The Nurse Agency Orientation

This packet includes important material about:

- The RN job description
- The CNA job description
- Patient Restraints
- Pain Management Standards
- The Nurse Agency's Drug Free Workplace Policy
- The Nurse Agency's Sexual Harassment Policy
- The Nurse Agency's Cultural Diversity and Sensitivity Policy
- JCAHO National Patient Safety Goals
- The Rights of Patients and Ethical Aspects of Care
- Sentinel Event Reporting
- The HCAHPS Survey – Frequently Asked Questions

After carefully reading through all of the materials please:

- Sign and date the form indicating that you have read all Orientation materials

The Nurse Agency Registered Nurse Job Description:

RN must have one year of recent experience in their area of expertise and must pass an area specific exam with an 80% or better.

RN must have knowledge of the information and techniques needed to diagnose and treat injuries, diseases, and deformities. This includes: symptoms, treatment alternatives, drug properties and interactions, and preventive health-care measures; knowledge of plant and animal living tissue, cells, organisms, and entities, including their functions, interdependencies, and interactions with each other and the environment; knowledge of principles and processes for providing customer and personal services including needs assessment techniques, quality service standards, alternative delivery systems, and customer satisfaction evaluation techniques.

RN must also possess the following skills and abilities: talking to others to effectively convey information; actively looking for ways to help people; the ability to communicate information and ideas in speaking so others will understand; the ability to listen to and understand information and ideas presented through spoken words and sentences; the ability to tell when something is wrong or is likely to go wrong. It does not involve solving the problem, only recognizing there is a problem.

The Nurse Agency Certified Nursing Assistant Job Description

Job Description:

CNAs provide basic patient care under the direct supervision of the nurses responsible for providing direct patient care. CNAs may spend more time with patients than anyone else on the health care team. For this reason, they can easily form lasting connections with patients, especially when they work in extended- care facilities where the same patients are cared for each day.

Duties and Responsibilities:

- Take vital signs (temperature, blood pressure, pulse, and respiratory rate).
- Provide direct patient care such as assisting with bathing, eating, dressing, and walking patients.
- Turn and reposition bedridden patients to prevent breakdown of their skin.
- Change bed linens.
- Record amount of oral intake and measure urinary output.
- Collect specimens for tests.
- Supply and empty bed pans.
- Interact with patients and family.
- Transport patients and equipment as needed.
- Keep a record of care given.
- Monitor patients and report any variances to normal to the nurse for further assessment.
- Follow infectious disease precautions to prevent the spread of organisms.
- Conduct blood glucose monitoring (if within the Hospitals' Policies and Procedures).

Personal Qualities:

CNAs spend much of their time with patients who are ill or injured, sometimes doing unpleasant work such as changing bedpans. They must be compassionate and truly interested in helping others. Other important qualities are patience, honesty, good health, and the willingness and ability to follow directions.

Physical Requirements:

CNAs spend a lot of time walking and moving about. They must have sufficient strength to turn, lift, and assist patients with movement.

Standards for Seclusion/Restraint for Behavioral Management: May 2000

Current Policy	HCFA Rules	JCAHO Standards	Action Plan
	Application: Rules related to restraint/seclusion concern their use in two situations: respectively, standard (e), use of restraint in medical and post-surgical care; and standard (f), **emergency** use of restraints/seclusion in behavior management. For both situations, it is important to note that these requirements **are not specific to any treatment setting**, but to the situation the restraint is being used to address. **Emergency:** a situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious dangers to the safety of the patient, other patients, staff, or others. **NOTE:** The behavior management standard does not apply to situations where the patient is restrained to address the risk of a fall or to control wandering.	**Application:** The behavioral health care standards for restraint/seclusion apply to any use of restraint and seclusion for behavioral health care reasons. Standards TX.7.1 through TX.7.1.16 apply to *all behavioral health care settings* in which restraint or seclusion is used. Selected standards TX.7.1.4.1, TX.7.1.5, TX.7.1.6 through TX.7.1.8 and Standards TX.7.1.10 and TX.7.1.11 apply to *non-behavioral health care settings* in which restraint or seclusion is used for behavioral health reasons: • acute care hospital that does not have a psychiatric unit; • acute care hospital to receive medical or surgical services; • emergency department for assessment, stabilization, treatment or awaiting transfer to a psychiatric hospital/unit; • awaiting transfer from a non-psychiatric bed to a psychiatric bed/unit after receiving medical/surgical care	
Definition of Restraint: placement of a patient in a posey vest and/or soft wrist/ankle restraints. **Definition of Seclusion:** placement of a patient in a locked security room.	**Restraint:** any manual method or physical or mechanical device that restricts freedom of movement or normal access to one's body, material, or equipment, attached or adjacent to the patient's body that he or **she cannot easily remove**. (Any object may be a restraint by functional definition: e.g., tucking sheets, side rails, geri chair, etc.). **Drug Used as a Restraint:** a medication used to restrict the patient's freedom of movement in medical-post surgical situations or for the emergency control of behavior, and is not a standard treatment for the patient's medical or psychiatric condition. **Seclusion:** involuntarily confining an individual alone to a room or an area where he/she is physically prevented from leaving. **Time Out:** restriction of a patient for any period of time to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to regain self-control.	**Restraint:** the direct application of physical force to an individual, without the individual's permission, to restrict his/her freedom of movement. **Seclusion:** the involuntary confinement of a person in a locked room. **Time-out:** a procedure used to assist the individual to regain emotional control by removing the individual from his/her immediate environment and restricting the individual to a quiet area or unlocked quiet room.	

Current Policy	HCFA Rules	JCAHO Standards	Action Plan
When is restraint/seclusion used: • When the patient poses an immediate danger to self an/or others; • When the patient threatens serious disruption to the therapeutic environment; • When less restrictive measures/approaches are/have been unsuccessful.	Seclusion or restraint can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective. Emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or others.	Restraint and seclusion are used only in an **emergency**, when there is an imminent risk of an individual physically harming himself or herself or others, including staff. Non-physical interventions are the **preferred** intervention, unless safety issues demand an immediate physical response. **Definition of Emergency:** when there is **imminent risk** of an individual physically harming himself or herself, staff or others; when non-physical interventions are not viable; and safety issues require an immediate physical response.	
	Initial Assessment: Comprehensive assessment is critical in coming to an effective intervention decision of what would be the greater benefit to a patient. Evaluation of whether devices could be used as restraints must include: • how they benefit the patient; • whether a less restrictive device/intervention could offer the same benefit at less risk. If the effect of using an object fits the definition of restraint for that patient at that time, then for that patient at that time, the device is a restraint.	**Initial Assessment:** The initial assessment of each individual at the time of admission or intake assists in obtaining information about the individual that could help minimize the use of restraint/seclusion. This initial assessment identifies: • techniques, methods, or tools that would help the individual control his/her behavior; • pre-existing medical conditions/physical disabilities and limitations that would place the patient at greater physical risk; and • any history of sexual/physical abuse that would place the patient at greater psychological risk.	

Orders:
• An attending physician must give the order to restrain/secure the patient.
• The RN may assume this responsibility in an emergency; but a physician's order must be obtained within one hour of placing the patient in restraints or seclusion.
• The MD order must include clinical justification for the use of restraint/seclusion, including specific behavior(s) which requires the need for such intervention.
• Written orders must be time-limited and may not exceed 4 hours for adults and 2 hours for adolescents.
• The MD may continue the original order, in 4-hour increments (2 hour for adolescents) for a maximum of 24 hours without a face-to-face contact.
• The use of PRN orders for restraint/seclusion is
	Orders for the use of Restraint/Seclusion:
	• Must be written by a physician or other licensed independent practitioner (LIP) permitted by the State and hospital to order a restraint/seclusion
	• May never be written as a standing order or on an as needed basis (i.e., PRN)
	• Must be time limited to 4 hours for adults; 2 hours for children and adolescents ages 10 to 17; or 1 hour for patients under 9 years of age
	• May only be renewed in accordance with these time limits for up to a total of 24 hours
	• Must be in accordance with a **written modification** to the patient's plan of care
	• Must be implemented in the least restrictive manner possible (i.e., less intrusive measures were tried/documented)
	• Must be in accordance with safe and appropriate
		Orders for the use of Restraint/Seclusion:
		• All restraint/seclusion is used and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his/her LIP designee
		• Written or verbal orders for initial and continuing use of restraint/seclusion are time limited to:
		  • **4 hours** for individuals **18 and older**
		  • **2 hours** for children and adolescents **9 to 17**
		  • **1 hour** for children **under age 9**
		• Orders for restraint/seclusion are not written as a standing order or on an as needed basis (i.e., PRN)
		• The organization may authorize qualified registered nurses or other qualified, trained staff members who are not LIPs to *initiate* the use of restraint/seclusion
		• The qualified RN or other qualified staff notifies the LIP and an order is obtained **no longer than one hour** after the	

strictly prohibited. • When restraints/seclusion are discontinued early and the same behavior is still evident, the original order can be reapplied if alternatives remain ineffective. The time limit for the original order is cumulative. Release of the patient from restraints/seclusion for a period longer than 60 minutes requires obtaining a new MD order to include additional clinical justification.	restraining techniques • Must be ended at the earliest possible time • If restraints/seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying the restraints and the requirements restart. • After the original order expires, a physician or LIP (if allowed under State law) must see and assess the patient before issuing a new order	initiation of restraint/seclusion • The LIP reviews with the staff the physical and psychological status of the patient, determines whether restraint/seclusion should be continued, gives staff guidance in identifying ways to help the individual regain control in order to discontinue restraint/seclusion, and gives an order • If restraint/seclusion needs to continue beyond the expiration of the time-limited order, **a new order (written or verbal) for restraint/seclusion is obtained** from the LIP, or his/her LIP designee limited to the time frames outlined above	

Ongoing Assessment of the Need for Continuation:
• The attending MD or his/her designee (i.e., RN) must reassess the patient's status every 4 hours to determine the need for continuation. Designation of this responsibility by the MD to the RN must be included in the written order.
	Ongoing Assessment of the Need for Continuation:
	• An MD or other LIP must see and evaluate the need for restraint/seclusion **within 1 hour** after the initiation of this intervention (*a telephone call is not adequate*)
	• The MD is not required to perform another face-to-face assessment of the patient after 4 hours (or 2 hours or 1 hour for younger patients). When the original order is about to expire, a nurse can telephone the MD or LIP, report the results of his/her most recent assessment, and request that the original order be renewed for another period of time (not to exceed the time limits established in the regulation).
		Ongoing Assessment of the Need for Continuation:
		• Individuals who are in restraint/seclusion are regularly reevaluated every
		  • **4 hours** for individuals **18 and older**
		  • **2 hours** for children and adolescents **9 to 17**
		  • **1 hour** for children **under age 9**
		• The LIP who is primarily responsible for the individual's ongoing care, or his/her LIP designee, conducts an in-person evaluation of the individual **within 4 hours** of the initiation of restraint/seclusion for individuals **ages 18 or over**; **within 2 hours** of initiation for children and adolescents **age 17 and under**
		• This in-person reevaluation may be delegated to:
		  • his/her LIP designee
		  • a **qualified RN** or other **qualified, trained staff** who is authorized by the organization to perform this function (see training requirements in intent)
		• **Minimum** time frames for an in-person reevaluation by the LIP are at least every
		  • **8 hours** for individuals **18 years and older**, and
		  • **4 hours** for individuals **ages 17 and younger**
		• If the individual is **no longer in restraint/seclusion** when an original *verbal* order expires, the LIP conducts an in-person evaluation of the individual **within 24 hours** of the initiation of restraint/seclusion	

Current Policy	HCFA Rules	JCAHO Standards	Action Plan
Notification Requirements: • All uses of restraint/seclusion are to be recorded on the Critical Incident Log for each new restraint/seclusion event • All uses of restraint/seclusion are reported daily to the Medical Director or a designee (Nurse Coordinator) for review. • If restraint/seclusion continues beyond 48 hours or if the patient requires restraint/seclusion more than 4 times in one week, the RN will request a case conference with the MD and other team members to discuss alternatives.	**Notification Requirements:** • The RN who initiates restraint/seclusion must consult with the patient's treating MD, as soon as possible, if the restraint/seclusion is not ordered by the patient's treating MD	**Notification Requirements:** • The individual's family is notified promptly of the initiation of restraint or seclusion, in cases where the individual has consented to have the family kept informed regarding his/her care and the family has agreed to be notified. • Clinical leadership is informed of instances in which individuals experience extended, or multiple episodes of, restraint/seclusion (e.g., remains in restraint/seclusion for **more than 12 hours**; experiences **2 or** more separate episodes of restraint/seclusion of any duration **within 12 hours**). The leadership is notified **every 24 hours** if either of the above conditions continue.	

Monitoring/Care Requirements:
• Each restrained/secured patient will be placed on the appropriate PICR (10/15 minute flow sheet)
• Nursing staff will check the patient every 15 minutes (or less) depending upon patient need. (Children 14 years of age or younger must be checked every 10 minutes or less).
• Each reassessment for monitoring purposes is used to determine the patient's well being and must be documented.
• If the patient's condition warrants, restraints are removed every 2 hours and the patient exercised (while awake). If the patient is assessed to be at risk for violence, the restraints will not be removed unless repositioning, circulation and mobility is impaired. (Under these circumstances, the restraint is removed from one extremity at a time with range of motion provided to the free extremity.)
• The personal needs of the patient (e.g., nourishment, fluids, hygiene, and use of the toilet) must be attended to every 2 hours while awake during each 8-hour shift. Other comfort measures are provided as appropriate and desired by the patient.
• If a patient is restrained in a security room, the door to the room may not be locked. Any patient in 4-point restraints will be monitored 1:1 by staff.
	Monitoring/Care Requirements:
	The frequency of monitoring will vary according to the type and design of the device/intervention as well as the emotional, psychological and physical condition, needs, and symptoms of the patient.
	• A restraint and seclusion may not be used simultaneously unless the patient is --
	  ➢ Continually monitored face-to-face by an assigned staff member; or
	  ➢ Continually monitored by staff using both video and audio equipment. (This monitoring must be done in close proximity to the patient.)
	• The condition of the patient who is in a restraint or in seclusion must be continually be assessed, monitored, and reevaluated.
	• The frequency of monitoring will vary according to the type and design of the device or intervention as well as the emotional, psychological and physical condition, needs, and symptoms of the patient.
	• Hospital policy should describe:
	  ➢ which staff are responsible for assessing and monitoring the patient;
	  ➢ time frames for monitoring vital signs, respiratory and cardiac status, skin integrity, intake/output, weight, hygiene, injury, etc.;
	  ➢ opportunities for offering fluids and nourishment,
		Monitoring/Care Requirements:
		• A **trained and competent staff member** assesses the individual **at the initiation** of restraint/seclusion and **every 15 minutes** thereafter, to include:
		  ➢ signs of injury;
		  ➢ nutrition/hydration;
		  ➢ circulation and range of motion in extremities;
		  ➢ vital signs;
		  ➢ hygiene and elimination;
		  ➢ physical and psychological status and comfort; and
		  ➢ readiness for discontinuation of restraint/seclusion.
		• Monitoring is accomplished through continuous in-person observation by an assigned staff member
		• After the first hour, an individual in seclusion only, may be continuously monitored using simultaneous video and audio equipment, if this is consistent with the individual's condition or wishes.
		• If the individual is in a physical hold, a second staff person is assigned to observe the individual.
		• The individual is made aware of the rationale for restraint/seclusion and the behavior criteria for its discontinuation (e.g., ability to contract for safety; orientation to the environment; and/or cessation of verbal threats).	

	toileting/elimination, range of motion, exercise of limbs and systematic release of restrained limbs; ➢ assessment of mental status; ➢ assessment and justification for continued use of restraint/seclusion; ➢ who has the authority to discontinue restraints or seclusion, and, under what circumstances.		
Documentation: The medical record for a restrained/secured patient must include: • precipitating factors and patient's behavior prior to intervention; • less restrictive alternatives used and the patient's response; • explanation given to patient addressing the reason for restraint seclusion and conditions for discontinuation; • RN assessment at the time of initiation and notification of attending MD; • initiation of PICR with visual checks every 15 minutes; • reassessment by the RN at regular intervals (at least once per shift); • attention to patient needs by nursing staff; • time of discontinuation of restraint seclusion and patient's response; • MD signature with date/time for each order received.	**Documentation:** Documentation in the patient's record should include: • the patient's behavior and the intervention used; • the rationale for the use of the physical restraint or seclusion; • the patient's response to the use of physical restraint/seclusion. Documentation in the patient's record should indicate a clear progression in how techniques are implemented with less intrusive restrictive interventions attempted (or considered) prior to the introduction of more restrictive measures.	**Documentation:** Medical records document that the use of restraint/seclusion is consistent with organization policy. The clinical record verifies: • that the individual/family was **informed of the organization's policy** on the use of restraint/seclusion; • any **pre-existing medical conditions** or any physical disabilities that would place the individual at greater risk during restraint/seclusion; and • any **history of sexual or physical abuse** that would place the individual at greater psychological risk during restraint/seclusion. **Each** episode of use is recorded to include: • the **circumstances** that led to their use; • consideration or failure of **non-physical interventions**; • the **rationale** for the type of physical intervention selected; • **notification** of the individual's family, when appropriate; • **written orders** for use; • **behavior criteria** for discontinuation of restraint/seclusion; • **informing the individual** of behavior criteria for discontinuation of restraint/seclusion; • **each verbal order** received from a LIP; • **each in-person evaluation** and reevaluation of the patient; • **15 minute assessments** of the patient's status; • **assistance provided** to the patient to help him/her meet the behavior criteria for discontinuation of restraint/seclusion; • evidence of **continuous monitoring**; • **debriefing** of the individual with staff; and • any injuries that are sustained and treatment received for these **injuries…**or any **deaths** resulting from injury. Documentation is accomplished in a manner that allows for the collection and analysis of data for performance improvement activities.	

Current Policy	HCFA Rules	JCAHO Standards	Action Plan
Staff Training: Staff with direct patient care responsibilities are trained in: • identification of potential risk behaviors; • the appropriate use of alternative strategies; • correct application and removal of restraints; • clinical strategies to meet emergent patient needs.	**Staff Training:** All staff who have direct patient contact must have ongoing education and training in: • the proper and safe use of restraint/seclusion application and techniques; • alternative methods for handling behavior symptoms, and situations that traditionally have been treated through the use of restraints/seclusion	**Staff Training:** **All direct care staff** are trained/competent to minimize the use of restraint and seclusion, and **demonstrate an understanding**: • of the underlying causes of threatening behaviors; • that some aggressive behavior may be related to a medical condition; • of how their own behaviors can affect the behaviors of patients; • of the use of de-escalation, medication, self-protection and other techniques, such as time-out; and • in recognizing signs of physical distress in individuals who are restrained/secluded. All staff **authorized to physically apply restraint or seclusion** receive **ongoing training** and **demonstrate competence** in the safe use of restraints, including: • physical holding techniques; • take-down procedures; and • the application and removal of mechanical restraints. Staff who are **authorized to perform 15 minute assessments** of individuals in restraint/seclusion **receive ongoing training** and **demonstrate competence** in: • taking vital signs and interpreting their relevance; • recognizing nutritional/hydration needs; • checking circulation and range of motion in extremities; • addressing hygiene and elimination needs; • addressing physical and psychological status and comfort; • assisting individuals in meeting behavior criteria for the discontinuation of restraint/seclusion; • recognizing when to contact a medically trained LIP or EMS to evaluate/treat the patient's physical condition. Staff who are **authorized to initiate restraint/seclusion**, in the absence of a LIP, and/or perform evaluations/reevaluations of individuals who are in restraint/seclusion are **educated** and **demonstrate competence** in: • recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact; and • the use of behavior criteria for the discontinuation of restraint/seclusion and how to assist individuals in meeting this criteria.	

PAIN MANAGEMENT STANDARDS

All patients should be assessed for pain factors and history, initially upon presentation to the facility, then subsequently thereafter according to assessment finding. All patients should receive treatment for pain relief as warranted and should be monitored for effectiveness.

ASSESSMENT/REASSESSMENT:

The RN should assess the patient for pain factors and history upon presentation during the initial assessment and document findings.

When pain is identified, either acute or chronic, a more comprehensive assessment should be performed and pain management implemented in the patient's multidisciplinary plan of care.

Pain intensity should be measured with an appropriate measurement tool.

1. A pain scale of 0 – 10 (0 = no pain, 10 = worst pain) should be utilized for adult patient. * If they cannot understand or are unwilling to use the scale the following tools may be utilized.
2. Wong Baker FACES pain scale (smile-frown).
3. Behaviors and/or symptoms should be evaluated regarding presence of pain on patients who are cognitively impaired or unable to communicate.

Description(s) of pain, noting patient's personal words, should be documented including:

1. Location of pain area(s)
2. Quality and/or patterns of radiation.
3. Onset, duration and/or precipitating factors
4. Pain management history and effectiveness:
   - Consider personal values, beliefs and culture.
   - Evaluate myths about opioid analgesics regarding addiction, physical dependence and/or tolerance to this type of medication.
   - Evaluate the type of communication the patient utilizes to report pain (verbal or behavioral).
   - Utilize family input if appropriate. **The patients personal interview should always be considered first if able to communicate and not cognitively impaired.**
5. Effects of pain on daily life – level of impact
6. Patients pain goal. (What level is acceptable?)
7. Patient's knowledge level of disease process(s) related to pain, medications and/or alternative treatment prescribed.

Either a RN or a LPN may perform the reassessment utilizing the Pain Management Flow sheet for documentation.

Reassessments should be performed according to type of pain and level of effectiveness regarding medication and or treatment utilized.

The following standards should be flexible according to individual patient responses to medication and/or treatment.

1. Cardiac pain should be reassessed every five – (5) minutes whenever the treatment prescribed warrants the use of nitrates and/or intravenous medication, ordered on five – (5) minutes intervals, to manage pain.

2. Acute/chronic pain should be reassessed thirty – (30) minutes to one (1) hour after medication(s) and/or alternative treatment(s) administered.

The physician should be notified when *any* type of prescribed pain management regimen is not effective in relieving patient's pain.

INTERVENTIONS:

Analgesics and treatments should be administered as prescribed.

Nurses should routinely (every 4 hours while the patient is awake) evaluate the patient for pain management.

PRN medications/treatments should be offered when the patients personal pain goal is exceeded or their pain is greater than four (4) on the pain scale.

Analgesics ordered should be administered by the least painful route, if possible.
Reassess the effectiveness according to the type of pain and the treatment rendered.

Non-pharmacological interventions should be offered and taught:

1. Heat/cold packs as prescribed
2. Repositioning, turning and/or ambulating as tolerated.
3. Relaxation exercises i.e.: deep breathing, rhythmic breathing and/or "peaceful past" memory meditation.
4. Distraction

The physician should be notified for any type of pain management, which is not effective.

AGE RELATED CONSIDERATIONS:

Geriatric:

1. Drug metabolism is slower in the elderly due to decreased hepatic and renal function.
2. At greater risk for drug-drug and drug-disease interactions due to multiple diseases and medications.
3. Barriers to pain assessment include cognitive, visual, hearing and motor impairments.
4. At risk for over and/or under treatment of analgesics:
   - NSAIDS increase the risk of renal toxicity
   - Opioids have a higher peak and last longer leading to prolonged sedation and respiratory depression.

Pediatric:

1. More frequent assessment/reassessment and intervention are required due to a higher metabolic rate.
2. Emotional distress accentuates pain.
3. Children in pain may regress.
4. Observation of behavior and self-report are the primary methods for assessment.

PATIENT EDUCATION:

Patient and/or family teaching should begin after initial pain assessment with identified knowledge deficit areas.

The Patient Education Record should reflect the type of teaching performed and patient/family response.

The Care Plan should reflect knowledge deficit areas and be evaluated once a day for progress toward stated goals.

The Physician should be notified for multiple, different interventions that are not effective and/or if patient/family is non-compliant.

STAFF EDUCATION:

Direct care employees should receive education/training regarding pain assessment and management initially during new employee hospital orientation then thereafter annually through hospital orientation.

After receiving education/training the employee should be able to:

1. Perform appropriate pain assessment and reassessments
2. Render appropriate pain management regimens through multidisciplinary efforts.
3. Teach patient/family appropriate pain management on individualized basis.

The Nurse Agency

Drug-Free Workplace Policy

The use of drugs undermines the quality and safety of job performance, endangers co-workers and patients, and brings discredit to The Nurse Agency and the nursing community. Addictive disorders affect all groups: men, women, those with high education, professionals, and youth. Many experts in the Behavioral Health field have identified that approximately *10 percent* of those who use addictive drugs will develop problems with dependency and impaired functioning.

If you are struggling with drug or alcohol addiction we strongly encourage you to contact Rush University Medical Centers *Professionals Treatment Program*. This program began in the Chicago area more than 20 years ago. It specializes in the treatment of high accountability professionals from the health and business community, including physicians, dentists, nurses, and lawyers. Further information about this program is listed on the following page and in the back of this binder. Please feel free to take copies of this information.

The Nurse Agency will not tolerate the use of drugs by its employees in any job-related context and is committed to the eradication of drugs from the workplace.

To this end, it is the policy of The Nurse Agency that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance on the job is strictly prohibited. Anyone in violation of this policy is subject to severe disciplinary action, including discharge.

Program Description

This nationally recognized program is designed specifically for the needs of impaired physicians and other healthcare professionals. It is also ideal for high accountability individuals from other vocations such as the law, clergy, and industry. The program philosophy is that professionals benefit from peer interaction and support with other professionals. Although the majority of the patients are professionals, the program design also includes non-professional patients to create a more representative life experience.

Program Structure

The program is based on a day hospital (Monday through Friday, 9:00 a.m. to 5:00 p.m. and Saturdays from 9:00 a.m. to 11:00 a.m.) model. Most of the patients live in an independent living community in nearby apartments. This provides an intensive 24-hour integration of the treatment program into a daily living routine which emphasizes self-responsibility for all daily living activities, as well as accountability to peers.

Program Components

- Physician leadership in daily program activities
- Interactive group psychotherapy
- Individual therapy and case management
- Community meetings
- Physical fitness/wellness groups and activities
- Special focus groups addressing mood disorder, eating disorders, trauma abuse, and other dual diagnosis issues, mindfulness and meditation.
- Physician led recovery/re-entry groups (Caduceus)
- Extended program (Phase II) which provides transitional treatment in preparation for return to home and professional life
- Didactic group workshops
- Family groups and a separate Family Week Program
- Advocacy with medical and licensing boards for patients in recovery

Length of Treatment

The treatment length is individualized according to need. Most healthcare professionals will be in the day hospital program a minimum of 6 to 8 weeks, followed by an extended period of less intensive treatment for at least 3 to 4 weeks. Some patients will be referred to the evening intensive outpatient program for part of the treatment stay.

For further information or to schedule an assessment, please call **(312) 563-3600**.

Contact: Joel Neuberger – Program Director   **Phone:** (312) 563-3600

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Policy Regarding Sexual Harassment in Employment

<u>Statement of Company Policy</u>

The Nurse Agency is committed to providing a workplace that is free from all forms of discrimination, including sexual harassment. Any employee's behavior that fits the definition of sexual harassment is a form of misconduct which may result in disciplinary action up to and including dismissal. Sexual harassment could also subject this company and, in some cases, an individual to substantial civil penalties.

The company's policy on sexual harassment is part of its overall affirmative action efforts pursuant to state and federal laws prohibiting discrimination based on age, race, color, religion, national origin, citizenship status, unfavorable discharge from the military, marital status, disability, and gender. Specifically, sexual harassment is prohibited by the Civil Rights Act of 1964, as amended in 1991, and the Illinois Human Rights Act.

Each employee of this company bears the responsibility to refrain from sexual harassment in the workplace. No employee -male or female- should be subjected to unsolicited or unwelcome sexual overtures or conduct in the workplace. Furthermore, it is the responsibility of all supervisors to make sure that the work environment is free from sexual harassment. All forms of discrimination and conduct which can be considered harassing, coercive or disruptive, or which create a hostile or offensive environment must be eliminated. Instances of sexual harassment must be investigated in a prompt and effective manner.

All employees of this company, particularly those in a supervisory or management capacity, are expected to become familiar with the contents of this Policy and to abide by the requirements it establishes.

<u>Definition of Sexual Harassment</u>

According to the Illinois Human Rights Act, sexual harassment is defined as: Any unwelcome sexual advances or requests for sexual favors or any conduct of a sexual nature when;

(1) submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment.

(2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or

(3) such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

The courts have determined that sexual harassment is a form of discrimination under Title VII of the Civil Rights Act of 1964, as amended in 1991.

One example of sexual harassment is where a qualified individual is denied employment opportunities and benefits that are, instead, awarded to an individual who submits

(voluntarily or under coercion) to sexual advances or sexual favors. Another example is where an individual must submit to unwelcome sexual conduct in order to receive an employment opportunity.

Other conduct commonly considered to be sexual harassment includes:

- Verbal: sexual innuendos, suggestive comments, insults, humor and jokes about sex, anatomy or gender-specific traits, sexual propositions, threats, repeated requests for dates, or statements about other employees, even outside their presence, of a sexual nature.
- Non-verbal: Suggestive or insulting sounds (whistling), leering, obscene gestures, sexually suggestive bodily gestures, "catcalls", "smacking", or "kissing" noises
- Visual: posters, signs, pin-ups or slogans of a sexual nature.
- Physical: Touching, unwelcome hugging or kissing, pinching, brushing the body, coerced sexual intercourse, or actual assault.

Sexual harassment most frequently involves a man harassing a woman. However, it can also involve a woman harassing a man or harassment between members of the same gender.

The most severe and overt forms of sexual harassment are easier to determine. On the other end of the spectrum, some sexual harassment is more subtle and depends to some extent on individual perception and interpretation. The trend in the courts is to assess sexual harassment by a standard of what would offend a "reasonable woman" or "reasonable man", depending on the gender of the alleged victim.

An example of the most subtle form of sexual harassment is the use of endearments. The use of terms such as "honey", "darling", and "sweetheart" is objectionable to many women who believe that these terms undermine their authority and their ability to deal with men on an equal and professional level.

Another example is the use of a compliment that could potentially be interpreted as sexual in nature. Below are three statements that might be made about the appearance of a woman in the workplace:

"That's an attractive dress you have on."
"That's an attractive dress. It really looks good on you."
"That's an attractive dress. You really fill it out well."

The first statement appears to be simply a compliment. The last is the most likely to be perceived as sexual harassment depending on the perceptions and values of the person to whom it is directed. To avoid the possibility of offending an employee, it is best to follow a course of conduct above reproach, or to err on the side of caution.

Responsibility of Individual Employees

Each individual employee has the responsibility to refrain from sexual harassment in the workplace.

An individual employee who sexually harasses a fellow worker is, of course, liable for his or her individual conduct.

The harassing employee will be subject to disciplinary action up to and including discharge in accord with the company's disciplinary policy and the terms of any applicable collective bargaining agreement.

The company has designated Ann Weist, Director of Staffing to coordinate the company's sexual harassment policy compliance. Ann can be reached at (773) 779-8200. She is available to consult with employees regarding their obligations under this policy.

Responsibility of Supervisory Employees

Each supervisor is responsible for maintaining the workplace free from sexual harassment. This is accomplished by promoting a professional environment and by dealing with sexual harassment as with all other forms of employee misconduct.

The courts have found that organizations as well as supervisors can be held liable for damages related to sexual harassment by a manager, supervisor, employee, or third party (an individual who is not an employee but does business with an organization, such as a customer, contractor, sales representative, or repair person).

Liability is either based on an organization's responsibility to maintain a certain level of order and discipline, or on the supervisor acting as an agent of the organization. As such, supervisors must act quickly and responsibly not only to minimize their own liability but also that of the company.

Specifically, a supervisor must address an observed incident of sexual harassment or a complaint, with seriousness, take prompt action to investigate it, report it, and end it, implement appropriate disciplinary action, and observe strict confidentiality. This also applies to cases where an employee tells the supervisor about behavior that constitutes sexual harassment but does not want to make a formal complaint.

In addition, supervisors must ensure that no retaliation will result against an employee making a sexual harassment complaint.

Supervisors in need of information regarding their obligations under this policy or procedures to follow upon receipt of a complaint of sexual harassment should contact Ann Weist, Director of Staffing at (773) 779-8200.

Procedures for filing a complaint of Sexual Harrassment

Internal

An employee who either observes or believes herself/himself to be the object of sexual harassment should deal with the incident(s) as directly and firmly as possible by clearly communicating her/his position to the supervisor, Ann Weist, and to the offending employee. It is not necessary for the sexual harassment to be directed at the person making the complaint.

Each incident of sexual harassment should be documented or recorded. A note should be made of the date, time, place, what was said or done, and by whom. The documentation may be augmented by written records such as letters, notes, memos, and telephone messages.

No one making a complaint of sexual harassment will be retaliated against even if a complaint made in good faith is not substantiated. Any witness to an incident of sexual harassment is also protected from retaliation.

The process for making a complaint about sexual harassment falls into several stages.

1. Direct Communication. If there is sexually harassing behavior in the workplace, the harassed employee should directly and clearly express her\his objection that the conduct is unwelcome and request that the offending behavior stop. The initial message may be verbal. If subsequent messages are needed, they should be put in writing in a note or a memo.

2. Contact Supervisory Personnel. At the same time direct communication is undertaken, or in the event the employee feels threatened or intimidated by the situation, the problem must be promptly reported to the immediate supervisor or the EEO Officer. If the harasser is the immediate supervisor, the problem should be reported to the next level of supervision of the EEO Officer.

3. Formal Written Complaint. An employee may also report incidents of sexual harassment directly to the EEO Officer. The EEO Officer will counsel the reporting employee and be available to assist with filing a formal complaint. The Company will fully investigate the complaint, and will advise the complainant and the alleged harasser of the results of the investigation.

External

The Company hopes that any incident of sexual harassment can be resolved through the internal process outlined above. All employees, however, have the right to file formal charges with the Illinois Department of Human Rights (IDHR) and/or the United States Equal Employment Opportunity Commission (EEOC). A charge with IDHR must be filed within 180 days of the incident of sexual harassment. A charge with EEOC must be filed within 300 days of the incident.

Guidelines for Nurses Interacting with Clients with Differing Culture or Ethnicity

As an RN working in the clinical setting you will be caring for many people who have a different culture or ethnicity than you. It is important that all patients be treated with respect and compassion. The following guidelines should help you accomplish this. Make sure when working through The Nurse Agency that you:

Convey respect for the individual and respect for his/her values, beliefs, and cultural and ethnic practices.

Learn about the major ethnic or cultural groups with whom you are likely to have contact.

Be aware of your own communication, e.g. facial expressions and body language, and how it may be interpreted.

Be aware of your own biases, prejudices, and stereotypes

When a patient describes a belief that differs from your own, e.g. the cause of her swollen feet, try to relate the patient's belief to your own, thus conveying interest and respect for the patient's belief.

Recognize the cultural symbols and practices that can often bring a patient comfort.

Support the patient's practices and incorporate them into nursing practice whenever it is possible and they are not contraindicated for health reasons.

Do not impose a cultural practice on a patient without knowing whether it is acceptable.

Be aware the color of a patient's skin does not always determine his/her culture.

Take time to learn how a client views health, illness, grieving, and the health care system.

Be aware of your own attitudes and beliefs about health and objectively examine the logic of those attitudes and beliefs and their origins.

Be open to learning about different beliefs and values and learn not to be threatened when they differ from your own.

Patients Rights and Ethical Aspects of Care, Treatment and Services

All persons are entitled to certain, specific rights while they are patients within a facility, including rights outlined by government mandate such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- The right to be treated with dignity and respect at all times and under all circumstances.
- The right to impartial access to care, treatment and other medical services that are available or medically indicated. This right is entitled regardless of race, creed, sex, national origin, communicable disease status, religion, marital status, veteran status, or any other protected class under relevant Federal or State law, or the ability to pay for treatments or services.
- The right to the truth in all aspects of care or treatments provided.
- The right to have personal, spiritual or cultural beliefs, preferences and/or choices respected at all times.
- The right to be actively involved in all treatment decisions including:
    - The right to access information, including access to medical records.
    - The right to be informed of alternative treatments and/or therapies.
    - The right to refuse treatment.
    - The right to receive an estimate of the cost of care or treatment options.
    - The right to receive clearly stated treatment goals and objectives in terms the patient can understand.
    - The right to appropriate medical consultations regarding treatment.
    - The right to question all aspects of treatment, care and the decisions made relative to that care and treatment.
- The right to have personal preferences and choices regarding treatment options or the refusal of treatment respected.
- The right to know the identity (including the name and professional status) of the attending physician and all health care providers who are involved with the patient's care, as well as the right to know the reason for the presence of any individual.
- The right to privacy and confidentiality (within legal limits) of all personal and/or medical information and preferences regarding patient care and treatment including, but not limited to the following:
    - The right to refuse to speak with or see anyone who is not directly involved in patient care activities (including visitors, family members or other individuals).
    - The right to be interviewed and examined in surroundings that assure reasonable visual and auditory privacy and confidentiality.
    - The right to expect that any discussion or consultation involving the patient's care will be conducted discreetly and that individuals who are not directly involved in the patient's care will not be present without the patient's permission.
- The right to be free from all restraints or seclusion (whether physical, chemical or other types) unless a restraint is being utilized for the express purpose of protecting personal safety of the patient or the patient's care providers.
- The right to receive as much or as little information about any proposed treatment or procedure in order to provide adequate knowledge to give an

informed consent or refusal for those treatments or procedures. Except in cases of emergency, this information shall include the following:

- o A description of the procedure or treatment.
- o The medically significant risks involved in the treatment.
- o Alternate plans of treatment and the risks involved in each of those alternatives.
- o Knowledge of the name of the person(s) who will perform the treatment or procedure.

- The right to continuity of care from the time of admission until the time of discharge including the ability to know, in advance, of the time and location of any appointments for treatment.
- The right to Spiritual Care upon request.
- The right to receive care in a safe, secure environment free from verbal or physical abuse or harassment, as well as the right to access protective services (including the right to notify government agencies of neglect or abuse).
- The right to effective management of pain (including the right to be informed that appropriate pain management is a goal of every patient care plan).
- The right to file a formal concern (grievance) regarding the care and treatments received and the right to prompt resolution of that concern. Formal concerns may be filed either in writing or by phone.
- The right to know the financial implications of all treatment choices and the right to have all bills and available payment options explained in understandable terms.
- The right to make an Advance Directive in order to state treatment preferences in the event a patient is unable to speak for him or herself. Advance Directives include a Rights of the Terminally Ill Declaration (Living Will) and a Durable Power of Attorney for Healthcare.
- The right to leave the hospital at any time (unless restricted by law), even against the advice of a physician or other health care provider.
- The right to take part in experimental treatments or research or to decline participation in experimental treatments or research without negative effects to other aspects of hospitalization or treatments.
- The right to be informed of the need for continuing health care requirements following discharge from the hospital.
- The right to know which hospital policies and/or procedures apply to a patient's conduct while they are a patient.
- The right to participate in ethical questions that may arise in the course of care and treatment, including:
  - o Ethical questions of the course of care or treatment being proposed.
  - o Issues of conflict resolution.
  - o Issues related to treatment decisions and options, including end-of-life treatment decisions such as forgoing or withdrawing life-sustaining treatment.
- The right to all of the seven rights outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which include all of the following:
  - o The right to receive notice of a health care provider's privacy policy and procedures.
  - o The right to view all of their personal, protected health information (PHI).
  - o The right to access a record of all disclosures related to their medical care.

- o The right to complain, both to the health care provider and the Department of Health and Human Services regarding any aspect of their care.
- o The right to receive confidential communications.
- o The right to request amendments and corrections to their personal information that is thought to be incorrect.
- o The right to request restrictions on the use and disclosure of their PHI.

National Patient Safety Goals Effective January 1, 2014

Hospital Accreditation Program

Goal 1

Improve the accuracy of patient identification.

NPSG.01.01.01

Use at least two patient identifiers when providing care, treatment, and services.

--Rationale for NPSG.01.01.01--

Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, or other person-specific identifier.

Elements of Performance for NPSG.01.01.01

1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11; NPSG.01.03.01, EP 1) **R C ⓜ △3**

2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1) **R A △3**

NPSG.01.03.01

Eliminate transfusion errors related to patient misidentification.

Elements of Performance for NPSG.01.03.01

1. Before initiating a blood or blood component transfusion:
   - Match the blood or blood component to the order.
   - Match the patient to the blood or blood component.
   - Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding.
   (See also NPSG.01.01.01, EPs 1 and 2) **R A △3**

2. When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient. **R A △3**

3. When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process, as determined by the hospital. **R A △3**

Goal 2

Improve the effectiveness of communication among caregivers.

NPSG.02.03.01

Report critical results of tests and diagnostic procedures on a timely basis.

--Rationale for NPSG.02.03.01--

Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

Elements of Performance for NPSG.02.03.01

1. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
   - The definition of critical results of tests and diagnostic procedures
   - By whom and to whom critical results of tests and diagnostic procedures are reported
   - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures

   R **A** Ⓓ

2. Implement the procedures for managing the critical results of tests and diagnostic procedures.

   R **A**

3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

   R **A**

KEY: 🖩 indicates risk area; **A** indicates scoring category; **C** indicates scoring category; Ⓓ indicates documentation is required; Ⓜ indicates Measure of Success is needed; ▲ indicates situational decisions rules apply; ⚠ indicates direct impact requirements apply

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Goal 3
Improve the safety of using medications.

NPSG.03.04.01
Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.

--Rationale for NPSG.03.04.01--
Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects basic principles of safe medication management, yet it is routine in many organizations.

The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at MM.05.01.09.

Elements of Performance for NPSG.03.04.01

1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.
   Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Refer to NPSG.03.04.01, EP 5, for information on timing of labeling.
   R **A** △3

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.
   R **A** △3

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
   - Medication name
   - Strength
   - Quantity
   - Diluent and volume (if not apparent from the container)
   - Expiration date when not used within 24 hours
   - Expiration time when expiration occurs in less than 24 hours
   Note: The date and time are not necessary for short procedures, as defined by the hospital.
   R **A** △3

4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
   R **C** Ⓜ △3

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.
   Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.
   R **A** △3

6. Immediately discard any medication or solution found unlabeled.
   R **A** △3

7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
   Note: This does not apply to multiuse vials that are handled according to infection control practices.
   R **A** △3

8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.
   R **C** Ⓜ △3

KEY: Ⓡ indicates risk area; A indicates scoring category; C indicates scoring category; Ⓓ indicates documentation is required; Ⓜ indicates Measure of Success is needed; ▲ indicates situational decisions rules apply; △ indicates direct impact requirements apply

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NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.
Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.

--Rationale for NPSG.03.05.01--

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients on this class of medications and result in better outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, and warfarin.

Elements of Performance for NPSG.03.05.01

1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
   Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.
   R A △3

2. Use approved protocols for the initiation and maintenance of anticoagulant therapy.
   R C Ⓜ△3

3. Before starting a patient on warfarin, assess the patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.
   Note: The patient's baseline coagulation status can be assessed in a number of ways, including through a laboratory test or by identifying risk factors such as age, weight, bleeding tendency, and genetic factors.
   R A △3

4. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.
   R A △3

5. When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.
   R A △3

6. A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants.
   R A Ⓓ △3

7. Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families. Patient/family education includes the following:
   - The importance of follow-up monitoring
   - Compliance
   - Drug-food interactions
   - The potential for adverse drug reactions and interactions
   R C Ⓜ△3

8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.
   R A

KEY: **R** indicates risk area; **A** indicates scoring category; **C** indicates scoring category; Ⓓ indicates documentation is required; Ⓜ indicates Measure of Success is needed; ▲ indicates situational decisions rules apply; △ indicates direct impact requirements apply

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Introduction to Reconciling Medication Information

The large number of people receiving health care who take multiple medications and the complexity of managing those medications make medication reconciliation an important safety issue. In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.

The Joint Commission recognizes that organizations face challenges with medication reconciliation. The best medication reconciliation requires a complete understanding of what the patient was prescribed and what medications the patient is actually taking. It can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient's ability and willingness to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As health care evolves with the adoption of more sophisticated systems (such as centralized databases for prescribing and collecting medication information), the effectiveness of these processes will grow.

This National Patient Safety Goal (NPSG) focuses on the risk points of medication reconciliation. The elements of performance in this NPSG are designed to help organizations reduce negative patient outcomes associated with medication discrepancies. Some aspects of the care process that involve the management of medications are addressed in the standards rather than in this goal. These include coordinating information during transitions in care both within and outside of the organization (PC.02.02.01), patient education on safe medication use (PC.02.03.01), and communications with other providers (PC.04.02.01).

In settings where medications are not routinely prescribed or administered, this NPSG provides organizations with the flexibility to decide what medication information they need to collect based on the services they provide to patients. It is often important for clinicians to know what medications the patient is taking when planning care, treatment, and services, even in situations where medications are not used. A new requirement in this NPSG addresses the patient's role in medication safety: it requires organizations to inform the patient about the importance of maintaining updated medication information.

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

--Rationale for NPSG.03.06.01--

There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future.

Elements of Performance for NPSG.03.06.01

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.
   Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.
   Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.   **R** **C** Ⓓ Ⓜ ⚠3

2. Define the types of medication information to be collected in non–24-hour settings and different patient circumstances.
   Note 1: Examples of non–24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.
   Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose.   **R** **A** ⚠3

KEY: ◨ indicates risk area; **A** indicates scoring category; **C** indicates scoring category; Ⓓ indicates documentation is required; Ⓜ indicates Measure of Success is needed; ▲ indicates situational decisions rules apply; ⚠ indicates direct impact requirements apply

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3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.
Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. (See also HR.01.06.01, EP 1)

4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).
Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01.

5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.
Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)

KEY: **R** indicates risk area; **A** indicates scoring category; **C** indicates scoring category; Ⓓ indicates documentation is required; Ⓜ indicates Measure of Success is needed; ▲ indicates situational decisions rules apply; ⚠ indicates direct impact requirements apply

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Goal 6

Reduce the harm associated with clinical alarm systems.

NPSG.06.01.01

Improve the safety of clinical alarm systems.

--Rationale for NPSG.06.01.01--

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety. As alarm system management solutions are identified, this NPSG will be updated to reflect best practices. *

Footnote *: Additional information on alarm safety can be found on the AAMI website http://www.aami.org/htsi/alarms/. Also, the ECRI Institute has identified alarm hazards as one of the top technology hazards for 2013; more information on this hazard list can be found at http://www.ecri.org/Forms/Pages/Alarm_Safety_Resource.aspx.

Elements of Performance for NPSG.06.01.01

1. As of July 1, 2014, leaders establish alarm system safety as a hospital priority. **R** **A**

2. During 2014, identify the most important alarm signals to manage based on the following: **R** **A**
   - Input from the medical staff and clinical departments
   - Risk to patients if the alarm signal is not attended to or if it malfunctions
   - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
   - Potential for patient harm based on internal incident history
   - Published best practices and guidelines
   (For more information on managing medical equipment risks, refer to Standard EC.02.04.01.)

3. As of January 1, 2016, establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following: **R** **A** **D**
   - Clinically appropriate settings for alarm signals
   - When alarm signals can be disabled
   - When alarm parameters can be changed
   - Who in the organization has the authority to set alarm parameters
   - Who in the organization has the authority to change alarm parameters
   - Who in the organization has the authority to set alarm parameters to "off"
   - Monitoring and responding to alarm signals
   - Checking individual alarm signals for accurate settings, proper operation, and detectability
   (For more information, refer to Standard EC.02.04.03)

4. As of January 1, 2016, educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible. **R** **C**

KEY: ▣ indicates risk area; **A** indicates scoring category; **C** indicates scoring category; Ⓓ indicates documentation is required; Ⓜ indicates Measure of Success is needed; ▲ indicates situational decisions rules apply; ⚠ indicates direct impact requirements apply

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Goal 7

Reduce the risk of health care–associated infections.

NPSG.07.01.01

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

--Rationale for NPSG.07.01.01--

According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, and services in a health care organization. Consequently, health care–associated infections (HAIs) are a patient safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, and monitors compliance and provides feedback.

Elements of Performance for NPSG.07.01.01

1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 5) **R A** ⚠3

2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 3) **R A**

3. Improve compliance with hand hygiene guidelines based on established goals. **R A**

NPSG.07.03.01

Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.
Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

--Rationale for NPSG.07.03.01--

Patients continue to acquire health care–associated infections at an alarming rate. Risks and patient populations, however, differ between hospitals. Therefore, prevention and control strategies must be tailored to the specific needs of each hospital based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent health care–associated infections from epidemiologically important multidrug-resistant organisms (MDROs).

Note: Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient's environment are essential strategies for preventing the spread of health care–associated infections. Hand hygiene is addressed in NPSG.07.01.01. Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs) are covered in IC.02.01.01, EP 3. Cleaning and disinfecting patient care equipment are addressed in IC.02.02.01.

Elements of Performance for NPSG.07.03.01

1. Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1-5) **R A**

2. Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care–associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter. **R C** Ⓜ
   Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the hospital.

KEY: 🅡 indicates risk area; **A** indicates scoring category; **C** indicates scoring category; Ⓓ indicates documentation is required; Ⓜ indicates Measure of Success is needed; ⚠ indicates situational decisions rules apply; ⚠ indicates direct impact requirements apply

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3. Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection prevention strategies. **R C   M**

4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.
   Note: Surveillance may be targeted rather than hospitalwide. **R A**

5. Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:
   - Multidrug-resistant organism infection rates using evidence-based metrics
   - Compliance with evidence-based guidelines or best practices
   - Evaluation of the education program provided to staff and licensed independent practitioners
   Note: Surveillance may be targeted rather than hospitalwide. **R A**

6. Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. **R A**

7. Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). **R C   △3**

8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.
   Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods. **R A   △3**

9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.
   Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both.
   Note 2: Each hospital may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation. **R A   △3**

NPSG.07.04.01

Implement evidence-based practices to prevent central line–associated bloodstream infections.
Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

Elements of Performance for NPSG.07.04.01

1. Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual's job responsibilities. **R C   M**

2. Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention. **R C   M**

3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). **R C   M △3**

4. Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospitalwide, not targeted. **R A**

KEY: **R** indicates risk area; **A** indicates scoring category; **C** indicates scoring category; **D** indicates documentation is required; **M** indicates Measure of Success is needed; **▲** indicates situational decisions rules apply; **△** indicates direct impact requirements apply

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5. Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. **R A**

6. Use a catheter checklist and a standardized protocol for central venous catheter insertion. **R C D M 3**

7. Perform hand hygiene prior to catheter insertion or manipulation. **R C M 3**

8. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable. **R C M 3**

9. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters. **R C M 3**

10. Use a standardized protocol for sterile barrier precautions during central venous catheter insertion. **R C M 3**

11. Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations. * **R C M 3**
Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. **R C D M 3**

13. Evaluate all central venous catheters routinely and remove nonessential catheters. **R C M 3**

NPSG.07.05.01

Implement evidence-based practices for preventing surgical site infections.

Elements of Performance for NPSG.07.05.01

1. Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual's job responsibilities. **R C M**

2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention. **R C M**

3. Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). **R C M 3**

4. As part of the effort to reduce surgical site infections: **R A**
   - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
   - Select surgical site infection measures using best practices or evidence-based guidelines.
   - Monitor compliance with best practices or evidence-based guidelines.
   - Evaluate the effectiveness of prevention efforts.
   Note: Surveillance may be targeted to certain procedures based on the hospital's risk assessment.

KEY: **R** indicates risk area; **A** indicates scoring category; **C** indicates scoring category; **D** indicates documentation is required; **M** indicates Measure of Success is needed; **3** indicates situational decisions rules apply; **3** indicates direct impact requirements apply

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5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The hospital's measurement strategies follow evidence-based guidelines.
Note 1: Surveillance may be targeted to certain procedures based on the hospital's risk assessment.
Note 2: The NHSN is the Centers for Disease Control and Prevention's health care–associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care–associated infections. For more information on NHSN procedural codes, see http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html.

6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.

7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations. *
Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations. *
Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

NPSG.07.06.01

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI). *
Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is no consensus that these practices apply to children.
Footnote *: Evidence-based guidelines for CAUTI are located at: Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals at, http://www.shea-online.org/about/compendium.cfm and Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009 at http://www.cdc.gov/hicpac/cauti/001_cauti.html

Elements of Performance for NPSG.07.06.01

1. Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:
- Limiting use and duration to situations necessary for patient care
- Using aseptic techniques for site preparation, equipment, and supplies

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2. Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:
   - Securing catheters for unobstructed urine flow and drainage
   - Maintaining the sterility of the urine collection system
   - Replacing the urine collection system when required
   - Collecting urine samples

3. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
   - Selecting measures using evidence-based guidelines or best practices
   - Monitoring compliance with evidence-based guidelines or best practices
   - Evaluating the effectiveness of prevention efforts
   Note: Surveillance may be targeted to areas with a high volume of patients using in-dwelling catheters. High-volume areas are identified through the hospital's risk assessment as required in IC.01.03.01, EP 2.

Goal 15

The hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01

Identify patients at risk for suicide.
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

--Rationale for NPSG.15.01.01--

Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Elements of Performance for NPSG.15.01.01

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

2. Address the patient's immediate safety needs and most appropriate setting for treatment.

3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

KEY: **R** indicates risk area; **A** indicates scoring category; **C** indicates scoring category; **D** indicates documentation is required; **M** indicates Measure of Success is needed; **▲** indicates situational decisions rules apply; **△** indicates direct impact requirements apply

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Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

The Universal Protocol is based on the following principles:
- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
- To the extent possible, the patient and, as needed, the family are involved in the process.
- Consistent implementation of a standardized protocol is most effective in achieving safety.

The Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. A hospital should consider its culture when designing processes to meet the Universal Protocol. In some hospitals, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements.

Hospitals should identify the timing and location of the preprocedure verification and site marking based on what works best for their own unique circumstances. The frequency and scope of the preprocedure verification will depend on the type and complexity of the procedure. The three components of the Universal Protocol are not necessarily presented in chronological order (although the preprocedure verification and site marking precede the final verification in the time-out). Preprocedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital.

Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.

UP.01.01.01

Conduct a preprocedure verification process.

--Rationale for UP.01.01.01--

Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:
- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient's identifiers
- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved. Possibilities include the following:
- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

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Elements of Performance for UP.01.01.01

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.
   Note: The patient is involved in the verification process when possible.

   R **A** ⬜ ⚠3

2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:
   - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
   - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
   - Any required blood products, implants, devices, and/or special equipment for the procedure
   Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

   R **A** Ⓓ ⚠3

3. Match the items that are to be available in the procedure area to the patient.

   R **A**

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Introduction to UP.01.02.01

Wrong site surgery should never happen. Yet it is an ongoing problem in health care that compromises patient safety. Marking the procedure site is one way to protect patients; patient safety is enhanced when a consistent marking process is used throughout the hospital. Site marking is done to prevent errors when there is more than one possible location for a procedure. Examples include different limbs, fingers and toes, lesions, level of the spine, and organs. In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.

Responsibility for marking the procedure site is a hotly debated topic. One position is that since the licensed independent practitioner is accountable for the procedure, he or she should mark the site. Another position is that other individuals should be able to mark the site in the interests of work flow and efficiency.

There is no evidence that patient safety is affected by the job function of the individual who marks the site. The incidence of wrong-site surgery is low enough that it is unlikely that valid data on this subject will ever be available. Furthermore, there is no clear consensus in the field on who should mark the site. Rather than remaining silent on the subject of site marking, The Joint Commission sought a solution that supports the purpose of the site mark. The mark is a communication tool about the patient for members of the team. Therefore, the individual who knows the most about the patient should mark the site. In most cases, that will be the person performing the procedure.

Recognizing the complexities of the work processes supporting invasive procedures, The Joint Commission believes that delegation of site marking to another individual is acceptable in limited situations as long as the individual is familiar with the patient and involved in the procedure. These include:
-Individuals who are permitted through a postgraduate education program to participate in the procedure
-A licensed individual who performs duties requiring collaborative or supervisory agreements with a licensed independent practitioner. These individuals include advanced practice registered nurses (APRNs) and physician assistants (PAs).

The licensed independent practitioner remains fully accountable for all aspects of the procedure even when site marking is delegated.

UP.01.02.01

Mark the procedure site.

Elements of Performance for UP.01.02.01

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
   Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

   R **C** **Ⓜ** **⚠**

2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.

   R **C** **Ⓜ** **⚠**

KEY: 🆁 indicates risk area; A indicates scoring category; C indicates scoring category; Ⓓ indicates documentation is required; Ⓜ indicates Measure of Success is needed; ⚠ indicates situational decisions rules apply; ⚠ indicates direct impact requirements apply

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3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:
- An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed
- A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.
Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.

4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.
Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).
Note: Examples of other situations that involve alternative processes include:
- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

UP.01.03.01

A time-out is performed before the procedure.

--Rationale for UP.01.03.01--

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.

A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.

Elements of Performance for UP.01.03.01

1. Conduct a time-out immediately before starting the invasive procedure or making the incision.

2. The time-out has the following characteristics:
- It is standardized, as defined by the hospital.
- It is initiated by a designated member of the team.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

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3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.

R **A** ⚠3

4. During the time-out, the team members agree, at a minimum, on the following:
   - Correct patient identity
   - The correct site
   - The procedure to be done

R **A** ⚠3

5. Document the completion of the time-out.
   Note: The hospital determines the amount and type of documentation.

R **C** Ⓜ ⚠3

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SENTINEL EVENT REPORTING

To report any sentinel events in the work place please call The Joint Commission on Accreditation of Healthcare Organization's (JCAHO) **"Sentinel Event Hotline"** at (630) 792-3700.

To report any perceived infraction or impropriety made by **The Nurse Agency, Inc.,** please call JCAHO's **"Complaint Hotline"** at (800) 994-6610. Please note that *no* retaliation will be taken against an employee who makes a report to JCAHO.

The HCAHPS Survey – Frequently Asked Questions

What is the purpose of the HCAHPS Survey?

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care. While many hospitals collect information on patient satisfaction, HCAHPS (pronounced "*H-caps*") created a national standard for collecting and public reporting information that enables valid comparisons to be made across all hospitals to support consumer choice. The HCAHPS sampling protocol is designed to capture uniform information on hospital care from the patient's perspective.

Three broad goals shape the HCAHPS Survey. First, the survey is designed to produce comparable data on patients' perspectives of care that allows objective and meaningful comparisons among hospitals on topics that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve quality of care. Third, public reporting serves to enhance public accountability in health care by increasing transparency. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful, and practical. This methodology and the information it generates are available to the public. More information about the HCAHPS Survey can be found at http://www.hcahpsonline.org/home.aspx.

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. Government agency.

What items are on the HCAHPS Survey?

The HCAHPS Survey is composed of 27 items: 18 substantive items that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness of the hospital environment, quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and recommendation of hospital); four items to skip patients to appropriate questions; three items to adjust for the mix of patients across hospitals; and two items to support congressionally-mandated reports. The HCAHPS Survey is available in English, Spanish, Chinese, Russian and Vietnamese in the mail format, and in English and Spanish in the telephone and Interactive Voice Response formats. On average, it takes respondents about seven minutes to complete the HCAHPS survey items. The core set of HCAHPS questions can be combined with customized, hospital-specific items to complement the data hospitals collect to support internal customer service and quality-related activities.

The actual wording of the HCAHPS questions and response categories, as well as the scripts for conducting the survey in the Telephone and Active Interactive Voice Response (IVR) modes, can be found under "Survey Instruments" on the HCAHPS On-line website, http://www.hcahpsonline.org/home.aspx. Complete information about how to implement the HCAHPS survey can be found in the HCAHPS Quality Assurance Guidelines, also available on this Web site.

How was the HCAHPS Survey developed?

The Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ), another agency in the federal Department of Health and Human Services, to develop HCAHPS. AHRQ carried out a rigorous, scientific process to develop and test the HCAHPS instrument. This process entailed multiple steps, including a public call for measures; literature review; cognitive interviews; consumer testing and focus groups; stakeholder input; a large-scale pilot test and a number of small-scale field tests. In addition, CMS responded to hundreds of public comments generated by several Federal Register notices.

In May 2005, the National Quality Forum (NQF)—which represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, Federal agencies, and research and quality organizations—endorsed the HCAHPS. In December 2005, the federal Office of Management and Budget gave its final approval for the national implementation of HCAHPS. HCAHPS was also endorsed by the Hospital Quality Alliance. CMS commissioned an independent research firm, Abt Associates Inc., to conduct an analysis of the benefits and costs of HCAHPS. The Abt report, which includes detailed cost estimates for hospitals, can be found at:
http://www.cms.gov/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf.

When did hospitals begin to implement the HCAHPS Survey?

Voluntary collection of HCAHPS data for public reporting began in 2006, and public reporting of HCAHPS scores began in 2008. Since July 2007, hospitals subject to IPPS payment provisions ("subsection (d) hospitals") must collect, submit and publicly report HCAHPS data in order to receive their full IPPS annual payment update (APU). IPPS hospitals that fail to report the required quality measures, which include the HCAHPS survey, may receive an APU that is reduced by 2.0 percentage points. Non-IPPS hospitals, such as Critical Access Hospitals, can voluntarily participate in HCAHPS. HCAHPS Survey results also form the basis for the Patient Experience of Care domain in the Hospital Value-Based Purchasing program.

Which modes of survey administration can be used for HCAHPS?

Because hospitals and survey vendors survey patients a number of ways, HCAHPS is available in four different modes: Mail Only, Telephone Only, Mail with Telephone follow-up (also known as Mixed mode), and Active Interactive Voice Response (IVR). Detailed information on the proper use of each mode of survey administration can be found in the HCAHPS Quality Assurance Guidelines manual, which is located at "Quality Assurance" at www.hcahpsonline.org.

CMS recognizes that patients' responses to the survey may be affected by the mode of survey administration. For instance, respondents typically give somewhat more positive responses when surveyed by telephone, as compared to mail. Thus, choice of mode of survey administration could potentially affect comparisons of hospitals. CMS conducted a large-scale experiment to test for mode effects, and based on this research an adjustment has been built into the calculation of HCAHPS scores to remove the effect of survey mode on how patients respond to HCAHPS survey items.

The Mode Experiment was based on a nationwide random sample of short-term acute care hospitals. Participating hospitals contributed patient discharges from a four-month period in 2006. Within each hospital, equal numbers of patients were randomly assigned to each of the four modes of survey administration. In total, 27,229 discharges from 45 hospitals were surveyed.

In general, patients randomized to the Telephone Only and active IVR provided more positive evaluations than those randomized to the Mail Only and Mixed modes. Mode effects varied little by hospital. More information, as well as an overview of the results of the mode experiment, can be found under "Mode Adjustment" at http://www.hcahpsonline.org/home.aspx.

What must hospitals do in order to participate in HCAHPS?

CMS has developed detailed Rules of Participation and Minimum Survey Requirements for hospitals that either self-administer the survey or administer the survey for multiple hospital sites, and for survey vendors that conduct HCAHPS for client hospitals. The HCAHPS Rules of Participation include the following activities:

- Attend HCAHPS Introduction and Update Training
- Follow the Quality Assurance Guidelines and Policy Updates
- Attest to the accuracy of the organization's data collection process
- Develop a HCAHPS Quality Assurance Plan
- Become a QualityNet Exchange Registered User for data submission
- Participate in oversight activities conducted by the HCAHPS Project Team.

Hospitals and survey vendors administering the survey must also meet HCAHPS Minimum Survey Requirements with respect to survey experience, survey capacity, and quality control procedures. Details about these activities and requirements can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

Note: If a hospital, or its survey vendor, is found to be non-compliant with these rules or requirements, the hospital's HCAHPS data may not be publicly reported and the hospital may be at risk for an annual payment update (APU) reduction.

Which patients are eligible to participate in HCAHPS?

The HCAHPS survey is broadly intended for patients of all payer types that meet the following criteria:

- 18 years or older at the time of admission
- At least one overnight stay in the hospital as an inpatient
- Non-psychiatric MS-DRG/principal diagnosis at discharge
- Alive at the time of discharge

Patients who meet these criteria (except those that fall into an exclusion category, described below) should be included in the sample frame from which the survey sample is drawn.

A patient's principal diagnosis at discharge is used to determine whether he or she falls into one of the three service line categories (medical, surgical or maternity care) for HCAHPS eligibility. The Medicare Severity-Diagnosis Related Group (MS-DRG) is the preferred method for determining whether the service line is Medical, Surgical or Maternity Care.

Pediatric patients (under 18 years old at admission) and psychiatric patients are ineligible because the current HCAHPS instrument is not designed to address the unique situation of pediatric patients and their families, or the behavioral health issues pertinent to psychiatric patients. Patients whose MS-DRG/principal diagnosis is Medical, Surgical or Maternity Care but who also have psychiatric comorbidities are eligible for the survey. Patients who did not have an overnight stay are ineligible because their experiences and interactions with the staff during the hospital visit may be limited.

There are a few categories of otherwise eligible patients who, because of logistical difficulties in collecting data, are excluded from the sample frame before the random sample is selected. These are:

- Patients discharged to hospice care
- Patients discharged to nursing homes and skilled nursing facilities
- Court/Law enforcement patients (i.e., prisoners)
- Patients with a foreign home address (excluding U.S. territories—Virgin Islands, Puerto Rico, and Northern Mariana Islands)
- "No-Publicity" patients (see below)
- Patients who are excluded because of rules or regulations of the state in which the hospital is located

Complete information about patient eligibility and exclusions for the HCAHPS survey can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

Note: A "No publicity patient" is a patient who requests at admission that the hospital: 1) not reveal that he or she is a patient; and/or 2) not survey him or her.

Note: Hospitals must document their use of all patient exclusions.

How are patients sampled for the HCAHPS survey?

The basic sampling procedure for HCAHPS is the drawing of a random sample of eligible discharges on a monthly basis. Smaller hospitals should survey all HCAHPS-eligible discharges. Data are collected from patients throughout each month of the 12-month reporting period. Data are then aggregated on a quarterly basis to create a rolling 4-quarter data file for each hospital. The most recent four quarters of data are used in public reporting. To ensure comparability, hospitals may not switch type of sampling, mode of survey administration, or survey vendor within a calendar quarter. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

How is the sample drawn for the HCAHPS Survey?

The basic sampling procedure for HCAHPS entails drawing a random sample of all eligible discharges from a hospital on a monthly basis. Sampling may be conducted either continuously throughout the month, or at the end of the month, as long as a random sample is generated from the entire month.

The target for the statistical precision of the publicly reported hospital scores is based on a reliability criterion. In brief, higher reliability means a higher ratio of "signal to noise" in the data. The reliability target for the HCAHPS global items and most composites is 0.8 or higher. Based on this target, hospitals must obtain at least 300 completed HCAHPS surveys over the 12-month reporting period.

The HCAHPS sample must be drawn according to this uninterrupted random sampling protocol. Hospitals/Survey vendors must sample from every month throughout the entire reporting period and not stop sampling or curtail ongoing interview activities once a certain number of completed surveys has been attained. All completed surveys should be submitted to the HCAHPS data warehouse. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

Note: Smaller hospitals that are unable to reach the target of 300 completes in a 12-month reporting period must survey ALL eligible discharges and attempt to obtain as many completes as possible.

When are patients surveyed?

Sampled patients are surveyed between 48 hours and six weeks after discharge, regardless of the mode of survey administration. Interviewing or distributing surveys to patients while they are still in the hospital is not permitted.

Data collection for sampled patients must end no later than six weeks following the date the first survey is mailed (Mail Only and Mixed Modes) or the first telephone attempt (Telephone Only and IVR Modes) is made. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

How is the HCAHPS Survey data analyzed?

Data submitted to the HCAHPS data warehouse is cleaned and analyzed by CMS, which then calculates hospitals' HCAHPS scores and publicly reports them on the Hospital Compare website.

Which results from the HCAHPS Survey are publicly reported?

Hospital-level HCAHPS results are publicly reported on the Hospital Compare website at http://www.hospitalcompare.hhs.gov. Results are reported for four quarters on a rolling basis, which means that the oldest quarter of survey data is rolled off as the newest quarter is rolled on. Ten HCAHPS measures are publicly reported on Hospital Compare:

Composite Topics

- Nurse Communication (Question 1, Q2, Q3)
- Doctor Communication (Q5, Q6, Q7)
- Responsiveness of Hospital Staff (Q4, Q11)
- Pain Management (Q13, Q14)
- Communication About Medicines (Q16, Q17)
- Discharge Information (Q19, Q20)

Individual Items

- Cleanliness of Hospital Environment (Q8)
- Quietness of Hospital Environment (Q9)

Global Items

- Overall Rating of Hospital (Q21)
- Willingness to Recommend Hospital (Q22)

All ten HCAHPS measures are publicly reported for each participating hospital, as well as the national and state averages for each measure. The survey response rate and the number of completed surveys (in broad categories) are also publicly reported on Hospital Compare. CMS publicly reports HCAHPS results for hospitals that obtain fewer than 100 completed surveys. However, a footnote is added when public reporting these results to denote the lower level of precision. Additional information about hospital performance on HCAHPS is available under "Summary Analyses" on the HCAHPS On-Line Web site, http://www.hcahpsonline.org/home.aspx.

How are HCAHPS results adjusted prior to public reporting?

To ensure that differences in HCAHPS results reflect differences in hospital quality only, HCAHPS survey results are adjusted for patient-mix and mode of data collection. Only the adjusted results are publicly reported and considered the official results. Several questions on the survey, as well as items drawn from hospital administrative data, are used for the patient-mix adjustment. Neither patient race nor ethnicity is used to adjust HCAHPS results; these items are included on the survey to support congressionally-mandated reports. The adjustment model also addresses the effects of non-response bias.

More information about the mode experiment, as well as patient-mix adjustment coefficients for publicly reported HCAHPS results, can be found under "Mode and Patient-Mix Adjustment" at http://www.hcahpsonline.org/home.aspx.

I, _____, have read The Nurse Agency's
Orientation materials regarding:

- The RN job description
- The CNA job description
- Patient Restraints
- Pain Management Standards
- The Nurse Agency's Drug Free Workplace Policy
- The Nurse Agency's Sexual Harassment Policy
- The Nurse Agency's Cultural Diversity and Sensitivity Policy
- JCAHO National Patient Safety Goals
- The Rights of Patients and Ethical Aspects of Care
- Sentinel Event Reporting
- The HCAHPS Survey – Frequently Asked Questions

I understand that failure to comply with these policies could result in disciplinary action
or termination of my employment.

Name: _____

Signature: _____

Date: _____