time (exception: if administered immediately)	✓ Double check required by second RN or LIP/ prior to administration when medication drawn up by a RN.	Per Protocol
limit drug rdered	Utilize order sets and guided protocols	✓ Double check required by second RN prior to administration and IVPB bag change; Smart pumps used	Per Protocol
nc. used. for ordered with restricted to ia.	Per PCA Power Plans. Per Epidural Power Plans.	✓ Double-check required by second RN/Licensed provider at initiation, all dose changes, solution replacement, & shift handoff.	Monitor vital signs, sedation level, signs of dizziness, diaphoresis, itching, orthostatic hypotension, or confusion.
e patient's d mg/kg dosing nt's current vided by and used by culate/confirm sing	Inpatient: Two pharmacy staff members will confirm appropriateness of weight based dosing	✓ Double check required by second RN or HN prior to administration. Inpatient: RNs confirm the appropriateness of weight based dosing.	
	Utilize Immunization Clinic SOP	✓ Bar code scanning is required; If Bar code scanning not available, a double check is required by second staff member	Per SOP

icies and designations of high-alert medications.

Medical Waste

MEDICAL WASTE
(Biohazardous)

USE FOR:
Items that are saturated with blood or bodily fluids **BUT does not contain sharps:**

- Blood bags and tubing
- Hemodialysis tubing
- Suction Canisters
- Pleurovac or hemovac containers
- Vials or containers contaminated with blood or body fluids

- MUST BE DOUBLE GOOSE NECK CLOSED & REMOVED WHEN BAG CONTAINER IS ¾ FULL, OR PRESENTS AN ODOR
- REMOVE CLOSED BAG & TRANSPORT TO INTERIM WASTE STORAGE ROOM AND PLACE IN SECONDARY TRANSPORT CONTAINER

MEDICAL WASTE
(Sharps)

USE FOR:
Sharp objects with blood or body fluids:

- Needles/syringes contaminated

- MUST BE CLOSED & REMOVED WHEN CONTAINER IS ¾ FULL (FILL LINE) OR PRESENTS AN ODOR
- REMOVE CLOSED CONTAINER & TRANSPORT TO INTERIM WASTE STORAGE ROOM AND PLACE IN SECONDARY TRANSPORT CONTAINER

Medical Waste

MEDICAL WASTE
(Non-Pourable Chemotherapy)

USE THE YELLOW BIN FOR:

- Non-pourable chemo (<3% by weight)
- Sharps contaminated with non-pourable chemo

USE THE YELLOW BAG FOR:

- Empty chemo bags
- Gloves
- Pads
- Gowns and masks

- MUST BE CLOSED & REMOVED WHEN ¾ FULL (FILL LINE), OR PRESENTS AN ODOR OR IS A YEAR FROM START DATE ON CONTAINER OR BAG
- CONTAINER TOP MUST BE LABELED WITH "CHEMOTHERAPY WASTE"
- REMOVE CLOSED CONTAINER & TRANSPORT TO INTERIM WASTE STORAGE ROOM AND PLACE IN SECONDARY TRANSPORT CONTAINER
- WASTE MUST BE TRANSPORTED TO B-35 WEEKLY AT HOSPITAL OR INTERIM WASTE ROOMS AT OUTLYING CLINICS

MEDICAL WASTE
(Pharmaceutical Waste)

USE FOR:

Items that are used to give medications or immunizations.

- Needles and syringes
- IV bags and tubing
- Ampules, vials, or pills

- MUST BE CLOSED & REMOVED WHEN ¾ FULL (FILL LINE), PRESENTS AN ODOR, OR A YEAR FROM START DATE
- CONTAINER TOP MUST BE LABELED WITH "INCINERATE ONLY"
- OUTLYING CLINICS MUST DATE CONTAINERS TO ENSURE REMOVAL A YEAR FROM START DATE
- REMOVE CLOSED CONTAINER & TRANSPORT TO INTERIM WASTE STORAGE ROOM AND PLACE IN SECONDARY TRANSPORT CONTAINER

CONTROLLED SUBSTANCES MUST BE UNUSABLE:

- Placed in CSRX for narcotics
- Pharmacy contracted technician will remove and replace these narcotics containers.

Disclosure

Disclosure is the process of informing the patient and when appropriate, the patient's family, of unanticipated outcomes of care. The unanticipated outcome may be positive or negative. The primary provider or his/her supervisor should expeditiously notify the appropriate hospital representatives of negative unanticipated outcomes.

Healthcare Resolutions is available to assist the primary provider in deciding who/how to make the disclosure. Ordinarily, the primary provider will make the disclosure. However, the facts and circumstances of each case are different and may dictate that another hospital representative make the disclosure.

Contact for Healthcare Resolution Specialist: Eve Currie, 719-3207

- Disclosure should be made as promptly as possible, given the patient's clinical condition.
- The nature, severity, and cause, if known, of the unanticipated outcome/ adverse event should be presented in a straight forward and non-judgmental fashion. Disclose only what is known at the time of the discussion. Stick to the facts. Do not speculate.
- Do not feel compelled to answer all questions at the first meeting. Disclosure usually occurs over a series of conversations.
- Title 10, U.S. Code Section 1102 states that information will not be provided to the patient and/or family.
- If the unanticipated outcome requires further medical intervention, describe what can be done and what actions will be taken to begin this process. A patient needs all information to make an informed decision for future care.
- The disclosure of an unanticipated outcome to a patient/patient's family should be documented in the chart. However, DO NOT write details of the disclosed event in the medical records. Details of the disclosed event should be documented on a QA event report form or as part of the PCA process. The note should be factual along with a brief summary of the conversation & plan of care.

Emergency Management—Overview

Emergencies can be threats to any health care organization and can adversely impact patient safety and the hospital's ability to provide care, treatment, and services for an extended length of time.

Power failures, water and fuel shortages, flooding, and communication breakdowns are just a few of the hazards that can disrupt patient care and pose risks to staff and the hospital. It is paramount that the organization creates plans to respond to the effects of potential emergencies that fall on a continuum from disruptive to disastrous.

The four phases of emergency management are **mitigation, preparedness, response, and recovery**. They occur over time: mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.

The Emergency Management Procedures **"Red Book"** is designed as a guideline for emergency responses on NHCP. Referred to "NHCP" throughout the manual. NHCP is committed to protecting the welfare of its staff, safeguarding property, and interests, and protecting the patient care environment.

The EM Dept. has established a guidance for incident prevention, planning, response, mitigation & recovery. The **"Red Book"** is a component of the Emergency Operation Plan (EOP). As staff, you play an important role in implementation and effectiveness in your workplace.

Staff are expected to follow QD issued directions in emergencies. Keep **"Red Book"** visible and readily available.

For more information contact NHCP MTF Emergency Manager at (760) 725-1369 during normal business hours. After hours Contact CDO at (760) 725-1288.

What is a Safety Data Sheet (SDS)? A **Safety Data Sheet (SDS)** is a document that contains detailed information about a specific chemical, including, but not limited to, its hazards, safe-handling procedures, control measures (PPE), and how to respond to exposure and spills.

How are chemicals stored?

(1) Chemicals such as acids, bases, and alcohols used in labs must be stored in separate cabinets designed to handle these types of chemicals.

(2) Special flammable cabinets are available for storing flammable chemicals.

What should I do if a hazardous materials spill occurs?

(1) Direct patients, employees, and/or visitors away from the spill.

(2) For **small chemical spills or releases**, after cleanup contact the local Environmental Office for proper disposal.

(3) For **large chemical spills or releases** staff (within Bldg. H-200) shall contact the Quarterdeck at **725-1222, for a CODE ORANGE**. Staff at outlying buildings, on-base clinics, and off-base clinics shall contact the local Fire Department.

The Biohazard Symbol is on the following:

(1) waste storage areas
(2) red biohazard bags
(3) storage containers
(4) sharps containers—considered **"full"** when it reaches **3/4** full or putrid
(5) transport cart

Pharmaceutical waste containers are labeled "Pharmaceutical Waste" and marked with the accumulation date and "Incineration Only." Pharmaceutical waste container need to be removed/disposed of when it becomes full, putrid or is approaching its **ONE** year storage time.

For more information on Hazardous Materials and Waste contact:
760.725.5858

Safety Office (Occupational Safety) - NHCP-Command-Safety-Binder (navy.mil)

Important Phone Numbers

NHCP

Emergencies within Hospital (All Codes).... 760 725-1222
Inpatient RRT, Nurse of the Day 760 685-3468
Ambulance. 9-911
Fire.....9-911
NHCP Emergency Department..... 760 719-3365
NHCP Officer of the Day. 760 696-8851
NHCP Command Duty Officer 760 685-3537
Quarterdeck. 760 725-1288
NHCP Security. 760 725-1602
NHCP Safety Office 760 725-1486
Patient Safety. 760 719 3058
Facilities Help Desk 24/7 ..... 760 719-3477
Social Work Department 760 725-1318
Chaplain.....760 450-4690
COVID POC.....442 288-9412
Medical Officer of the Day 760 696-6496

DITS TRAINING FOLDER AUDIT TOOL

Department:

Directorate:

Auditor:

Date:

Name:	Role:	Signed Privacy Act Statement *(Signed Once)*	PositionDescription w/ Member and Supervisor Signature *(Signed Once/Civ DPMAP is annual)*	Environment of Care *(Sign One Time at Unit Orientation)*	Departmental Orientation *(Sign One Time)*	RELIAS Transcripts *(Print or Save Copies every 6 months)*	BLS/Resuscitative Training/TCCC/HMSB *(Print or Save Copies As Needed)*	Initial and Annual competency / Primary Source Verification	Equipment Competency *(Sign One Time)*	Comments
1										
2										
3										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										

Your Department Information

Department Duties:

_____

Job Description:

_____

_____

Collateral Duties:

_____

Watch Assignments:

_____

Committee Memberships:

_____

BLS Expires: _____

Where is the Patient Bill of Rights?

_____

How do you handle Advance Directives?

_____

Who is the Area Safety Rep? _____

Where are the following items located?

Fire Alarm Pull Box: _____

Fire Extinguisher: _____

Medical Gas Shutoff Valve: _____ **Authorized Supervising Medical Authority (Senior Medical Officer/ Charge Nurse) for gas shutoff:**

_____

Evacuation Route: _____

READY RELIABLE CARE
ANYTIME, ANYWHERE

Naval Hospital Camp Pendleton
Quality Management Department
200 Mercy Circle
Camp Pendleton, CA 92055

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