

# *Naval Hospital Camp Pendleton*

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## *Joint Commission Survey Readiness Handbook*



MIFU QR CODE  
Login: nhcp  
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NHCP TJC Handbook  
QR Code

Updated January 2023

Table of Contents	Page(s)
1. DHA - Ready, Reliable Care	3
2. Staff Knowledge Check	4–6
3. TJC Prep Checklist	7- 14
4. The Accreditation Process and 5 W's	15–19
5. How to Participate in the Survey	20 - 21
6. TJC Word Scramble	22
7. Handoff Communication Tools TeamSTEPPS, SBAR	23 - 24
8. National Patient Safety Goals (NPSGs)/ Universal Protocol	25 - 27
9. Rights & Responsibilities of the Individual (RI)	28 - 31
10. Provision of Care, Treatment & Services (PC)	32 - 37
11. Medication Management (MM)	38 - 44
12. Infection Prevention and Control (IC)	44 - 49
13. Patient Safety	50
14. Risk Management	51 - 53
15. Disclosure	54
16. Record of Care, Treatment & Services (RC)/ Information Management (IM)	55
17. Performance Improvement (PI) Lean Six Sigma/DMAIC Process/PDCA/FMEA/RCA	56 - 59
18. Environment of Care (EC)/ Life Safety (LS)/ Emergency Management (EM)	59 - 60
19. Hazardous Materials & Waste	60 - 61
20. Physical Environment	61 - 62
21. Medical Staff (MS)	62
22. Nursing (NR)	63
23. Waived Testing (WT)	63
25. Primary Care Medical Home	65 - 67
24. Emergency Codes	64




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

## Emergency Codes

**\*Code Blue\*** Cardiac Arrest– Call 725-1222

**\*Code Purple\*** OB Emergency– Call 725-1222

**\*Code Red\*** Fire– Call 911

For the codes listed below please contact the Quarter Deck:  
725-1288

**\*Code Pink\*** Infant Abduction

**\*Code Green\*** Security Assistance

**\*Code Magenta\*** Nuclear

**\*Code Grey\*** Disaster

**\*Code Black\*** Bomb Threat

**\*Code Orange\*** HazMat Spill

**\*Code Silver\*** Child/Adult/ Lost Eloped

**\*Code White\*** Armed Intruder/Active Shooter

**\*Code Yellow\*** Utility Failure

**Emergencies outside NHCP—Call 911**



MHS personnel rely on the following principles and domains to guide reliable operations and foster a system-wide commitment to high reliability. Ready Reliable Care drives continuous improvement that delivers great outcomes in readiness and health.

### READY RELIABLE CARE DOMAINS OF CHANGE

Efforts to improve care and advance a ready, reliable MHS are described against four domains of change.



**LEADERSHIP COMMITMENT**  
Prioritize Ready Reliable Care at all levels of leadership



**CULTURE OF SAFETY**  
Commit to safety and harm prevention



**CONTINUOUS PROCESS IMPROVEMENT**  
Advance innovative solutions and spread leading practices



**PATIENT CENTEREDNESS**  
Focus on patients' safety and quality of care experience

### READY RELIABLE CARE PRINCIPLES

MHS leaders, staff, and patients contribute to high reliability by embodying the seven Ready Reliable Care principles in their daily work.



**PREOCCUPATION WITH FAILURE**  
Drive zero harm by anticipating and addressing risks



**SENSITIVITY TO OPERATIONS**  
Be mindful of how people, processes, and systems impact outcomes



**DEFERENCE TO EXPERTISE**  
Seek guidance from those with the most relevant knowledge and experience



**RESPECT FOR PEOPLE**  
Foster mutual trust and respect



**COMMITMENT TO RESILIENCE**  
Leverage past mistakes to learn, grow, and improve processes



**CONSTANCY OF PURPOSE**  
Persist through adversity towards the common goal of zero harm



**RELUCTANCE TO SIMPLIFY**  
Strive to understand complexities and address root causes

### THE MHS QUADRUPLE AIM AND HIGH RELIABILITY

Ready Reliable Care enables a unified MHS and drives achievement against every component of the MHS Quadruple Aim:

#### BETTER HEALTH

Excellent care delivery, supported by systemwide teamwork and accountability, provide beneficiaries with better care experiences, better outcomes, and better overall health.

#### LOWER COST

High reliability addresses unwarranted variability across the system, resulting in improved efficiency. A commitment to zero harm contains avoidable costs due to medical error.

#### BETTER CARE

Commitment to a safety culture and to continuous process improvement enables the systemwide spread of leading clinical practices and improved administrative and business processes. Together, these improvements drive great outcomes, satisfied patients, and fulfilled staff.

#### IMPROVED READINESS

High reliability equips a Ready Medical Force with the innovation and teamwork capabilities necessary to respond effectively in an unpredictable deployed environment.

High reliability drives the better health and better care that sustain a **Medically Ready Force**.



Find Ready Reliable Care resources for staff at [info.health.mil/sites/hro](https://info.health.mil/sites/hro) (CAC-enabled). Visit our public website at [health.mil/ReadyReliableCare](https://health.mil/ReadyReliableCare).

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 is our department’s manuals/SOPs located?
- How do you access new policies?
- Where are emergency telephone numbers are posted?
- How/When to complete a patient safety report (PSR)?
- What is our “Grievance Process” for staff?
- Where are community resources listed on the SharePoint?
- What type of education the staff has received related to their job in the last 12 months? Why?
- What education they have received on Information Management (medical records, computerized information, HIPAA)?
- Know your Codes (Red, Green, White, etc.) How do you announce? Who responds?
- Where is the nearest fire alarm pull box?
- Where is the nearest fire extinguisher?
- Where are the fire exits?
- Who decides whether they evacuate the building or stay (know the evacuation route and muster sites)?
- How do you evacuate? How do patients evacuate?
- What does PASS, RACE stand for?
- Location of shut off of medical gases in case of emergency and know who can shut off medical gas and turn back on
- What is “H-R-O”?

## Primary Care Medical Home (PCMH) continued

h. Tracer activity for PCMH Clinics include:

- (1) Information provided to patients related to access to care, treatment and services, as well as primary care clinician information (documented)
- (2) Tracking and follow-up on referrals and test results
- (3) Interdisciplinary team collaboration and communication
- (4) Involvement of patients in establishing treatment goals (documented)
- (5) How patients are assessed for health literacy (documented)
- (6) 24/7 access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
- (7) Competence of primary care clinicians
- (8) PI activities related PCMH

### Instructions/Policies related to PCMH:

**TRICARE Policy for Access to Care**—February 23, 2011

**BUMEDINST 6300.19** - Primary Care Services in Navy Medicine

**BUMEDINST 6000.15** - Navy Medicine Referral Management Program Behavioral Health Integration Program in the Medical Home Port—February 2012

**NAVHOSPCAMPENINST 6010.4 series** - Business Standards for Clinical Operations

## Primary Care Medical Home (PCMH) continued

### d. Coordinated Care.

(1) The PCMH coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and support.

(2) Concepts addressed in JC PCMH include the following:

- (a) Use of internal and external resources to meet patient needs
- (b) Responsibility for care coordination
- (c) Team-based approach

### e. Superb Access to Care.

(1) The PCMH delivers accessible services with shorter waiting time for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as e-mail and telephone.

(2) Concepts addressed in JC PCMH include the following:

- (a) Enhanced access, defined as responsiveness to patients' preference regarding access, including timely response to and shorter wait times for urgent needs, flexible appointment hours and days of service, telephonic or electronic access to a member of the care team, and alternative methods of communication such as e-mail.
- (b) Availability 24 hours a day, 7 days a week
- (c) Access for non-visit related patient needs
- (d) Access for patient with special communication needs

### f. Systems-Based Approach to Quality and Safety.

(1) The PCMH demonstrates a commitment to quality and quality improvement through ongoing engagement in activities such as using evidence-based medicine and clinical decision support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management.

(2) Concepts addressed in JC PCMH include the following:

- (a) Population-based care
- (b) Use of health information technology, including electronic prescribing
- (c) Primary care clinician and team members who function within their scope of practice and in accordance with law and regulation and privileges granted
- (d) Use of evidence-based medicine and decision support tools
- (e) The provision of care to a panel of patients

- When does the patient have to have a History & Physical completed and/or reassessments done? What about nursing staff's assessments?
- Where is the patient/family education documentation located in the medical record?
- Who assesses cultural/religious preferences of the patient and where is this documented?
- What is your policy on pain assessment and reassessment?
- How do you obtain an interpreter (language, sign language)?
- Screening criteria for requesting a dietary consult—Inpatient/Outpatient?
- Screening criteria for requesting a Rehab (PT, OT, Speech) consult—Inpatient/Outpatient?
- Screening criteria for requesting a Pharmacy, Pastoral Care or other consult—Inpatient/Outpatient?
- What does the "right to know" mean?
- How are you preventing infections?
- What are your two patient identifiers?
- Who and when can you turn off patient alarms on monitoring equipment?
- When do you require site/site marking?
- What is your surgical site verification process?
- What is the MIFU and where it is located?
- How long do you use alcohol-based hand sanitizer for?
- What is our "Standardized Language for Patient Safety"?

- What does the “right to refuse” mean?
- What requires “read back” (verbal orders and critical values)?
- Who can receive verbal orders or critical values?
- Where is the unapproved abbreviations listing?
- What do you do if an unapproved abbreviation is used in an order?
- What is the definition of a sentinel event?
- What is your process for reporting a sentinel event?
- What is “point of use decontamination”?
- What are the hazardous materials used on the unit/clinic/department?
- Where are the eyewash stations located and how to use/test an eye wash station?
- Name two PI initiatives for your area?
- Is your unit/clinic/dept collecting ORYX/HEDIS data? If yes, what are they and what are your outcomes?
- Can you name the current National Patient Safety Goals (NPSG) that pertain to your area?
- Where is our Work Place Violence Policy?
- **BONUS**
- **CPI:**  
What is a Failure Mode Effects Analysis (FMEA)?  
Any conducted within the last 18 months? Outcomes/  
changes  
What departmental CPI projects are you working on?

## 26. Primary Care Medical Home (PCMH)

a. Primary Care Medical Home Model—the medical home is a model of primary health care that has the following core functions and attributes:

- (1) Patient-centered care
- (2) Comprehensive care
- (3) Coordinated care
- (4) Superb access to care
- (5) Systems-based approach to quality and safety

### b. **Patient-Centered Care.**

(1) The PCMH practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, PCMH practices ensure that patients are fully informed partners in establishing care plans.

(2) Concepts addressed in Joint Commission (JC) PCMH include the following:

- (a) Patient-selected primary care clinician
- (b) Primary care clinician and interdisciplinary team work in partnership with the patient
- (c) Consideration of the patient's cultural, linguistic, language, and educational needs and preferences
- (d) Patient involvement in establishing the treatment plan
- (e) Support for patient self-management

### c. **Comprehensive Care.**

(1) The PCMH is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.

(2) Concepts addressed in JC PCMH include the following:

- (a) The provision of acute, preventive, and chronic care
- (b) Provision of continuous and comprehensive care
- (c) Team-based approach and the use of a multidisciplinary team to provide care
- (d) Use of internal and external resources to meet patient needs
- (e) Primary care clinician with the educational background and broad-based knowledge and experience necessary to handle most medical needs of the patient and resolve conflicting recommendations of care.
- (f) Primary care clinician who works collaboratively with an interdisciplinary team
- (g) Care that addresses various phases of a patient's life span,



## Nursing (NR).

**Overview:** The quality of nursing services is built upon the leadership of a nurse executive and the work of a qualified staff. The nurse executive promotes quality by incorporating current nursing research findings, nationally recognized professional standards, and other expert literature into policies and procedures governing the provision of nursing care, treatment, and services.

## Waived Testing (WT).

**Overview:** Test results that are used to assess a patient condition or make a clinical decision about a patient are governed by the federal regulations known as a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). CLIA '88 classifies testing into four complexity levels: high complexity, moderate complexity, provider-performed Microscopy (PPM procedures, a subset of moderate complexity), and waived testing.

a. **What is a "Waived Test"?** As defined by The Joint Commission, a Waived Test is a test that meets the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) requirement for waived tests and is cleared by the Food and Drug Administration (FDA) for home use. These tests employ methodologies that are so simple and accurate that the likelihood of erroneous results is negligible, or they pose no risk of harm to the patient, resident, or individual served if the test is performed incorrectly.

b. **What is "Point-of-Care Testing (POCT)?"** As defined by The Joint Commission, Point-of Care Testing (POCT) is analytical testing performed at sites outside the traditional laboratory environment, usually at or near where care is delivered to individuals. Testing may be categorized as waived, moderate, or high complexity under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). Testing may range from simple waived procedures, such as fecal occult blood, to more sophisticated chemical analyzers.

c. **Are all Point-of Care Tests considered Waived Tests? Aren't they the same thing?** No. Though these terms are often erroneously used interchangeably, not all point-of-care tests are waived tests. Some point-of-care tests are considered moderate or high complexity under CLIA '88.

## 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)?
- Zero gaps and discrepancies noted and follow up?

## HAZARDOUS MATERIALS:

- Hazardous materials labeled correctly (original/taped labels with content defined)
- Hazardous materials stored correctly (out of the reach of children)
- High level disinfectant (HLD) procedures–
- Who can perform? Proof of annual competency and educational updates, able to do the entire procedure in front of a surveyor? Step-by-step process indicated?
- 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?

**Communications/Education:**

- Staff educational materials/offerings are posted in staff areas
- Patient education materials stocked and/or displayed on the unit—vaccine info current (CDC website for VIS)
- Patient education materials are current, meet our age-specific and multi-cultural standards
- Staff know how to access translation services when needed for patients (NHCP 6320.100E - Translation Line Communication Accessibility for Non-English Speaking and Speech Impaired Beneficiaries)
- Patient Rights and Responsibilities are posted in the access areas or brochure available

**Life Safety (Fire Safety):**

- Supplies/equipment storage doesn't exceed 18 inches from the bottom of the sprinkler heads. (Check those closets and storage areas)
- 8" rule (off the floor) met EVERYWHERE. Wire racks with a SOLID bottom to protect supplies. (IC manual – Supply Storage Utility Rooms)
- Medical/Dental Record cabinets/racks are closed
- Oxygen storage:  
“Full” tanks stored in separate racks—labeled with a full tag.  
“In-Use” tanks (regulator attached) are stored separately with the “Empty” tanks and are tagged
- **No doorstops** are visible on the unit, anywhere, at all, ever, at any time
- Know your equipment. Do you have the most current manufacturer's **Instructions For Use (IFU)**?
- Preventive maintenance current (Bio Med Sticker)?
- Is it being cleaned appropriately? How do you know?
- No holes in the walls or ceilings (Status of DMLSS TICKET?)
- No (flammable) papers on walls, doors—must be in page protector or laminated
- The **fire extinguishers are all current** (must be checked monthly). If unclear as to last check, contact the Safety Office
- Batteries stored in RCRA or HazMat container
- Resuscitation Equipment—maintained, locked, READY-FOR-USE!

**Physical Environment continued**

b. It is important the physical environment is functional and promotes healing and caring. Certain key physical elements in the environment are significant in their ability to not only improve patient safety, but to also positively influence patient outcomes and satisfaction. These elements can also contribute to creating the positive feel and function of space which patients, families, visitors, and Staff experience in the service delivery system.

c. **EVERYONE** at NHCP is responsible for maintaining a safe and functional environment by:

- (1) Eliminating and/or addressing propping of doors or use of door wedges and door stops
- (2) Making sure exists, fire extinguishers, and fire alarm pull stations are not blocked
- (3) Maintaining egress
- (4) Making sure items/supplies are not sitting on the floor
- (5) Making sure nothing is stored within 18 inches of ceilings or sprinklers
- (6) Reporting stained ceiling tiles
- (7) Keeping furnishings and equipment safe and in good repair, and ensuring areas used by patients are clean and free of offensive odors
- (8) Reporting lighting issues deemed unsuitable for care, treatment, and services.

**Medical Staff (MS)**

a. **Overview:** The Medical Staff provides oversight of the quality of care, treatment, and services provided, and is responsible for the on-going evaluation of the competency of practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners, and providing leadership in performance improvement activities within the organization.

**b. How do I know if a Medical Staff Member, Resident or visiting provider has privileges to perform a procedure?**

Individual physician privileges can be found using the Intranet—click on Provider Privileges (red button)

**Providers** click on Provider Credentials

**Visiting Providers** click on ICTB

**Residents** click on resident Supervision Matrix



## Hazardous Materials & Waste continued

### c. 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. At NHCP call **725-5858**.

(3) For **large chemical spills or releases** staff (within Bldg. H-200) shall contact the Quarterdeck at **725-1288/1289**. Staff at outlying buildings, on-base clinics, and off-base clinics shall contact the local Fire Department.

d. 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

e. 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:**  
Reggie Holman - 725-5858

## Physical Environment.

a. Everyone who works in the organization is responsible for safety and the successful management of risks in the physical environment. The most well-designed plans and procedures are of no value if those who work in the organization do not know how to follow them. It is important for you to know how to identify and minimize risks, what actions to take when an incident occurs, and how to report it.

### LIFE SAFETY (Fire safety) continued:

- All exit signs are illuminated (check them often)—some may not turn on or illuminate
- **No** paper boxes, etc. stored on floor (including the closet) as they are a mold risk
- **No** shipping label boxes for storage – fuel for pests
- All doors to the outside close completely without forcing it
- Staff knows where the nearest fire extinguishers and pull stations are located (within 75 feet?)
- \*Staff knows RACE/PASS without hesitation and can explain it completely
- \*Can staff explain the Emergency Evacuation Plan and muster location

### MEDICAL RECORDS:

- Evidence of an Advanced Directive and documented in “Notes” 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 24hours 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

**PEDIATRIC CARE RECORDS:**

- As appropriate to the setting, inpatient or outpatient, the assessment of infants, children, and adolescents includes:
  - \* Developmental age
  - \* Length/height
  - \* Head circumference
  - \* Weight
  - \* Consideration of the patient's educational needs and daily activities
  - \* Immunization status (if behind, what is your policy to assist them in updating immunizations)
  - \* Family/guardian expectations for, and involvement in the assessment, initial treatment and continuing care of the patient are documented

**OUTPATIENT CARE RECORDS:**

- An official summary of care list (Problem Summary List) is present which outlines:
  - \* Known significant medical diagnoses and conditions
  - \* Known significant operative and invasive procedures
  - \* Known adverse and allergic drug reactions
  - \* Medication reconciliation
  - \* Learning Needs Questionnaire completed and in record and reviewed at each subsequent visit
  - \* Pain assessment/reassessment
  - \* Height/Weight documented (growth curve and weight in kg for pediatric patients)
  - \* Standby documented for sensitive exams
  - \* Physical exam documented
  - \* Intra-facility transfer process including hand offs and required documents

**ORGANIZING PAPER:**

- All current and new policies are in the manuals/easy access via computer
- All outdated reference books are gone (PDRs, Drug Books, policy manuals, safety manuals should all be current)
- Printers, copy machines, fax machines in a monitored location. Do staff members retrieve printouts immediately? Does staff know the proper way to fax documents containing PHI?

**Environment of Care (EC)/Life Safety (LS)/Emergency Management (EM) continued**

b. **Life Safety (LS) Overview:** 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.

**c. Emergency Management (EM) Overview:**

(1) 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.

(2) 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.

**Hazardous Materials & Waste**

a. **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.

**b. 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.

## Continuous Process Improvement (CPI) continued

### f. What is a “Root Cause Analysis (RCA)” and how is it used to address a Sentinel Event?

(1) A **root cause analysis (RCA)** is defined by the Joint Commission, is “a process for identifying basic or causal factors underlying variation in performance, including the occurrence or possible occurrence of a sentinel event.” In other words, an RCA is a problem-solving method aimed at identifying the root causes of problems or events so they can be addressed, corrected, or eliminated, as opposed to only addressing the immediately obvious or superficial symptoms of a problem.

(2) One important goal of an RCA is to identify improvements to systems or processes in order to decrease the likelihood of the event reoccurring.

## Environment of Care (EC)/Life Safety (LS)/Emergency Management (EM).

a. **Environment of Care (EC) Overview:** To promote a safe, functional, and supportive environment so that quality and safety are preserved. The environment of care is made up of three (3) basic elements:

(1) The building or space, including how it is arranged and special features that protect patients, visitors, and staff.

(2) Equipment used to support patient care or to safely operate the building or space

(3) People, including those who work within the organization, patients, and anyone else who enters the environment, all of whom have a role in minimizing risks

### ELECTRICAL SAFETY:

- Biomedical equipment is tagged with current tag (last review date and next review date noted)
- Maintenance of significant medical equipment used in the patient care area will be tagged and included in the medical equipment inventory by Biomedical Engineering
- All other electrical equipment has been checked/tagged by Biomedical Engineering before use in patient care areas
- Medical equipment must only be plugged into approved power taps when used in the patient care area.
- No CPUs permanently stored on the floor (need to protect the equipment from dust/dirt and be able to clean under and around it)
- Patients/Staff who bring in electrical devices must have them checked prior to use by Safety Office

### SAFETY/SECURITY:

- Staff's personal items are locked/protected from the public
- Patient's personal items are locked/protected from the public
- At all times, staff, volunteers, students, contracted staff and vendors are wearing nametags above the waist
- Patient's identification bands are correct
- Know the 2 patient identifiers (patient full name and date of birth)
- Code cart checks are done per shift and recorded (including checking the defibrillator paddles for burns, check it plugged in), all blanks on the form must be filled in and only one month's worth of checks located on the cart. Previous months are filed. On days the unit/clinic/dept is closed, that is noted on the daily check sheet). Defibrillators are tested daily according to policy and recorded
- Staff readily knows their role in emergency events, fires, abductions and restraint of a patient for behavioral management

### 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?

**INFECTION CONTROL**

(Infection Control Manual located on NHCP intranet):

- What is the contact time for Hydrogen Peroxide wipe, Germicidal Bleach wipes, and Multi-Surfac 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 know that it's functioning properly.
- 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
- 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
- Mattress pads/wheelchair cushions are without cuts or tears
- Large dirty linen containers protected from public access and has closing lid
- Personal protective equipment readily available to staff, especially in areas where hazardous work is occurring
- Isolation rooms are well marked
- 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
- Biohazard boxes are well labeled, covered, not overflowing, not readily available to the public
- Wheelchairs, carts and IV poles clean and staff should be prepared to answer 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)
- Dirty rooms have hand hygiene in room, sink preferred.

**Continuous Process Improvement (CPI) continued**

e. **How does NHCP identify and reduce adverse events and safety risks?**

(1) One method utilized is the **Failure Mode and Effects Analysis (FMEA)**.

(a) A FMEA is a team-based, systematic, and proactive approach for analyzing a high-risk process and identifying ways the process can fail, why it might fail, and how it can be made safer.

(b) Its **purpose** is to prevent problems before they occur.

(c) The **focus** of a FMEA is “something can go wrong and let's fix it before it does,” rather than “nothing can go wrong” or “something has already gone wrong.”

(d) Each FMEA has a Lean Six Sigma Project conducted in parallel.

(e) FMEAs completed by the hospital over the past few years:

1. 2009 Outpatient Infusion Care
2. 2010 Transport via ACLS BLS patients
3. 2011 Coordination of potentially aggressive patient
4. 2013 Standardization of Disinfectants
5. 2015 Improving Follow-up Phone Calls and Appointments at Discharge
6. 2017 Colorectal Screening
7. 2018/2019 Reduction of Specimens with no-orders (lab ordering process)
8. 2019/2020 Standardization of Ultrasound probe HLD

**More information is available on the SharePoint site—FMEA—Patient Safety/Risk Management SharePoint Site**

(2) A **second approach** to identifying adverse events and safety risks lies in Patient Safety Report trend analysis. Process failures are evaluated for LSS project initiation based on patient risk severity and probability of occurrence. In addition, number of category-specific PSRs may be used as a performance metric where a reduction can correlate to elimination of the specific problem.

## Continuous Process Improvement (CPI) continued

d. **Plan-Do-Check-Act (PDCA) Cycle.** PDCA is a repetitive four-stage model for continuous process improvement similar to the Lean aspect of Lean Six Sigma. The model is implemented to improve the quality and effectiveness of processes.

**(1) Plan:** Define the problem to be addressed, collect relevant data, and ascertain the problem's root cause.

**(2) Do:** Develop and implement a solution; decide upon a measurement to gauge its effectiveness.

**(3) Check:** Confirm the results through before-and-after data comparison.

**(4) Act:** Document the results, inform others about process changes, and make recommendations for the problem to be addressed in the next PDCA cycle.



## HUMAN RESOURCES:

- Job position description current and signed annually
- Privacy Act certification signed by both staff and leadership
- Life Safety/Environment of Care orientation to unit/clinic/department completed prior to providing patient care
- Orientation to hospital and unit/clinic/department within 14 days of reporting day
- Initial competency assessment completed during orientation phase, each line must be initialed and dated and signatures and stamp or legible signature/printed name
- Ongoing education for new equipment or procedures and new services
- Annual performance review
- Competency assessments with annual competency review documented (observations, testing)
- Annual mandatory education; safety, information management and compliance

## REFRIGERATORS:

- Refrigerators are clean, defrosted
- Thermometers are in ALL refrigerators
- ALL 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
- Patient food refrigerators have no medications in them
- All food is labeled and dated; no printed patient labels allowed due to HIPAA
- No leftover food stored/unlabeled in the patient refrigerator
- Medication refrigerators have no food in them
- Juices/Milk/Popsicles must have an expiration date if removed from the original box-- make sure they are labeled once removed

**MEDICATIONS:**

- Can staff identify high alert/look alike sound alike meds? I
- s 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
- All medications are labeled appropriately (**"If it hits the table it needs a label"**)
- No medications are expired
- \*All medications of discharged patients are returned to Pharmacy
- All open single dose vials are discarded, multi-dose vials are good for 28 days, unless taken into a patient room and therefore are considered a single dose
- 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

**Continuous Process Improvement (CPI)**

a. **Quality Management (QM)** -activities are aligned with those of Navy Medicine and focus on improving quality of patient care and services. Performance is a measure of how well the important organizational functions are carried out. The level of quality is the degree to which these services are effective, appropriate, available, timely, continuous, safe, efficient, caring, and respectful. QM is an ongoing cycle of planning, designing, measuring, assessing, and improving performance.

b. **Methodology:** A variety of tools are employed during performance improvement activities. The two primary approaches at NHCP are the **Lean Six Sigma's** Define-Measure-Assess-Improve-Control (**DMAIC**) Model and the Plan-Do-Check-Act Cycle.

c. **The DMAIC Process.** **Lean Six Sigma (LSS)** uses a data-driven approach with strict controls that ensure corrective actions are sustained. **LSS methodology** is used to improve patient care, safety and satisfaction.

(1) **Define.** What is important to the customer?

- (a) Project selection
- (b) Team formation
- (c) Establish goal

(2) **Measure.** How well are we doing?

- (a) Collect data
- (b) Construct process flow
- (c) Validate measurement system

(3) **Analyze.** Analyze the process.

- (a) Analyze data
- (b) Identify root causes

(4) **Improve.** Improve the process performance measures.

- (a) Prioritize root causes
- (b) Innovate pilot solutions
- (c) Validate the improvement

(5) **Control.** Control the process gains.

- (a) Ensure solution is sustained

(6) DMAIC is a structured problem solving methodology that includes a set of valuable tools to help people find permanent solutions to long-standing or complex problems.

**Contact for Command LSS Black Belt / CPI Program Manager—**  
Quality Management Department

**More information is available on the SharePoint site—** Command—  
Continuous Process Improvement



## Record of Care, Treatment and Services (RC) \* Information Management (IM)

**Overview:** To provide timely access to complete and accurate health information needed to aid in clinical decisions making and continuity of care, and to ensure information used by the hospital is categorized, filed, and maintained in a manner to ensure its privacy, security, and integrity.

a. **How are medical records secured?** The paper medical record is maintained in secure areas at all times. The electronic medical record is secured by several different methods, access is based on the staff's role and security, through screen savers, auto timeout, and by logging off the workstation.

b. **How is the confidentiality of patient information protected?**

- (1) Patient's privacy is maintained, whether the information is written, verbal, or electronic
- (2) Computerized systems are password protected
- (3) Privacy Act and HIPAA Operations training is done annually on your birth month.

c. **How are information needs of Staff met?**

- (1) Based on job function, appropriate access is provided to data, reports, and other information
- (2) Knowledge-based information (reference books, professional journals, library resources, etc.) are available. For more information go to the intranet under Resources Clinical tab- Medical Library .

## How to Use This Book.

The handbook is only a guide and not a replacement of the actual Comprehensive Accreditation Manual. The TJC Manual should be used for further clarification.

a. This Survey Readiness Handbook has been developed and updated to provide education regarding accreditation standards, information about how NHCP utilizes these standards to improve processes to continually provide exceptional care, treatment, and services to our patients and their families.

b. Our goal is for the information contained in this pocket guide to assist you in preparing for interacting with the surveyor and serve as a reference guide during our ongoing journey to excellence.

c. If you have any questions, please contact *Quality Management* at 719-3171.

## What is The Joint Commission?

A. The Joint Commission is the recognized global leader for health care accreditation. We are an independent, not-for-profit organization, offering unbiased assessment of your quality achievement in patient care and safety.

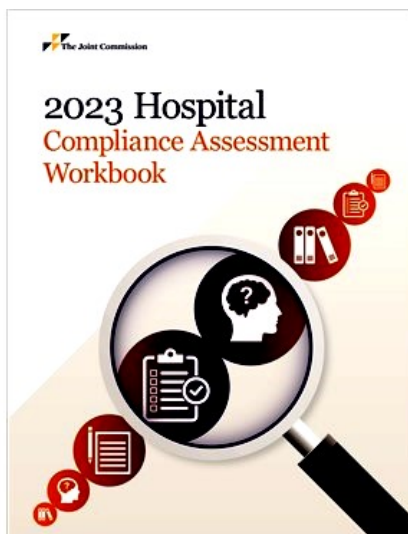
B. **How to contact the Joint Commission.** **The Joint Commission's Office of Quality Monitoring may be contacted by mail or online.**

Online: [www.jointcommission.org/report\\_a\\_complaint.aspx](http://www.jointcommission.org/report_a_complaint.aspx)

Mail: Office of Quality Monitoring  
The Joint Commission  
One Renaissance Boulevard  
Oakbrook Terrace. IL 60181

## Accreditation Survey

- a. The Joint Commission's accreditation process seeks to help organizations identify and resolve problems and to inspire them to improve the safety and quality of care and services provided.
- b. The survey focuses on **continuous operational improvement** in support of safe, high-quality care, treatment and services. This assessment is accomplished through evaluating a compliance with the applicable standards in the accreditation manual, based on the following:
- (1) Tracing the care delivered to patients
  - (2) Verbal and written information provided to TJC
  - (3) On-site observations and interviews by surveyors
  - (4) Documents provided by the organization
- c. The Joint Commission survey process is data-driven, patient-centered and focused on evaluating actual care processes. The objectives of the survey are not only to evaluate the organization but also to provide education and "good practice" guidance that will help staff continually improve the organization's performance. Joint Commission surveys are designed to be organization-specific, consistent and to support the organization's efforts to improve performance. Survey length is determined by information supplied on the application.



## Disclosure.

- a. Disclosure is the process of informing the patient and, when appropriate, the patient's family, in the event of unanticipated or adverse outcomes to care. These outcomes may be positive or negative.
- b. The primary provider or his/her supervisor should expeditiously notify the appropriate hospital representatives of negative unanticipated outcomes. The command Special Assistant for Healthcare Resolutions is available for providers, staff, and patients to assist with disclosure conversations. The Special Assistant may assist the primary provider in deciding who will 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.
- c. Documentation that the disclosure has been held with the patient and/or family and the facts of the medical case should be entered into the medical record as well as any responses by the patient and/or family.
- d. Other pertinent or topics of the conversation should be documented in the Patient Safety Report.

### For more information refer to:

**DoD 6025.13** Medical Quality Assurance in the Military Health System

**BUMEDINST 6010.28** Healthcare Resolution Program

**Contact for Healthcare Resolution Specialist:**

Eve Currie, 719-3207

## Risk Management continued

### j. Employee's Responsibilities in a Sentinel Event:

- Notify your Division Officer, Department Head, and the Clinical Risk Manager at **719-3455** of a possible Sentinel Event
- Secure all evidence and documentation about the event (equipment, syringes, IV bags, medication bottles and vials, etc.). DO NOT change any settings on equipment
- Participate in the investigation of the Root Cause Analysis (RCA), if requested
- Participate in changes made to systems or processes via redesign or redevelopment to reduce the risk of recurrences

k. **Quality of Care Concerns.** Naval Hospital Camp Pendleton wants to know if you have a concern about patient safety or the quality of care provided to our patients. We encourage you to bring your concerns to the attention of your supervisors, leaders and/or the **Patient Safety Specialist at 719-3213** or the **Clinical Risk Manager at 719-3455**.



See Sentinel Event Alert Issue 60, "Developing a reporting culture: Learning from close calls and hazardous conditions," for more information, including examples of establishing trust, adopting a just culture to encourage reporting, learning from close call reporting, leadership engagement and accountability, as well as links to some videos that show leadership communicating commitment to just reporting and learning culture.

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## Tracer Methodology.

A. One key part of The Joint Commission's on-site survey process is the **tracer methodology**. The types of tracers used by The Joint Commission during the on-site survey are:

(1) **Individual tracer activity:** These tracers are designed to "trace" the care experiences that a patient had while at an organization. Patients selected for these tracers will likely be those in high-risk areas or whose diagnosis, age or type of services received may enable the best in-depth evaluation of the organization's processes and practices.

(2) **System tracer activity:** While individual tracers follow a patient through his or her course of care, the system tracer evaluates the system or process, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes. The three topics evaluated by system tracers are:

- a) Data management
- b) Infection control
- c) Medication management.

B. What will the surveyor review during the tracer?

- 1) Review the medical record with staff
  - (a) Observe direct patient care
  - (b) Observe the medication process
  - (c) Observe the care planning process
  - (d) Observe equipment used
- (2) Review competencies, evaluations, and continuing education for Staff with whom the surveyor has interacted with
- (3) Interview the patient and/or family
- (4) Review additional medical records, as needed, from other settings
- (5) Observe Staff-level interaction
- (6) Observe the environment of care and environmental safety
- (7) Discuss National Patient Safety goals and improvements made to patient care and services

## Tracer Methodology continued

c. Which patients are likely to be “traced”?

- (1) Patients with frequently seen diagnoses (the key populations for which we provide care)
- (2) Patients who have received multiple and complex services (often those patients close to discharge)
- (3) Patients who cross programs (e.g., hospital and practice)
- (4) Patients who encounter these processes: Infection Control, Medication Management, Surgery, Sedation, Outpatient Care

d. How many patients will be “traced”, and how long will the tracer take?

- (1) The number of tracers completed can vary, but anticipate two tracers per surveyor per day
- (2) Tracers can take 90 minutes or more per patient
- (3) Tracers begin in the setting where the patient is located, and move to other areas the patient has encountered or is scheduled to encounter

## Risk Management continued

g. Patient Safety Reports (PSRs). What type of events should I report?

- (1) GOOD CATCH!!! (AKA Near-Miss)
- (2) Potential Events/Unsafe Conditions
- (3) Actual Events
- (4) Sentinel Events
  - (a) Patient suicide—includes suicides within 72 hours of discharge
  - (b) Unanticipated death of full-term infant
  - (c) Discharge of infant to wrong family
  - (d) Patient abduction
  - (e) Any elopement leading to death, permanent harm, or severe temporary harm
  - (f) Hemolytic transfusion reactions
  - (g) Rape, assault, or homicide
  - (h) Wrong patient, site, or invasive procedure/surgery
  - (i) Unintended retention of a foreign object
  - (j) Severe neonatal hyperbilirubinemia
  - (k) Prolonged fluoroscopy
  - (l) Fire, flame, or unanticipated smoke, heat, or flashes
  - (m) Intra-partum maternal death
  - (n) Severe maternal morbidity
  - (o) Falls. A fall resulting in fracture, surgery, casting, traction, neurosurgery or general surgery consult, patient with coagulopathy who receives blood products, or permanent harm or death as a result of injuries sustained from a fall.
- h. Potential events, near misses, and actual events include or relate to, but are not limited to, care management, environmental, patient protection, potential criminal, device or product, or anesthesia, invasive procedure, or surgical related events.
- i. Patient safety event resulting in death, permanent harm, or severe temporary harm.
- j. In general, all episodes of care that may, or actually did, jeopardize patient safety, or any near miss or unexpected, unusual, or unplanned event that could have, or in fact, affected a patient should be reported.

## Risk Management

- a. **Potential Event** - any circumstance that increases the probability of a patient safety event
- b. **Near Miss** - a process variation, error, or other circumstance that could have resulted in harm to a patient, but through chance or timely intervention did not reach the patient
- c. **Adverse Event** - unintended occurrences or conditions associated with care or services that reach the patient and may or may not result in harm; may be because of acts of commission or omission
- d. **Sentinel Event** - an unexpected occurrence involving death or serious injury
- e. **How do I report an event?**
  - (1) Complete a **Patient Safety Report (PSR)** using the desktop shortcut icon.
  - (2) Ensure appropriate leadership (e.g., Division Officer, Department Head) is notified of event via face-to-face or telephone contact, NOT via email or other written correspondence.
- f. **What happens to the report after I submit it?**
  - (1) The Clinical Risk Manager reviews the submission and assigns a reviewer to investigate, provide additional details, implement process or system improvements to prevent recurrence, and respond to the PSR
  - (2) Data from reports is analyzed and collated and shared with appropriate committees to improve patient safety

## Survey Analysis for Evaluating Risk “SAFER Matrix

SAFER™ matrix is a scoring approach used for surveys of health care organizations. It is a transformative approach for identifying and communicating risk levels associated with deficiencies cited during surveys. It helps organizations prioritize and focus corrective actions and provides a single comprehensive visual representation of survey findings.

- A. **How the SAFER™ Matrix scoring process works.** The performance expectations for determining if a standard is in compliance are included in its elements of performance (EPs).
  - B. If an EP is determined to be out of compliance, it will be cited as a Requirement for Improvement (RFI).
  - C. Each RFI is placed in the SAFER™ Matrix according to how likely it is that the RFI will harm a patient(s), staff, and/or visitor (low, moderate, high) and the scope, or prevalence, at which the RFI was cited (limited, pattern, widespread).
  - D. As the risk level of a finding or an observation increases, the placement of the standard and EP moves from the bottom left corner (lowest risk level) to the upper right corner (highest risk level).

		Immediate Threat to Life		
Likelihood to Harm a Patient/Staff/Visitor	HIGH			
	MODERATE			
	LOW			
		LIMITED	PATTERN	WIDESPREAD
		Scope		

**~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!

**14. Patient Safety.**

**Overview:** Patient safety is the ongoing proactive evaluation of processes to recognize, analyze, and change the way care is delivered to avoid medical errors and improve the quality of care for our patients.

**a. Key Building Blocks .**

- (1) Report adverse events, sentinel events, close calls/near misses
- (2) Identify underlying causes and system changes that can reduce the potential for recurrence
- (3) Determine cause aimed at **system and process** issues **rather than individual blame/punishment** with a goal of promoting a “no blame” non-punitive culture
- (4) Disseminate safety alerts and lessons learned (share information, communicate)
- (5) Conduct prospective analysis of delivery systems before an adverse event occurs to identify redesigns that will reduce the likelihood of error
- (6) Train staff and encourage initiatives and actions to reduce risks
- (7) Implement continuous process improvement measures for patient safety

**b. What do we expect regarding Patient Safety?**

- (1) Recognition and acknowledgement that there are patient safety risks in the care environment
- (2) Prevention of injury, and management of injury that does occur to minimize negative consequences
- (3) Enhanced performance through:
  - (a) Comprehensive monitoring
  - (b) Standardized reporting
  - (c) Thorough analysis of untoward events
  - (d) Evidence of a “culture of safety” at NHCP



## Infection Prevention and Control (IC) continued

## When are Privacy Curtains Changed?

- ▶ When visibly soiled or stained and following discharge of an isolation patient.

## ▶ Call Linen Operations:

▶ 760-719-3226 operating hours 04:00-15:00

▶ after hours Housekeeping Supervisor  
760-458-1756

- ▶ On a routine schedule per OPMAN.

▶ Refer any questions regarding  
schedule to Linen Operations  
760-719-3226

- ▶ For details see “Healthcare Textiles - Linen, Laundry, Curtains” in IC Manual.

## IMPORTANT NOTES

- ☐ Focus on the **excellent service** or care you provide!
- ☐ Show off the great care and **teamwork**!
- ☐ Listen- if the surveyor goes into teaching mode, listen patiently and thank them for the information.
- \*\*Surveyors have interesting solutions to complex issues that plague hospitals.**
- ~What is a \*\*BEST PRACTICE that they have witnessed\*\***

## 3-SECOND RULE

- Try to answer the surveyor's question within three seconds.
- If you do not know the answer:
  - ☐ (1) Ask the surveyor to **repeat** the question.
  - ☐ (2) Ask for **clarification** if you don't understand
  - ☐ (3) **Redirect** the question to someone who can answer the surveyor's question.

## HOW TO RESPOND

- ☐ Answer **HONESTLY** only the question(s) you are asked.
- ☐ Always start your reply with, "Our Process is..."
- ☐ When asked how to use or how to clean **equipment**, reply with, "The manufacturer's recommendation is..." or "The Instructions for Use (or IFU) says..."
- ☐ Always **remain courteous**, professional, and maintain eye contact.
- ☐ Concentrate on the tasks you do every day like hand washing, using 2 patient identifiers, etc.



## HOW NOT TO RESPOND

- ☐ Do not use: "I think we..." or "Usually we do..." or "We are supposed to..." or "On my shift we..."
- ☐ Do not give your opinion. For example, do not say, "I think they should..." or "I think it should be..."
- ☐ Do not **Challenge the surveyor's findings** or attempt to sway their opinion.

## Joint Commission Word Scramble

1. NAHD IGYEEHN \_\_\_\_\_
2. TOW AITNPTE TREFNIISE \_\_\_\_\_
3. SINNLTEE ETNEV \_\_\_\_\_
4. OMIRNFED EONSTCN \_\_\_\_\_
5. ATHTCERE EFNTINCOI \_\_\_\_\_
6. VNIGAEET PUSRRSEE ITNTNEIVLAO \_\_\_\_\_
7. RTAEUPERTME TMDIHUY LGO \_\_\_\_\_
8. RREILDLBTIOAF CHSKEC \_\_\_\_\_
9. WROK LAPCE ECVOLIE YOCLPI \_\_\_\_\_
10. NTIAEOCIMD AINCRLNCIOETIO \_\_\_\_\_
11. ENMYECERG DRE BOKO \_\_\_\_\_
12. GHENEETI CSEHIN \_\_\_\_\_
13. OD TNO SEU AESVOBRBAINTI \_\_\_\_\_
14. EREHT UTMNIE ACTTNCO MTIE \_\_\_\_\_
15. DONIFERM NENTOCs \_\_\_\_\_
16. IUECSID KSIR SSETESNSMA \_\_\_\_\_
17. NADTDRSA OEARGTIPN ECUDREPOR \_\_\_\_\_
18. OINENLVTEAMR EPSCTA STEHE \_\_\_\_\_
19. EDNGIS TIONPOIS POICTERDINS \_\_\_\_\_
20. OAENNXLO PRRINSCBEGI \_\_\_\_\_
21. ADHN EYIGNHE IWHT FCCID \_\_\_\_\_
22. LDEPEO LCIDH RO AUDLT \_\_\_\_\_
23. DTSANDR PENSORCATUI \_\_\_\_\_
24. DOOBL AISRTONFNU OLICPY \_\_\_\_\_
25. TDLINIARNGEEC RSEOPC \_\_\_\_\_
26. DMISSAOIN RKSI NAEMTSSSES \_\_\_\_\_
27. TLSREIE ALHDNNGI PERRCUEDO \_\_\_\_\_
28. OTPANIREAS FO LNCEA YIRTD \_\_\_\_\_
29. ETARRITNS SUNCIELOS LYCPIO \_\_\_\_\_
30. CNPATLMIO ICGVAEENR ICYOPL \_\_\_\_\_

## Infection Prevention and Control (IC) continued

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



## Infection Prevention and Control (IC) continued

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

- At **POINT OF USE:**
- Use proper PPE: gloves, impervious gown, and face shield.
- Remove gross bioburden from instruments with water not normal saline
- Open instruments and use nylon brushes to remove visible bioburden/debris.
- Dispose of and replace brushes daily.
- Place instruments in red biohazard labeled instrument transport bin
- Thoroughly coat instruments with Enzymatic Debridement Solution/Gel (i.e. Pre-Klenz Gel).
- Secure lid on bin to delay Pre-Klenz transport Gel from drying out on instrumentation.
- Transport instruments to dirty side of SPD in bin with the lid secured daily.
- Ensure clinic instrument processing form is correctly filled out and verified with SPD staff member.
- Bring soiled instruments to dirty side of SPD from 0730 – 1600.
- Have a PLAN to Control Infection!!



## TeamSTEPPS®- Team Strategies and Tools to Enhance Performance and Patient Safety Core Teamwork Skills

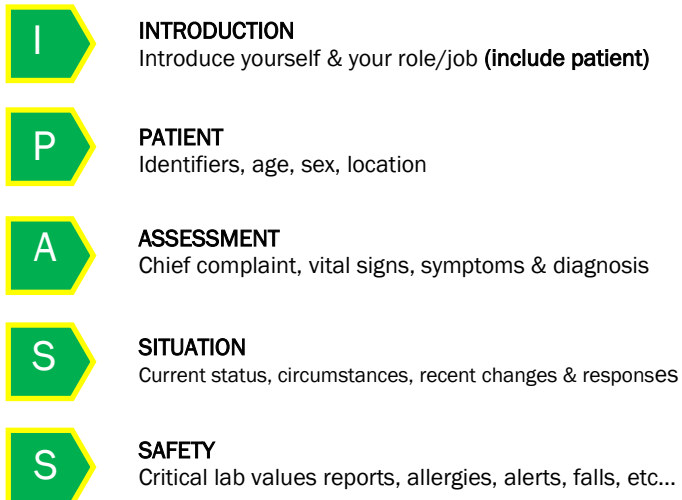
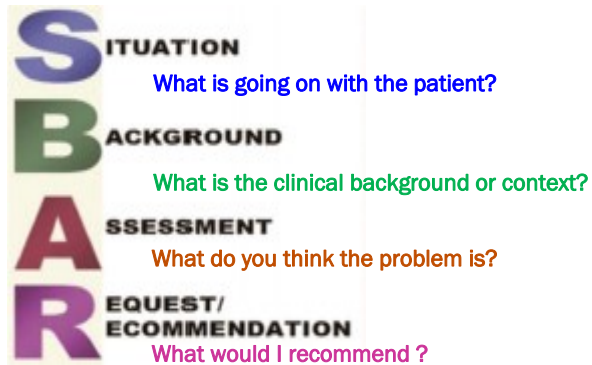


TeamSTEPPS® provides higher quality, safer patient care by producing highly effective medical teams that optimize the use of information, people and resources to achieve the best clinical outcomes for patients; increasing team awareness and clarifying team roles and responsibilities; resolving conflicts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

**TeamSTEPPS® is the Standardized language structure of communication used at NHCP**

**SBAR** provides a framework for team members to effectively communicate information to one another.

Communicate the following information:



## Infection Prevention and Control (IC) continued

**CONTACT TIME:**  
SURFACE STAYS WET FOR REQUIRED TIME

Hydrogen Peroxide	Germicidal Bleach	Multi-Surface Alcohol Quat
<b>1</b> MINUTE For General Use	<b>1</b> MINUTE For General Use	<b>2</b> MINUTES For General Use

## Infection Prevention and Control (IC) continued

b. **How should I clean my hands?** You can use either soap and water or an approved hand sanitizer, depending on the situation:

(1) When hands are visibly dirty, contaminated, or soiled, wash them with soap and water for 15 seconds

(2) If hands are NOT visibly soiled, use an alcohol-based hand sanitizer for routinely decontaminating hands

c. **Important Points:**

(1) Jewelry should be removed prior to hand cleaning

(2) Artificial nails should not be worn by employees who provide direct patient care or who handle or prepare food or medications

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

d. **What's Your Risk?** If you come in **DIRECT CONTACT** with blood, mucous membranes, non-intact skin, or other potential infectious material by handling contaminated items or surfaces? Do you perform vascular access procedures? Then you are at risk for **Bloodborne Pathogens**.

e. **Standard Precautions.**

(1) An approach to infection control that treats **all body fluids** and substances as if they were infectious for HIV and HBV or other Blood-borne Pathogens.

(2) **Standard precautions include:** hand hygiene, appropriate personal protective equipment (PPE) such as **gloves, gowns, masks**, whenever touching or exposure to patients' body fluids is anticipated.

f. **Personal Protective Equipment (PPE).** Used for your eyes, face, hands, and extremities. Includes protective clothing, respiratory devices, and shields/barriers. Keep PPE clean and store it where you will most likely need to use it.

**For more information refer to: Infection Control Manual**

◆ It is critical that ALL staff are familiar with TJC National Patient Safety Goals (NPSGs) and incorporate them into daily practice.

(1) **Goal 1: Improve accuracy of patient identification.**

(a) Use at least two ways to identify patients. For example, use the patient's name and date of birth.

(b) Label containers used for blood and other specimens in the presence of the patient.

(c) Use distinct methods of identification for newborn patients.

(2) **Goal 2: Improve the effectiveness of communication among caregivers.**

(a) Develop procedures for managing critical results

(b) Implement the procedures for managing critical results.

(c) Evaluate the timeliness of reporting critical results.

(d) Know that NHCP HAS a policy on communication of critical results.

(3) **Goal 3: Improve the safety of using medications.**

(a) Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

**"If it hits the table it needs a label".**

(b) Take extra care with patients who take medicines to thin their blood.

(c) Medication Reconciliation:

1. Find out what medications/supplements the patient is current taking.

2. Compare those medicines to new medicines given to the patient.

3. Make sure the patient leaves and understands which medicines to take when they are home

**For more information refer to: Labeling of Medications Policy, Anticoagulation Therapy Policy, and Med Rec Policy.**



(4) **Goal 6: Improve the safety of clinical alarm systems.** Make improvements to ensure that alarms on medical equipment are heard and/or visualized responded to promptly.

**For more information refer to: Alarm Management Policy**

(5) **Goal 7: Reduce the risk of health care –associated infections.**

(a) Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

(b) Use proven guidelines to prevent infections that are difficult to treat.

(c) Use proven guidelines to prevent infection of the blood from central lines.

(d) Use proven guidelines to prevent infection after surgery.

(e) Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

**For more information refer to: Resource Clinical—Infection Control Manual**

(6) **Goal 15: Identify safety risks inherent in its patient population.** Identify patients at risk for suicide.

**For more information refer to:**

1. *Work Place Violence Policy*
  2. *NHCP SOP: Nursing Care of Mental Health Patients*
- NAVHOSPCAMPENINST 1720.4
3. Care of a Suicidal Patient and 1:1 policy

## Medication Management Continued

f. **Adverse Drug Reactions.** An Adverse Drug Reaction (ADR) is an unintended, undesired, unexpected side effect or allergy that a patient experiences from a medication or administered medical product. Any physician, nurse, Hospital Corpsman, pharmacy staff or healthcare provider can **report an ADR** electronically using the **Event Reporting tab**, located on the **command intranet**.

g. **What has been done to reduce the risk of medication incidents in my area?**

(1) Limiting the number of medications concentrations available on each unit (i.e. Heparin concentrations)

(2) Double check requirement for High-Alert Medications

(3) Identifying patients using two unique identifiers prior to medication administration

(4) Identifying and Addressing use of “Do Not Use” abbreviations

(5) Processes for managing “Look-a-Like, Sound-a-Like” medications

## 13. Infection Prevention and Control (IC).

**Overview:** To develop and maintain an effective Infection Prevention and Control program that addresses a wide range of situations and incorporates activities of planning, implementation, and evaluation.

a. **Hand Hygiene. When should I clean my hands?**

- (1) Before and after contact with patients
- (2) Before and after wearing gloves
- (3) After contact with blood, body fluids, non-intact skin, or mucous membranes
- (4) After contact with equipment
- (5) Before and after eating
- (6) After using the bathroom
- (7) After sneezing or coughing



## Medication Management Continued

### e. 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 use of carbon or faxed copies result in tenfold overdose	<b>Never</b> 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	<b>Always</b> 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 handwritten, 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	Misread as Morphine Sulfate	Write "morphine sulfate"
MS MSO4	Misread as Magnesium Sulfate	Write "magnesium sulfate"
T.I. W.	Misinterpreted as "three times a day" or "twice a week"	Write "three times a week"
SS	Misinterpreted as "55"	Write "sliding scale" Use "one-half" or 1/2
H.S.	Mistaken for either half-strength or hour of sleep (at bedtime). q.H.S. mistaken for every hour. All can result in dosing error	Write "half-strength" or "at bedtime"

## NPSGs continued

### b. Universal Protocol: Prevent errors in surgical and non-surgical invasive procedures.

#### (1) Pre-procedure verification.

(a) Verify that you have the correct patient, correct procedure and correct site

(b) Verify that all necessary documents, relevant information, equipment and blood products are available

(c) Match the items that are to be available in the procedure area to the patient

#### (2) Site Marking.

(a) Mark the part of the body where procedure or surgery will be done; if possible with active patient involvement

(b) Continuous presence exemption: Site marking is not required when the individual performing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure

#### (3) Time-out.

(a) Perform a "time-out" before the invasive procedure

(b) The team performing the procedure must agree on:

1. Correct patient identity
2. The correct site
3. The procedure to be done

(4) When flammable germicides or antiseptics are used during surgeries utilizing electrosurgery, cautery, or lasers, the following are required (EC.02.03.01)

(a) Nonflammable packaging

(b) Unit-dose applicators

(b) Preoperative time-out prior to the initiation of any surgical procedure to verify the following:

1. Application site is dry prior to draping and use of surgical equipment
2. Pooling of solution has not occurred
3. Solution-soaked materials have been removed from the operating room prior to draping and use of surgical devices.

## Rights & Responsibilities of the Individual (RI).

a. **Overview:** To recognize and respect the rights of the patient, and provide care, treatment and services in a manner that respects and fosters the patient's dignity, autonomy, positive self-regard, civil rights, and involvement in his or her care. Care, treatment, and services should also be carefully planned and provided with regard to the patient's personal values, beliefs, and preferences. (below are a few examples of Patient/Family Rights)

b. Patient/Family Rights.

- (1) To be granted access to care and treatment
- (2) To receive an explanation of any procedures or treatments, so that you may give informed consent
- (3) To have pain managed and participate in how pain is managed
- (4) To be treated with respect and courtesy
- (5) To have medical record information treated as confidential
- (6) To expect the visit will be as safe and comfortable as possible
- (7) To receive complete and current information about diagnosis, treatment, medications, and proposed future health care needs in a language you can understand

c. **How are patients informed about their Rights & Responsibilities?**

- (1) Upon admission, each patient is given the Patients Bill of Rights and Responsibilities
- (2) The Patients Bill of Rights and Responsibilities is posted on the NHCP Internet, Intranet, and in clinical areas of the hospital

d. **Does a patient have a right to refuse treatment?**

- (1) **Yes.** Patient and family involvement in care decisions is encouraged, including the right to refuse care, treatment, and services to the extent permitted by law and to be informed of the consequences of your decision. You have the right to leave the facility against medical advice to the extent permitted by law.

**For more information refer to:** *The Patients Bill of Rights (current version)*

## Medication Management continued

d. Medication Expiration

(1) **To identify the expiration date—do I write the date opened, or the last day the product may be used?** The Joint Commission requires organizations to store all medications labeled with an expiration date, and has clarified “expiration date” to mean the *last date* the product may be used. Further, the original expiration date for all drugs is valid under the assumption the product has not been opened. For multi-dose vials, once the vial is opened or punctured, the original expiration date is no longer valid and a revised expiration date must be identified. The Joint Commission requires multi-dose vials be relabeled with the revised expiration date once the vial is opened or punctured. Therefore, the *last date* the product may be used, **not** the date the product was opened, must be identified on the label.

(2) **Exceptions to the 28 day expiration of multi-dose vials are included below:**

- (a) The manufacturer identifies an extended expiration date in the product packaging, indicating the manufacturer has conducted testing beyond the minimum required 28 days.
- (b) The manufacturer identifies an expiration date earlier than the 28-day expiration date, in which case the earlier date must be used.
- (c) Currently, vaccines are exempted from this requirement (Please review the CDC Vaccine Storage and Handling Toolkit, JAN 2019). The Centers for Disease Control and Prevention (CDC) Immunization Program states that vaccines are to be discarded per the manufacturer's expiration date (Exceptions: PPD expires 30 days from date of opening). 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 the vaccines are stored and handled appropriately (for proper labeling guidance review the DHA Vaccine Guide 2017).

**For more information refer to:**

**Infection Control Manual** (*titled: Multi-dose Medications*) on the intranet under *Resource Clinical*

PREPARING/ DISPENSING	ADMINISTRATION	MONITORING
Per standard heparin Power Plans for both Cardiology and DVT/PE. Heparin added to parenteral solutions only by Pharmacy. Warfarin: Inpatient orders renewed daily after daily chart and INR reviews.	<input type="checkbox"/> Double-check (UFH): required by second RN (Boluses, dose changes, new bag hung and each shift change); Smart pumps used. <input type="checkbox"/> Double-check (Oral Tabs): 2 person verification 1 of which must be an RN and the other may be an HN.	Heparin Drip: Per Protocol (doses adjusted based on Anti-Xa levels); Recheck at least daily (every 6 hours if changes to dosing). Oral Anticoagulants: Per NHCP Protocol **Warfarin: monitor daily PT/INR prior to each dose.
All intravenous compounding of KCl done in Pharmacy. NaCl fluid orders exceeding 0.9% require pharmacist review and approval.	<input type="checkbox"/> Double-check required by second RN prior to infusion; 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
Wards/ER guided by protocol. Standard drip concentration= 1 unit/1ml (100ml bag)	<input type="checkbox"/> Double check: 2 person verification 1 of which must be an RN and the other may be an HN.	Monitor blood glucose as ordered.
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)	<input type="checkbox"/> Double check required by second RN or LIP/ prior to administration when medication drawn up by a RN.	Per Protocol
Utilize order sets and guided protocols	<input type="checkbox"/> Double check required by second RN prior to administration and IVPB bag change; Smart pumps used	Per Protocol
Per PCA Power Plans. Per Epidural Power Plans.	<input type="checkbox"/> Double-check required by second RN at initiation, all dose changes, solution replacement, & shift handoff.	Monitor vital signs, sedation level, signs of dizziness, diaphoresis, itching, orthostatic hypotension, or confusion.
Inpatient: Two pharmacy staff members will confirm appropriateness of weight based dosing	<input type="checkbox"/> Double check required by second RN or HN prior to administration.  Inpatient: RNs confirm the appropriateness of weight based dosing.	

## RI continued

### e. What is “Informed Consent?”

(1) **Informed Consent** is a process that allows the patient, or the patient’s legal representative, full participation in decisions regarding the patient’s care, treatment, and services.

(2) Informed consent can only occur when the patient, or the patient’s legal representative, fully understands the nature of the intervention and its risks and benefits, as well as the alternatives and their risks and benefits.

(3) Informed consent occurs when the patient, or the patient’s legal representative, accepts or rejects a medical intervention willingly and without coercion.

**For more information refer to: NAVHOSPCAMPENINST 6320.16 series— *Informed Consent for Medical and Dental Treatment and Minor Consent***

### f. What is an “Advance Directive,” and who needs one?

(1) An Advance Directive is a legal document indicating what life-sustaining treatment is to be administered, discontinued, or withheld if an individual has lost his or her ability to make medical decisions about his or her own health care.

(2) Patients 18 years or older are legally considered adults, and expected to make their own decisions, unless a legally recognized surrogate decision-maker is identified.

(3) It is our responsibility to ask all patients who are 18 years or older if they have an Advance Directive.

**For more information refer to: NAVHOSPCAMPENINST 6320.71 series—*Advanced Health Care Directives and Do Not Attempt Resuscitation Orders***

**g. Providing Information in a Manner Patients and Families Understand.** NHCP makes reasonable efforts to tailor information to the patient’s age, language, and ability to understand, as well as to the communication needs of patients and families. Below are some of the services offered to provide for effective communication.

**RI continued**

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h. **Individuals with limited English proficiency.** Language Line services— NHCP has a contract with a Telephone Interpretation Services. To utilize the services contact the Command Duty Officer (CDO) at the Quarterdeck. The Language Line service provides support in over 151 languages, and is available 24/7.

i. **Hearing Impaired/Deaf Individuals.**

(1) Sign Language interpreting services is provided by Deaf Community Services of San Diego (DCS).

(2) Assistance may be requested Monday thru Friday 0730-16:00 by contacting Patient Relations at (760) 725-1436 or in person at the information desk which is located on the 1st Floor. Patient Relations will arrange for the service. After hour, weekend and Federal holidays the OOD will arrange the service.

**For more information refer to: NAVHOSPCAMPENINST 6320.100**  
series— *Translation Line Communication Accessibility for Non-English Speaking and Impaired Beneficiaries*

## Quiz Questions

- 1) What do you do to prevent the spread of disease?  
Answer: Wash my hands or use hand sanitizer before and after each patient interaction
- 2) How do you know you have washed your hands long enough?  
Answer: I wash my hands with soap and water for thirty seconds or use alcohol-based hand sanitizer for at least 15 seconds until dry
- 3) How do we ensure we have the right patient for treatment or services?  
Answer: I ask them two patient identifiers every time I work with a patient. (name and date of birth)
- 4) What policies are in place to maintain cleanliness in your clinic?  
Answer: We do weekly field days led by our leadership and record results in the Weekly Field Day Tracer log online or emailed to QM.
- 5) How often do you clean patient exam tables or equipment.  
Answer: After each patient encounter or visibly soiled.
- 6) How often do you change the curtains in your area?  
Answer: Facilities Housekeeping changes our curtains every year or every six months, or we call them to change them sooner if they are visibly soiled. The phone number is \_\_\_\_\_
- 7) How often do we check our crash cart and/or AEDs?  
Answer: Every day when open according to policy and recorded on the log book
- 8) How do you know the proper way to clean your equipment?  
Answer: Our department refers to the MIFU online at onesource/docs.com the log in is "nhcp" and password is "nhcp1"
- 9) What do you do in case of a CODE RED?  
Answer: First, we R-A-C-E then we P-A-S-S  
R- rescue; A- alarm; C- confine; E- extinguish/evacuate  
P- Pull the pin; A- aim the extinguisher; S- Squeeze the trigger; S- Sweep the spray
- 10) How do you know if your providers are privileged to perform certain procedures?  
Answer: The privileging list is on our command SharePoint under Clinical Support Services → Provider Privileges
- 11) How do you call a CODE BLUE?  
Answer: I look at my Command Badge Card and call 725-1222 with age, male/female

## RI continued

**J. Complaints, Concerns, & Grievances. If a patient or family member has a complaint, concern, or grievance, how do I assist them?**

(1) Complaints, concerns, and grievances are always taken seriously, and an attempt is made to resolve them at the level closest to the patient whenever possible.

(2) Patients and families can fill out a Patient Relations Worksheet either by requesting a form from any department or via the internet at [www.med.navy.mil](http://www.med.navy.mil).

(3) ICE Complaints (click on "HEALTH"):

(a) NHCP:

[https://ice.disa.mil/index.cfm?fa=site&site\\_id=148](https://ice.disa.mil/index.cfm?fa=site&site_id=148)

(b) Yuma:

[https://ice.disa.mil/index.cfm?fa=site&site\\_id=250](https://ice.disa.mil/index.cfm?fa=site&site_id=250)

(4) Patients and families may share their concerns after trying to resolve with NHCP with The Joint Commission:

(a) Online: [www.jointcommission.org](http://www.jointcommission.org) click on "Report a Safety Event" button on the home page of the website under "Connect With Us".

(b) Fax: (630) 792-5636 Office of Quality Monitoring

(c) Mail: Office of Quality and Patient Safety

The Joint Commission

One Renaissance Boulevard

Oakbrook Terrace, IL 60181

**For more information refer to:**

**BUMEDINST 6300.10** series— Medical and Dental Treatment Facility Customer Relations Program

## Provision of Care, Treatment and Services (PC)

a. **Overview:** To create and support a care process that is integrated and cyclical, and that allows care to be delivered according to patient needs and the hospital's scope of services. This care process may occur between multiple organizations or it may be limited to the organization itself. The complexity of providing care, treatment, and services through this process requires an interdisciplinary collaborative approach and a mutual effort among those who work in the organization to coordinate care in a manner that is conducive to optimal patient outcomes, quality, and safety.

b. **Four core components of the care process**

- (1) Assessing patient needs
- (2) Planning care, treatment, and services
- (3) Providing care, treatment, and services
- (4) Coordinating care, treatment services

c. Within these core process, care activities include the following:

- (1) Providing access to levels of care and/or disciplines necessary to meet the patient's needs
- (2) Interventions based on the plan of care, including the education or instruction of patients regarding their care, treatment, and services
- (3) Coordinating care to promote continuity when patients are referred, discharged, or transferred
- (4) Communication collaboration, and coordination are among the most important in order to provide the highest level of care, treatment, and services.

DRUG/Confused Drug Name	SAFETY STRATEGIES (pairs grouped by common safety strategies)
cloNIDine AND clonazEPAM celecoxib (CeleBREX® ) AND/OR citalopram (CeleXA®) AND/OR fosphen- ytoin (Cerebyx®)	* Indicate standard directions and indication in the SIG section. Pharmacist to verify indication with patient or medical record when not included in SIG.
Diazepam AND diltiazEM	
hydrOXYzine AND hydralazine	
topirimate (Topamax®) AND metoprolol (Toprol XL®)	
ePHEDrine AND ePINEPhrine	* 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.
HYDROmorphine (Dilaudid®) AND Morphine (Astromorph®,Dura morph®)	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 interchangeable.
Insulin Products Lantus® and Lente®; Lispro® and Lantus®; Humalog® and Humulin®;Novolog® and Novolin®;Humulin® and Novolin®; Humalog® and Novolog®	Limit the variety of insulin products stored in patient care areas. Do not stock the 500 units/ml concentration of insulin outside of pharmacy.
oxyCONTIN® (oxycodone controlled- release) AND oxyCODONE (immediate release)	Verify with provider when it is unclear if the immediate release or controlled release 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.
buPROPion SR AND buPROPion XL	Default SIGS to indicate BID vs. Daily dosing  Extended Release Formulations flagged as **ONCE DAILY DOS-  ING**
divalproex AND divalproex ER	
metoprolol (Lopressor®) AND metoprolol ER (Toprol L®)	
tolterodine AND tolterodine (Detrol LA®)	
GENERAL SAFETY STRATEGIES FOR STORAGE IN PATIENT CARE AREAS	
Storage within Pyxis® MedStation® AND CUBIE drawers is maximized to allow user access ONLY to the medication selected vice any medication in a particular drawer.  Tall Man Lettering utilized in ‘MHS Genesis’ for confused drug names where technology supports Pyxis® MedStation® provides “Look-Alike Sound-Alike” warning upon removal of medication  Routine verbal orders are not authorized  Medication storage areas are surveyed to ensure physical separation of any products with LASA based on medication name or physical appearance of the product; pharmacy is contacted to arrange purchase of alternate products  Affix “LOOK ALIKE SOUND ALIKE” stickers to storage locations where appropriate  Errors and near misses are reported via the Joint Patient Safety Report Tool	
GENERAL SAFETY STRATEGIES WHEN DISPENSING PRESCRIPTIONS FROM PHARMACY	
Prescriptions filled using bar coding technology  Tall Man Lettering utilized in order entry system for confused drug names  Affix “LOOK ALIKE SOUND ALIKE” stickers to storage locations where appropriate  Errors and near misses are reported via the Joint Patient Safety Report Tool	



## Medication Management

a. **Overview:** The safe and effective management of medication through carefully planning and implementing medication management processes based on the care, treatment, and services provided by the organization. A safe and effective medication management system addresses critical medication processes identified below:

- (1) Planning
- (2) Selection & Procurement
- (3) Storage
- (4) Ordering
- (5) Preparing & Dispensing
- (6) Administration
- (7) Monitoring
- (8) Evaluation

b. **Medication Security. Who has access to medication storage areas?** Access to medication storage areas is limited to authorized personnel involved in the dispensing, administration, and distribution of medications. All inpatient and outpatient locations that have medication storage areas are responsible for ensuring that only authorized individuals have access to these areas.

c. **Naval Hospital Camp Pendleton HIGH-ALERT MEDICATIONS (HAMS).** High-alert medications (HAMS) are drugs that bear a heightened risk of causing significant patient harm when they are used in error and are involved in a high percentage of errors and/or sentinel events. Although error may or may not be more common with these medications, the consequences of an error are clearly more devastating to patients.

**REQUIREMENT:** The Joint Commission Hospital Accreditation Standards. MM.01.01.03, "The hospital safely manages high-alert and hazardous medications."

**REFERENCE:** Institute for Safe Medication Practices (ISMP) List of High-Alert Medications in Acute Care Settings

## PC continued

d. Patient Assessment. **How are the needs of the patient known or identified?**

(1) Information about the patient's physical, psychological, social, cultural, and spiritual needs are obtained during the initial assessment, primarily by the physician and nurse caring for the patient. Other members of the health care team— such as case managers, social workers, dietitians, pharmacists, and rehabilitation or respiratory therapist also assist with needs identification.

(2) Upon admission, assessments include questions geared toward identification of functional, nutritional, and spiritual needs. Based on the results of these assessments, referrals are made to the appropriate services.

**For more information refer to:**

**BUMEDINST 6010.17 series**

**NAVHOSPCAMPENINST 6010.26 series—Medical Staff Bylaws**

**Departmental SOPs**

**Nursing Unit SOPs.**

(3) **If I suspect a patient is a victim of abuse, what should I do?**

(a) Contact the Social Work Department as soon as possible. During normal working hours, staff social workers report suspected abuse incidents to the appropriate agencies.

(b) For branch health clinics, staff health care providers are responsible for reporting suspected abuse incidents to the appropriate agencies.

**For more information refer to:**

**NAVHOSPCAMPENINST 5800.4 series—Child Abuse Protocol**

**NAVHOSPCAMPENINST 5800.5 series—Dependent Adult & Elder Abuse**

**NAVHOSPCAPENINST 6320.29 series—Spouse & Partner Abuse Protocol**

## PC continued

## e. Pain Assessment &amp; Management

(1) **What are my responsibilities related to pain assessment and management?**

(a) Each health care provider is expected to aid in the management of pain based on his or her area of specialty.

(b) Pain intensity is documented in the patient's record.

(2) **When and how is pain assessed?** Pain is considered the fifth vital sign and is assessed at least as frequently as vital signs are taken.

(a) **When.**

1. Upon Admission
2. After all operative or invasive procedures
3. After procedures associated with pain
4. After significant change in the patient's condition
5. Within 1 hour following any pain intervention
6. Each outpatient visit

(b) **How.**

1. Questions to ascertain if pain is present  
 2. Assessment of nonverbal cues indicating the presence of pain. If pain is present, further evaluation and intervention is initiated.

(3) **What do I do if the patient does have pain?**

(a) Patients who report pain are further assessed to determine the quality, location, frequency, duration, aggravating and alleviating factors.

(b) The pain scales used are FLACC, Defense Veteran Pain Rating Scale FACES, numerical rating scale and 18 Multi-Language Pain Assessment Scale

(c) Patient's response to comfort measures and analgesic medications are **evaluated within one hour after the intervention/medication administration.**

**For more information refer to:**

**Pain Management Resource Guide:** Intranet-Resource Clinical NAVHOSPCAMPENINST 6320.101 series—*Pain Management Policies & Procedures*

**Nursing Unit SOPs and Departmental SOPs**

## PC continued

I. **Patient & Family Education.**(1) **When are patient and family education needs determined?**

(a) Initially at the time of admission, and subsequently throughout the patient's stay, the health care team assesses the patient and family to determine their individual education needs.

(b) The patient and family education needs assessment includes an assessment of learning and communication preferences, including the preferred language for discussing health care, and any barriers to learning and communication, such as sensory impairment, language barriers, as well as cultural and religious beliefs.

(2) **What type of education is provided to patients and families?**

- (a) The patient's plan for care, treatment and services
- (b) Patient safety
- (c) Safe and effective use of medications
- (d) Nutrition, including weight management
- (e) Pain (risk of, assessment of, methods and importance of pain management)
- (f) Tobacco cessation
- (g) Cholesterol and diabetes education
- (h) Childbirth education

j. **Discharge Planning. When is discharge planning initiated?**

Discharge planning begins prior to, or upon admission and continues throughout the hospital stay.

## PC continued

(1) **What is the hospital's policy on the use of restraints and preventive strategies?** Prior to restraint initiation, alternative and preventive strategies are attempted. Alternative strategies include, but are not limited to:

- (a) Providing companionship—family or friends sitting with the patient
- (b) Diversionary activities—television or radio
- (c) Decreasing environmental stimuli—light, noise, or temperature modification
- (d) Assessing patient for pain and offering PRN medications
- (e) Attending to physical needs—hydration, nutrition, or toileting
- (f) Pharmacological interventions—benzodiazepines or antipsychotics
- (g) One-on-one care
- (h) Verbal redirection, de-escalation, or limit setting

(2) **When might it be necessary to restrain a patient?**

(a) If alternatives are ineffective in protecting the safety of the patient or others, restraints may be necessary. Clinical justification and other requirements must be documented.

(b) **Restraints are always discontinued at the earliest possible opportunity.**

(3) **What type of restraint devices are used?** No makeshift restraint devices will be used. Physically holding the patient is only authorized during the restraint application, and will not exceed 30 minutes. Authorized restraint devices are:

- (a) Soft limb
- (b) Hand mitts
- (c) Hard limb

(4) **Required documentation.**

- (a) ED Restraint Order/Release or ICU/MSW Restraint Order set
- (b) ICU/MSW Restraint Note
- (c) Safety checks every 2 hours (non-behavioral) or 15 minutes (behavioral)

**For more information refer to:**

**NAVHOSPCAMPENINST 5530.3 series — Restraint of Patients**

## PC continued

f. **Rapid Response Team (RRT). Why does the Hospital have a Rapid Response Team?**

(1) The majority of patients who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a patient's condition by specially trained individuals may reduce cardiopulmonary or respiratory arrest and patient mortality. The hospital's RRT includes:

- (a) Intensive Care Unit Charge Nurse
- (b) Respiratory Therapy Technician
- (c) Medical Officer or the Day (MOOD). The MOOD will request notification of the duty Pediatrician or Family Medicine Attending if further consultation is required.
- (d) Nurse of the Day (NOD)

g. **How do I contact the Rapid Response Team (RRT)?**

(1) **Who?** Any member of the health care team concerned about a patient's change in condition

(2) **Why?** Acute change in patient status

(3) **How?** Any staff member will call the Quarterdeck to initiate the RRT. Caller will state "RRT (adult, pediatric, or neonate)", and give their name, location, and unit telephone number.

**For more information refer to:**

**RRT Program Policy** - (Intranet - Event Reporting- CPR Committee—Instructions and Policies)

h. **Restraints.** NHCP recognizes the patient's right to be free from restraints. All patients are treated with the least restrictive measures, consistent with their individual safety and the safety of others in the environment.