East Georgia Regional Medical Center (Statesboro, GA)

- READ - Annual Required Inservice (ARI) Manual
- ARI Test
- Compliance/HIPAA overview
- HIPAA form
- Confidentiality Statement
- Addendum 4 – Substance Policy Consent Form
- Student Data Sheet
- Scope of Practice
ANNUAL REQUIRED INSERVICE

2015
Dear EGRMC Associate:

This booklet contains information to satisfy requirements for Annual Required Inservice Training for 2015.

We are also required to provide this information to the Associate in a particular time frame. For this reason, this booklet must be read, quiz completed and returned to your Department Manager, Clinical Director or to the Human Resources Department, no later than July 31, 2015.

Instructions:

- Please read the entire booklet.
- Complete the Safety Quiz.
- Complete the 2015 Annual Safety Booklet Evaluation.
- Return all of the above to your Department Manager, Clinical Director, or the Human Resources Department no later than July 31, 2015.

If you have any questions concerning any information presented in this booklet, you may contact one of the following:

<table>
<thead>
<tr>
<th>Contact Person</th>
<th>Telephone</th>
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<tr>
<td>Human Resources Department</td>
<td>486-1540</td>
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<tr>
<td>Leslie Fordham</td>
<td>486-1507</td>
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<td>Employee Health</td>
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<tr>
<td>Dawn Cheney</td>
<td>486-1542</td>
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<td>Infection Control</td>
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<tr>
<td>Nakesha Rolle</td>
<td>486-1506</td>
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<tr>
<td>Risk Manager/Facility Compliance Officer</td>
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<tr>
<td>Mike Motes</td>
<td>486-1651</td>
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<td>Plant Operations/Safety Officer</td>
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<tr>
<td>Shelley Harris</td>
<td>486-1761</td>
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<td>Facility Privacy Officer</td>
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<td>Rhonda Jones</td>
<td>486-1118</td>
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<td>Quality Management</td>
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<tr>
<td>Conan Stuart</td>
<td>486-1731</td>
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<td>Facility Information Security Officer</td>
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Mission
The mission of East Georgia Regional Medical Center is to provide quality healthcare services in a safe and compassionate environment.

Vision

The vision of East Georgia Regional Medical Center is to be the premier regional provider of a continuum of healthcare services.

Statement of Values

- Delivering to our patients and their families a level of care we would expect for ourselves and our families.
- Treating internal and external customers with courtesy and respect.
- Recognizing that individual actions can reflect on the medical center as a whole.
- Attracting highly qualified, well-trained physicians to promote quality patient outcomes.
- Demonstrating an atmosphere of cohesive teamwork among all healthcare providers.
- Committing to our community through participation in regional activities.
- Using opportunities for professional and personal development to benefit the medical center and region.
- Expecting integrity and loyalty from ourselves and our colleagues.
- Providing a safe environment for staff, patients and visitors.
Cultural Diversity

EGRMC is committed to promoting the cultural diversity of its staff through:
1. Ensuring that all staff, irrespective of race, gender, creed or culture, receives fair and just treatment.
2. Creating an environment where the cultural skills and talents of all staff contribute to the goals of the Facility.
3. Developing EGRMC as an example of harmonious and creative cultural diversity in its own sphere of operation and to the wider community.

The term cultural diversity incorporates cultural differences based on race, color of skin and national or ethnic origin.

Drug Free Workplace

It is a condition of employment to refrain from taking drugs on or off the job. All Associates are expected to report to work and perform their duties free of drugs and/or alcohol and to remain in this condition in order to perform their job duties safely and efficiently. Possession and/or use of an illegal, unprescribed, controlled drug or usage of unauthorized alcoholic beverages are prohibited on EGRMC premises.

Associates must notify their supervisor when under any medication that may limit their ability to perform their job duties. All confidentiality will be maintained.

EGRMC will conduct drug and alcohol testing for (1) post–offer/pre-employment prospective associates (2) reasonable suspicion (3) failure to waste narcotics, (4) post- accident (5)fitness for duty, (6) absence from position after 90 days, (7) Transferring from another facility, (8) random (9) follow-up. An Associate who refuses to consent to a test for drugs or alcohol may be discharged from employment.

All contractors/volunteers/student workers are covered under the Substance Testing/Fitness for Duty policy.
Compliance Program &
Code of Conduct

East Georgia Regional Medical Center’s mission is to provide quality healthcare services in a safe and compassionate environment. In fulfilling this mission, this hospital is dedicated to adhering to the highest ethical standards and, accordingly, recognizes the importance of compliance with all applicable state and federal laws. We have a Compliance Program that is designed to ensure that our employees are generally familiar with the laws, rules, and regulations which govern their specific employment responsibilities. Through our Compliance Program, we provide a way to report concerns about inappropriate conduct. Each employee becomes an important part of ensuring compliance throughout our business operations.

The Compliance Program is a system of checks, balances, and controls designed to deter, detect, and prevent fraud, abuse, and mistakes. The Office of the Inspector General (OIG) developed a set of guidelines for hospital compliance programs in 1997. Our Compliance Program follows the seven elements outlined by the OIG:

- Written standards, policies, and procedures;
- Individuals with oversight responsibilities;
- Training process;
- Auditing and monitoring process;
- Anonymous reporting mechanisms;
- Investigative process;
- Corrective action process.

Our policies require that all employees receive Compliance education. New employees receive Compliance and HIPAA training within 30 days of hire. All employees receive annual training on Compliance and HIPAA.

The Code of Conduct provides formal guidance regarding the ethical behavior that is expected from all employees to ensure compliance with applicable laws. The Code provides guidance, resources, and expected behaviors that our leaders believe are needed to best position us to achieve our mission. The success of the Compliance Program depends on the efforts and dedication of every employee.

Facility Compliance Officer
Nakesha Rolle (912) 486-1506

Confidential Disclosure Program Hotline: 1-800-495-9510

Corporate Compliance and Privacy Officer
Community Health Systems Professional Services Corporation
4000 Meridian Boulevard
Franklin, Tennessee 37067
**Good Body Mechanics**

Low back pain is one of the most common ailments. As a back owner, you will find this information useful in the proper care of your low back. This is designed to start you thinking about your back and help answer questions you may have.

A healthy back is strong, flexible, and pain-free. Its chief functions are to support your upper body, protect your spinal cord, allow flexibility, and provide a point of attachment for your muscles and ligaments, which help the body move. A healthy spine is properly aligned, with its three natural curves in their normal, balanced position, supported by strong back, abdominal, buttock, and leg muscles.

Since the disks, ligaments, and muscles of the back are supplied by many nerve endings, there are various, often interrelated conditions that can cause back pain. In addition to the common physical causes, the stress, fatigue and anxieties of daily life can significantly increase low back pain.

There is no simple solution to back pain. Although your doctor can guide you on the road to recovery, a healthy, pain-free back is almost always up to you. Only YOU can improve your posture and learn ways to prevent back strain in your daily activities.

The following is a list of do’s and don’ts to maintain good body mechanics so as to avoid back injuries/pain:

<table>
<thead>
<tr>
<th>DO’S</th>
<th>DON’TS</th>
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<tr>
<td><strong>Lifting:</strong></td>
<td></td>
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<tr>
<td>Bend with your knees, not your back!</td>
<td>Lifting:</td>
</tr>
<tr>
<td>Lift with your legs and hold objects close to your body.</td>
<td>Don’t bend over with legs straight or twist while lifting. Avoid trying</td>
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<tr>
<td>Lift objects only chest-high; stand on a stool, if necessary.</td>
<td>to left above shoulder level. These positions may cause injury.</td>
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<td>When a load is heavy, get help and plan ahead to avoid sudden load</td>
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<tr>
<td>shifts. Always be sure of your footing.</td>
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<tr>
<td><strong>Standing/Walking:</strong></td>
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<tr>
<td>Stand with one foot up; change positions often.</td>
<td>Don’t stand in one position too long. Don’t bend forward with straight</td>
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<tr>
<td>Stand with your back’s three natural curves in their normal,</td>
<td>legs, or walk with poor posture. Don’t wear high-heeled or platform</td>
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<td>balanced alignment. Walk with good posture, keeping head high,</td>
<td>shoes when standing or walking for long periods.</td>
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<tr>
<td>chin tucked in, and toes straight ahead. Wear comfortable, low-heeled</td>
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<tr>
<td>shoes.</td>
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<tr>
<td><strong>Driving:</strong></td>
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<tr>
<td>Move your car seat forward to keep knees level with hips.</td>
<td>Driving:</td>
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<tr>
<td>Sit straight; drive with both hands on the wheel. To support your</td>
<td>Don’t drive sitting far back from the wheel. Stretching for the pedal</td>
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<tr>
<td>lower back, place a lumbar support or a rolled-up towel behind your</td>
<td>and wheel decreases your low back curve and produces strain.</td>
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<tr>
<td>back.</td>
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<td><strong>Sitting:</strong></td>
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<tr>
<td>Sit in chairs low enough to place both feet flat on the floor with</td>
<td>Sitting:</td>
</tr>
<tr>
<td>knees level with hips. Sit firmly against the back of your chair.</td>
<td>Don’t slump. Don’t sit in a chair that’s too high or too far from your</td>
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<tr>
<td>Protect your lower back with a lumbar support or rolled-up towel.</td>
<td>work—-avoid leaning forward and arching your back.</td>
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<tr>
<td><strong>Sleeping:</strong></td>
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<tr>
<td>A good night’s sleep on a firm mattress is good for you and your</td>
<td>Sleeping:</td>
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<td>back. Sleep on your side with knees bent, or on your back with a</td>
<td>Don’t sleep or lounge on soft, sagging, non-supporting mattresses or</td>
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<tr>
<td>pillow under your knees. Choose the position that feels most</td>
<td>cushions. Swayback and back strain will result, especially when</td>
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<tr>
<td>comfortable for you.</td>
<td>sleeping on your stomach.</td>
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Signs & Symptoms of Musculoskeletal Disorders

What is a Musculoskeletal Disorder (MSD)?
An MSD is an injury or illness affecting muscles, nerves, tendons, ligaments, joints, cartilage, blood vessels, or spinal discs.

What are the signs and symptoms of MSD that you should be aware of?
Individuals who suffer from MSD may notice that they have less strength for gripping, a decreased range of motion, loss of muscle function, and inability to do routine tasks. Some of the most common symptoms are:

- Painful joints
- Stiffness
- Burning sensation
- Back or neck pain
- Swelling or inflammation
- Pain in wrists, shoulders, forearms, knees
- Pain, tingling, or numbness in hands or feet
- Shooting or stabbing pains in arms or legs
- Fingers or toes turning white

What are the most common types of MSD?
- Carpal tunnel syndrome
- Rotator cuff syndrome
- De Quervain’s disease
- Trigger finger tendonitis
- Sciatica
- Epicondylitis
- Herniated spinal disc
- Raynaud’s phenomenon
- Carpet layer’s knee
- Low back pain
- Hand-arm vibration syndrome
- Tension neck syndrome

What causes MSD?
Exposure to the following risk factors while working can cause MSD:

- **Repetition** - Doing the same motions over and over can cause stress to muscles and tendons. The severity of the risk is determined by how often the motion is repeated, how fast the movement occurs, the muscles involved, and the amount of force exerted.

- **Forceful Exertions** - Force is the amount of physical effort necessary to do a task (such as lifting a heavy object) or to maintain control of equipment or tools used in a task. The amount of force is determined by the type of grip, the weight of the object, body position, type of activity, and length of the task.

- **Awkward Postures** - Posture is the position your body is in, which determines the muscles involved in the activity. Awkward postures include repeated or prolonged reaching, twisting, bending, kneeling, squatting, working overhead with the hands or arms, or holding the same position for a period of time.

- **Contact Stress** - Pressing the body or a body part against a hard or sharp edge can cause too much pressure on nerves, tendons, and blood vessels. For example, using the palm of the hand as a hammer can increase risk of suffering an MSD.

- **Vibration** - Operating tools that vibrate, such as sanders, grinders, drills, jackhammers, and saws can cause nerve damage.

What should you do if you have signs or symptoms of an MSD?
You should report the signs and symptoms to your supervisor, complete an Employee Accident/Injury Form, and see the Employee Health Nurse. If you do not report the MSD signs and symptoms early, you could suffer a permanent disability.
Employee Accident/Injury/Exposure Reporting

If you are involved in an accident or injured while on the job, you must report the accident/injury immediately. THE WORKERS COMPENSATION FIRST REPORT CAN BE PRINTED OFF THE EGRMC INTRANET WEBSITE. The accident must be reported within a 24 hour period and if not reported immediately, the associate and director must explain to the administrative team why the accident/injury was not reported in a timely manner.

If you have an accident or receive an injury while on the job, you should:

Immediately report the accident, injury, or exposure to your Director or House supervisor if your director is unavailable. The supervisor will then print the material off of the intranet so that the associate can fill out the information on the accident that occurred. The supervisor will take the associate to the ER to be seen. The supervisor will assist with paperwork (and source patients material) and leave the paperwork for the w/c coordinator. The supervisor will call Ext 1112 and leave a message for the W/C Coordinator. Drug screens are not required unless the supervisor has reasonable suspicion.

The First Report of Injury form must be filled out and turned in at the time of the accident.

The First Report of Injury can be turned in at the Mailroom or outside of W/C Coordinators office. The supervisor will call the w/c coordinator if the w/c accident happens on the weekend or holidays so the form can be turned in within 24 hours. The supervisor will scan forms to the w/c coordinator.

Important points to Remember:

All exposures need to be seen immediately. (Do not wait several hours before being seen)

Please bring name and acct number of source patient with you to the supervisor’s office so that the correct information can be collected by Supervisor. If prophylaxis medication is needed, these medications need to be initiated within two (2) hours of exposure for best results.

If you are seen in the Emergency Department for work related injury, you must follow up with W/C Coordinator and Employee Health the next business day.

If you need additional treatment after being seen in the ER for your work related injury, you must have approval from W/C coordinator for all tests and appointments.

Failure to report an injury within 24 hours of the injury occurring will result in the employee/supervisor explaining to the Administrative team the reasons the injury was not reported in a timely manner.

On all w/c exposure, there are several pages of questions that need to be filled out completely for employee health nurse.
Event Reporting

Effective June 30, 2014, East Georgia Regional Medical Center will utilize the ERS on-line event reporting system. The link to the online system can be found on the hospital’s intranet page. Categories of events that may be reported online include the following:

- Medication Variances
- Adverse Drug Reactions
- Falls
- Surgical/Invasive/Tests or Procedures
- Equipment
- Perinatal
- Miscellaneous and Pressure Ulcers
- Behavioral
- Complaints and Grievances
- Needlestick and Sharps Injuries

The event reporting systems establishes a standardized mechanism for reporting events. Analysis of events allows us to trend events to prevent harm, improve patient safety, improve healthcare quality, and improve healthcare outcomes.

When completing an event report:

- **DO** document the details of a patient incident in the medical record.
- **DO** document the facts.
- **DO** document follow-up treatment and/or action taken.
- **DO** complete all required information (outlined in blue).
- **DON’T** record in the medical record that an event report was completed or the Risk Manager was called.
- **DON’T** document your opinion.
- **DON’T** tell the patient/family a report has been written.
- **DON’T** copy/print and distribute the event report to anyone other than the Risk Manager.

Event Reports should be completed in following circumstances (this is not an all-inclusive list):

**Serious Reportable Events as defined by the National Quality Forum:**

**SURGICAL:**
- Surgery or other invasive procedure performed on the wrong site.
- Surgery of other invasive procedure performed on the wrong patient.
- Wrong surgical or other invasive procedure performed on a patient.
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
- Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient

**PRODUCT OR DEVICE EVENTS:**
- Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
- Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
PATIENT PROTECTION EVENTS:
- Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
- Patient death or serious injury associated with patient elopement (disappearance).
- Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

CARE MANAGEMENT EVENTS:
- Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
- Patient death or serious injury associated with unsafe administration of blood products.
- Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
- Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
- Any stage and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
- Artificial insemination with the wrong donor sperm or wrong egg.
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
- Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

ENVIRONMENTAL EVENTS:
- Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.
- Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.
- Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

RADIOLOGIC EVENTS:
- Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

POTENTIAL CRIMINAL EVENTS:
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- Abduction of a patient/resident of any age.
- Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.
- Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

Sentinel Events (as defined by the Joint Commission) should be reported immediately to the Risk Manager and the Administrator on Call:
- Unanticipated death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition;
- Suicide of any patient receiving care, treatment and services in a staffed around-the-clock setting or within 72 hours of discharge;
- Unanticipated death of a full-term infant;
- Abduction of any patient receiving care, treatment, and services;
- Discharge of an infant to the wrong family;
- Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services;
- Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization;
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups);
- Invasive procedure, including surgery, on the wrong patient, wrong site, or wrong procedure;
- Unintended retention of a foreign object in a patient after surgery or other invasive procedures;
- Severe neonatal hyperbilirubinemia (bilirubin > 30 milligrams/deciliter);
- Prolonged fluoroscopy with cumulative dose of > 1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.

When a reportable event occurs, make sure that you first get the patient or other person affected by the event the appropriate treatment. An event report should be completed by the individual most knowledgeable about the event and should be completed during the shift when the event occurred. Describe the event using facts, not opinions or judgments. Complete all required sections of the report (those in blue boxes). Do not discuss with the patient/visitor any outcomes or actions that may occur as a result of the event. A determination of the hospital's responsibility can only be made after a thorough investigation.

If you are contacted by an attorney regarding a patient or incident, refer the attorney to the Risk Manager. Never discuss anything regarding an event or patient with an attorney without the permission of the Risk Manager. Any information you give to an attorney can be used in court against you or the hospital. Do not accept a subpoena or summons unless it is specifically directed to you. Never accept one for someone else. Notify Risk Management immediately upon service or attempted service of any court document related to hospital business.

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**Patient Safety**

Medical errors happen when something that was planned as a part of the medical care doesn't work out, or when the wrong plan was used in the first place. Medical errors can occur anywhere in the health care system. Errors can involve: medicines, surgery, diagnosis, equipment, lab reports, etc. They can happen during even the most routine tasks, such as when a hospital patient on a salt-free diet is given a high-salt meal.

Specific attention is to be directed at educating patients and families about their role in helping to facilitate the safe delivery of care. What can healthcare workers do to get patients involved in their healthcare?

- encourage patients to be active and involved in decisions about their health
- encourage patients to ask questions about procedures they do not understand
- encourage patients to let healthcare workers know about everything they are taking which includes prescription and over-the-counter medicines (herbal remedies and dietary supplements)
- inform patients on importance of knowing allergies and adverse reactions to medications
- healthcare workers are to wash hands and encourage patients to wash their hands
- explain treatment plan to patients before discharge
- explain surgery process prior to surgical procedures
- give clear explanation about test and treatment reports
Patients have a right to be informed of outcomes, even unintended outcomes. It is the responsibility of the attending physician and administrative representatives to inform the patient of any unanticipated/adverse outcomes.

**Failure Mode Effects Analysis** is a systematic process for looking at how a design or process could fail and the possible results of the failure. The FMEA is used to identify ways failures could occur and consequences of the failure on performance and the consequences on outcome. An example: a medication error occurred and may have been caused by illegible orders.

**Sentinel Event** – An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. See the Event Reporting section for a complete listing of sentinel events, as defined by the Joint Commission.

**Adverse Event** – An unexpected event that caused or may cause a negative effect on patient care, the safety or well-being of the patient, staff or visitors, or loss/damage to property or resources.

**Near Miss** – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of serious adverse outcome.

If you are aware of any of the above examples, please complete an Event Report and immediately notify your Department Manager or Risk Management. A Root Cause Analysis (RCA) may need to be conducted. Root Cause Analysis = a process used to determine the cause of a sentinel event or serious safety event. For further information read your Sentinel Event policy located in the administrative manual.

**Patient Complaints/Grievances**

The Centers for Medicare and Medicaid Services (CMS) requires that the hospital establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.

The hospital must provide the following to the patient:

- Information on the hospital’s internal grievance policy, including whom to contact.
- Information on how to lodge a grievance with the State Agency, including the telephone number and address. (This is not dependent upon whether the hospital’s grievance procedure was used first.)
- Information on the premature discharge appeal process.

The hospital’s Board of Trustees must approve and be responsible for the effective operation of the grievance process. They must review and resolve grievances unless:

- Written responsibility is delegated to a Grievance Committee.
- If delegated to a Grievance Committee, the committee’s membership is comprised of the Chief Nursing Officer, Risk Manager, and Patient Advocate. The Committee must meet monthly, and the reports are integrated into the performance improvement program.

The CMS interpretive guidelines §482.13 (a)(2) state the “patient should have reasonable expectations of care and services, and the facility should address those expectations in a timely, reasonable and consistent manner.”
Definitions:

**Complaint** - an expression of displeasure or discontent about a situation (housekeeping issue, food dissatisfaction, etc.) requiring a response taken to address the concern at issue.

**Grievance** - a formal/informal written or verbal complaint made to the hospital by the patient or patient’s representative (when the complaint is not resolved at the time of the complaint) regarding the patient’s care, abuse or neglect, or issues related to the hospital’s compliance with the CMS Conditions of Participation (CoP).

The following situations are not considered to be a grievance:

- Post-hospital verbal communication regarding patient care that would routinely have been handled by staff present if the communication had occurred during the hospital stay.
- Billing issues are usually not considered grievances, unless the complaint also contains elements addressing patient service/care issues, or the complaint is by a Medicare beneficiary related to rights and limitations provided by 42 CFR 489.
- Information obtained through satisfaction surveys, unless an identified patient writes or attaches a written complaint on a survey and requests resolution.

Examples of grievances:

- A written complaint is always considered a grievance. This would include an e-mail or fax.
- Allegations of abuse or neglect are always considered a grievance.
- Whenever a patient or patient representative requests the complaint to be handled as a formal complaint, it is considered a grievance.

**Patient Complaint/Grievance Process:**

**Patient still in hospital:**

- Staff present will listen to patient/patient representative for concerns and immediately address any concerns. If Patient Advocate is on duty, involve Patient Advocate. Patient Advocate will initiate the resolution process.
- If Patient Advocate is not on duty, record patient/patient representative’s concerns in an Event Report and advise Nursing Supervisor/Department Director, who will address concerns if able and record resolution in the Event Report.
- If concerns are considered resolved by patient/patient representative, record resolution in the Event Report.
- If concerns are not resolved, apologize then advise patient/patient representative that his/her concerns will be investigated and a hospital representative will communicate the resolution to him/her. Make sure the Event Report identifies the issues which are not resolved.

**Patient no longer in hospital:**

**Phone complaints:**

- Should be routed to the Patient Advocate (if on duty). Patient Advocate will initiate the resolution process.
- If Patient Advocate is not on duty, staff taking the call will record patient/patient representative’s concerns in an Event Report, apologize to the patient/patient representative, and advise him/her we will investigate their concerns and communicate our resolution to him/her in writing.

Letters or other forms of written complaints:
• Written complaints are considered grievances.
• Whoever receives the written complaint will complete an event report forward the letter to Patient Advocate/Risk Management.
• Upon receipt of the complaint/grievance, Patient Advocate/Risk Management will route the complaint to the department director for investigation and follow-up, and for grievances will send an Initial Written notice to the patient/patient representative, acknowledging the receipt of the grievance, advising him/her the resolution process will begin and he/she should expect another letter upon conclusion of the investigation.
• Patient Advocate/Risk Management will route the complaint or grievance to the relevant department director(s) for investigation and appropriate follow up. The investigation must be completed within seven (7) days of receipt from patient/patient representative.
• Department Director will forward completed investigation to Patient Advocate/Risk Management.
• Patient Advocate/Risk Management/Administration will send a final letter to the patient/patient representative advising him/her of the resolution and contact information for further questions. A follow up response may include a formal meeting with the patient/patient representative and administrative staff. Patient Advocate/Risk Management will document the meeting discussion.

In the grievance resolution process, the appropriate time frame for the written response is seven (7) days. If the hospital is unable to resolve the issue in seven days, the patient/patient representative must be informed that the hospital is still working to resolve the grievance and will follow up with a written response within a stated number of days in accordance with policy.

The written response must include the following:
• Notice of hospital’s decision.
• Hospital contact information.
• Steps taken to investigate the grievance.
• Results of the grievance process.
• Date of completion.

All complaints/grievances are to be entered into the Event Report database. This provides a consistent method for tracking, trending, and analyzing complaints and grievances and ensures compliance with CMS requirements.

Joint Commission’s 2015 National Patient Safety Goals (NPSG)

Goal 1 – Improve the accuracy of patient identification.
Wrong-patient errors occur in 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.

• Use at least two patient identifiers when administering medications, blood/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.
• Label containers used for blood and other specimens in the presence of the patient.
• Before initiating a blood/blood component transfusion: match the blood/blood component to the order; match the patient to the blood/blood component; use a two-person verification process.
• When using a two-person verification process prior to administering blood/blood products, one individual conducting the identification verification is the qualified transfusionist who will
administer the blood/blood component to the patient and the second individual is qualified to participate in the process, as determined by the hospital.

**Goal 2 – Improve the effectiveness of communication among caregivers.**
Critical results of test/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.

**Goal 3 – Improve the safety of using medications.**
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. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings.

- In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered, even if there is only one medication being used. Labeling must also occur when any medication or solution is transferred from the original packaging to another container. Labeling occurs at the time that the medication or solution is placed in the container, **not before**.
- Medication or solution labels include the following: medication name; strength; quantity; diluent and volume (if not apparent from the container); expiration date and expiration time. Label each medication or solution as soon as it is prepared, unless it is immediately administered. Immediately discard any medication or solution found unlabeled.
- Verify all medication/solution labels, both verbally and visually, 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. 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.
- Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
- Reduce the likelihood of patient harm associated with the use of anticoagulant therapy by using only oral unit-dose products, prefilled syringes, or premixed infusion bags of anticoagulants when available.
- Use approved protocols for the initiation and maintenance of anticoagulant therapy.
- Before starting a patient on warfarin, assess the patient’s baseline coagulation status; for all patients receiving warfarin therapy, use a current INR to adjust therapy. Baseline and current INR are documented in the medical record. Written policy addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.
- Manage potential food and drug interactions for patients receiving warfarin.
- When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.
- Provide education regarding anticoagulant therapy to 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.
- 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.
- 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. A good faith effort to obtain this information from the patient and/or other sources must be made.
- 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.
• 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).

• Explain the importance of managing information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter. Instruct the patient to give a list of 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.

Goal 6 – Improve the Safety of Clinical Alarm Systems
Clinical alarm systems are intended to alert caregivers of potential problems, but if they are not properly managed, they can compromise patient safety. 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. That is an important safety issue.

Goal 7 – Reduce the risk of health care-associated infections.
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.

• The current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines are: 1. wet hands, 2. apply soap, 3. apply friction for 20 seconds, 4. rinse, 5. dry, 6. turn off faucet with papertowel. Set goals and improve compliance with hand hygiene guidelines.

• Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms, central line-associated blood stream infections, surgical site infections, and catheter associated urinary tract infections in hospitals.

Goal 15 – The hospital identifies safety risks inherent in its patient population.
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.

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

• Address the patient’s immediate safety needs and most appropriate setting for treatment.

• Provide suicide prevention information (such as crisis hotline) to the patient/family on discharge from the hospital.

Universal Protocol
The Universal Protocol focuses on safety for all procedures (all surgical and non-surgical invasive procedures that expose patients to more than minimal risk). Hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

• Conduct a pre-procedure verification process to verify the correct procedure, for the correct patient, at the correct site. Involve the patient in the verification process when possible.

• The procedure site is marked by the licensed independent practitioner or an approved designated representative who will be involved in the performance of the procedure. Site marking is performed before the procedure and, if possible, with the patient involved.

• A time-out is performed immediately before starting all invasive procedures or making the incision and has the following characteristics: initiated by a designated member of the team; 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 the other active participants who will be present from the beginning. During the time-out, the team
members agree, at a minimum, on the following: correct patient identity; correct site; the procedure to be performed.

- 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.
- Completion of the time-out must be documented in the record according to hospital policy.

**Patient Rights**

Patients of East Georgia Regional Medical Center, have the right……..

- To expect a prompt and reasonable response to your requests and needs regarding treatment or services.

- To access available or medically indicated care, regardless of your age, race, creed, sex, national origin, religion, or sources of payment for care.

- To be treated with consideration and respect at all times and under all circumstances, with acknowledgement of your personal values and beliefs.

- To be informed about and involved in decisions involving your health care. To the degree possible, this shall be based on a clear explanation of your condition and of all proposed procedures, including the possibilities of any risk of death or serious side effects, problems related to recovery, and the probability of success. You have the right to be informed of medically significant alternatives for care and treatment.

- To have knowledge of the identity and role of each person treating you.

- To not be subjected to any procedure without your voluntary, competent, and understanding consent, or that of your legally authorized representative. Parents and/or guardians have the right to consent to or refuse treatment of underage patients.

- To request that treatment be withheld or withdrawn to the extent permitted by law.

- To designate someone else to make decisions for you in the event you are incapable of understanding a proposed treatment or procedure, unable to communicate your wishes regarding care, or are a minor.

- To form advance directives such as a Living Will and a Durable Medical Power of Attorney for Health Care.

- To death with dignity. You have the right to be provided comfort, to the fullest extent possible, through treatment of primary and secondary symptoms and pain management.

- You have the right to acknowledgment of your and your family's psychosocial and spiritual concerns regarding death and the grieving process.

- To assessment and management of pain.

- To privacy while receiving care.
To participate in the consideration of ethical issues that arise during the provision of your health care. Such issues may be referred to the Ethics Committee for its recommendations.

To be informed if the hospital wants to perform clinical research affecting your care or treatment. You have the right to refuse to participate in any such activity.

To obtain information about your treatment, including names of your care providers.

To expect that your medical information will be kept confidential and will not be released to anyone outside of the hospital without your written permission.

To receive pastoral counseling to meet your spiritual and emotional needs.

To open communication with your care providers and the outside world and to receive assistance with this communication if you have a hearing or speech impairment. You have the right to have any restriction of communication (phone, visitors, mail) for therapeutic reasons discussed with you and your family.

To assistance from the hospital and staff if you need access to protective services.

To care without verbal, physical, psychological, sexual, or emotional abuse or harassment.

To personal safety, security, and comfortable surroundings.

To express complaints to staff for prompt resolution without adverse effect on patient care.

To receive information concerning this patient's rights policy when you are admitted to the hospital, as well as what to do if you think your rights are not being respected.

To be informed of any clinical restrictions to your visitation rights. Otherwise, EGRMC gives full and equal visitation privileges with any family member or friend you designate without restrictions based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. You have the right to withdraw consent for visitation with any chosen guest at any time.

**Patient Responsibilities**

**Patients of East Georgia Regional Medical Center, have the responsibility....**

- To be honest and direct about everything that relates to you medically. In order to assist your healthcare providers, you should answer all questions honestly and completely.

- To cooperate with physicians and EGRMC personnel caring for you by following their instructions and by asking questions if directions and instructions are not clear. You are responsible for your actions if you refuse treatment or do not follow the instructions of your healthcare provider.

- To inform your physician or caregiver if your financial status may affect your ability to follow your plan of care.

- To communicate all information concerning medications or drugs recently or previously taken, as well as the purpose of such medications or drugs.

- To be respectful of others and respect their right of privacy. It is also your responsibility to ensure that your visitors are considerate of others and that unnecessary noise does not annoy nearby patients. It is your responsibility to ensure that visitors observe the visiting hours.
To allow hospital staff the opportunity to do their jobs and not make unnecessary demands upon the Hospital or upon those responsible for your care.

To abide by EGRMC policies, rules and safety regulations. This includes regulations prohibiting smoking and the use of cellular phones inside the building.

To pay your bills promptly; ask questions concerning your hospital bill and to provide Hospital with all necessary information for processing insurance and other claims.

Consent for Medical Treatment

Georgia’s informed consent law requires that a patient undergoing surgery with certain types of anesthesia, amniocentesis, and diagnostic procedures involving injection of contrast materials be informed, in terms he can understand, certain information related to his diagnosis and proposed procedure. Consents for procedures or treatments requiring informed consent must be in writing and must include specific information. Consents for procedures and treatments not requiring informed consent must also be in writing and disclose in general terms the treatment for which the consent is given. In order to ensure that the patient has received the information needed to make an informed consent, a “teach back” process has been developed in which the patient is asked to explain what he/she understands regarding the procedure.

Georgia law specifies the order of priority for individuals who can legally give consent for medical treatment. In general, the person giving consent usually must be an adult (18 years old); however, there are specific situations in which a minor can give consent. The law also provides specific priorities for individuals who can consent for treatment for an adult who is unable to consent related to health conditions or mental incompetence. Please refer to Policy I-C-008 Consent for Medical Treatment or Transfer/Discharge in the Administrative Manual for specific information.

Orientation of Forensic Personnel

Upon determination that a patient is being accompanied/guarded by forensic (law enforcement) personnel, the forensic staff member will be oriented to the building. Registration clerks, emergency personnel and/or the nursing staff will notify the administrator-on-call and the security officer on duty. In the event a security officer is not on duty, plant operations will be notified to provide the orientation information.

The security officer on duty or plant operations staff member will provide the forensic staff member with an identification badge to be worn while on hospital premises, along with information on the hospital emergency codes, responsibilities in interacting with patients, communication procedures and procedures for responding to security issues, clinical matters and administrative matters, differences in clinical and administrative restraint, standard precautions and hazardous material procedures.

Forensic staff will be requested to sign a receipt indicating that orientation materials have been received and reviewed by them. The receipt will be maintained on file by security.

The security officer or plant operations staff member will notify the nursing supervisor of the presence of forensic personnel who will be remaining with a patient. Additionally, the security officer/ plant operations staff member will inform the on-coming security officer at the change of shift of the presence of forensic personnel.
A log is maintained by security with the name of the forensic officer, the responsible agency to be contacted as needed, room number and name of patient to which the officer is assigned, the reason for assignment and any unusual circumstances.

Upon discharge of the patient, the forensic officer will be requested to return his ID badge to the security officer/plant operations staff member. Every Associate is responsible for ensuring this policy is followed by checking to see if all forensic officers with a patient are wearing a green ID badge. In the event no badge is visible, the security officer or plant operations should be called immediately.

**Harassment**

What is Harassment? It includes but is not limited to unwelcome sexual advances, requests for sexual favors, or other verbal, visual or physical conduct of a sexual nature where the conduct is explicitly or implicitly a condition of employment, submission or rejection of the conduct is used as a basis for employment or promotion, or the conduct interferes with the individual’s work performance or creates a hostile or offensive working environment.

What is a hostile work environment? Some examples of a hostile work environment might include off-color language, lewd or suggestive remarks or jokes, sexually explicit posters, pictures, cartoons, greeting cards or other means of communication that is offensive to an Associate and interferes with their ability to perform their job.

What makes a remark offensive or an action one of harassment? The action or remark is not judged by the intentions of the person making it but by the perceptions of the recipient.

Basically, it’s offensive if the recipient finds it offensive. If you feel you have experienced any type of harassment on the job, report it to your supervisor. If you do not feel comfortable talking to your supervisor, you can report your concerns to HR or any member of management.

**Disruptive Behavior**

It is the policy of EGRMC that all individuals within the facility be treated courteously, respectfully, and with dignity. To that end, EGRMC requires that all individuals, employees, physicians, and other independent practitioners conduct themselves in a professional and cooperative manner while in the Hospital or while involved in Hospital business.

**Definition of Disruptive Behavior:**
Disruptive behavior is any inappropriate and/or abusive behavior that may disrupt hospital operations, create a hostile or dangerous work environment or which may negatively impact patient care.

**Disruptive Behavior Includes, But Is Not Limited To:**
- Verbal abuse of any individual;
- Verbal abuse, which is directed to a group at large, but would reasonably be perceived by a member of that group to be offensive;
- Unjustifiable delay in the progress of any diagnostic, surgical, or therapeutic procedure to inappropriately reprimand staff member(s);
- Throwing, tossing, flinging, or slamming down any equipment, instrument, record, or any other materials;
- Any behavior that is a violation of State and Federal laws and regulations, hospital or medical staff policy, rules and regulations;
- Attacks (verbal or physical) leveled at other appointees of the Medical Staff, hospital personnel, or patients which are personal, irrelevant, or go beyond the bounds of fair professional conduct;
Any behavior that disrupts the ability of other individuals to provide quality care, disrupts hospital operations, or which may interfere or be inconsistent with a reasonable and safe working environment;
- Impertinent and inappropriate comments or illustrations made in patient medical records or other official documents, impugning the quality of care in the Hospital or attacking particular physicians, practitioners, nurses, or Hospital policies and procedures;
- Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.
- Reluctance or refusal to answer questions, return phone calls or pages;
- Condescending language or voice intonations and impatience with questions;
- Refusal to accept medical staff assignments or participate in committees or departmental affairs, on anything but under his or her own terms, or to do so in a disruptive manner.

Documentation of disruptive conduct is critical. An event report should be completed each time and include:
- The date and time of the behavior;
- The patient's name, if the behavior affected or involved a patient in any way;
- The circumstances which precipitated the situation;
- A description of the behavior limited to factual, objective language as much as possible;
- The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;
- A list of witnesses to the disruptive behavior;
- Record of any action taken to remedy the situation, including date, time, place, action, and the name(s) of those intervening.

Reporting Disruptive Behavior:
- The immediate supervisor/director, Human Resources, or Risk Manager may be immediately contacted to report disruptive behavior directed at an Associate or volunteer.
- If the alleged victim is a patient or visitor, the complaint shall be referred immediately to the department supervisor, Hospital CEO, and the Risk Manager.
- If the alleged victim is a Physician or Allied Health Professional, the complaint shall be referred to the Chief of Staff and the Hospital CEO.
- All complaints regarding a Physician or Allied Health Professional, including employed physicians, engaging in disruptive behaviors shall be referred to the Chief of Staff, the Hospital CEO, and Risk Manager.

**Sexual Misconduct**

**Sexual misconduct** is sexual touching of a patient and/or any activity or verbal behavior that is sexual in nature.

**Sexual abuse** includes acts of a sexual nature committed for the sexual gratification of anyone upon or in the presence of a vulnerable adult, without the vulnerable adult’s informed consent, or a minor.

**Sexual Misconduct Includes:**
- Sexual intercourse;
- Touching body parts, except as consistent with accepted community standards of practice for examination, diagnosis, and treatment and within the health care practitioner’s scope of practice;
- Any physical action with a patient for sexual gratification;
- Kissing, hugging, touching, fondling, or caressing of a romantic or sexual nature;
- Not allowing a patient or client privacy to dress or undress except as may be necessary in emergencies or custodial situations; not providing the patient or client a gown or draping;
- Dressing or undressing in the presence of the patient, client, or other;
- Removing a patient’s or client’s clothing or gown or draping without consent, emergent medical necessity or being in a custodial setting;
- Any sex act in the presence of the health care provider; or by the healthcare provider in the presence of the patient or other;
- Soliciting a date with a patient, client, or other;
- Any behavior, gestures, or expressions that may reasonably be interpreted as seductive or sexual;
- Making statements regarding the patient, client or other’s body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;
- Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient, client or other;
- Photographing or filming the body or any body part or pose of a patient, client, or other, other than for legitimate health care purposes; and
- Showing a patient, client or other sexually explicit photographs, other than for legitimate health care purposes.

A Health Care Provider Shall NOT:
- Offer to provide health care services in exchange for sexual favors;
- Use health care information to contact a patient, client or key party for the purpose of engaging in sexual misconduct;
- Use health care information or access to health care information to meet or attempt to meet the health care provider’s sexual needs.

Responsibilities of Staff Regarding Allegations:
- Report the allegations immediately to your immediate supervisor and the nursing supervisor, who should in turn immediately inform the Risk Manager.
- Do not discuss the allegations with coworkers.
- Assist your supervisor and the Risk Manager in the investigation as requested.

Performance Improvement

Why do we have a Performance Improvement Plan?
The purpose of the Performance Improvement Plan is to provide a system that allows us to evaluate the safety and quality of healthcare services our facility provides. Evaluating the services provided at our facility gives us an opportunity to identify any areas for improvement. This knowledge allows appropriate changes to be made in the way we provide care or services in order to fulfill our mission; to provide quality healthcare services in a safe and compassionate environment.

How is performance evaluated?
Many dimensions of performance are evaluated throughout the facility. At East Georgia Regional Medical Center, we assess our performance by observing what is done and how well it is done. Our goal is to provide care that is safe, timely, efficient, effective, caring, compassionate, and respectful among many other things. We measure quality of care provided by observing staff in their roles, reviewing medical records, monitoring patient outcomes, monitoring patient satisfaction or perception of the care they were provided, and by comparing the quality of care provided with the cost of the healthcare provided.

In a nutshell.....
We have a Performance Improvement Plan to ensure that we are DOING THE RIGHT THING EVERY TIME and doing it WELL.

We use the FOCUS-PDCA process to monitor performance and develop action plans for improvement in
Performance Improvement Methodology

**Find a Process to Improve**

**Organize to Improve the Process**

**Clarify Current Knowledge of the Process**

**Understand Sources of Process Variation**

**Select the Process Improvement**

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**Act**
- To hold gain
- To continue collection improvement

**Plan**
- Improvement
- Data

**Check**
- Data for process improvement
- Customer View
- Worker View
- Lessons learned

**Do**
- Improvement
- Data collection
- Data analysis
Latex Allergies

East Georgia Regional Medical Center and agencies like the National Institute for Occupational Safety and Health (NIOSH) now recognize that natural rubber latex (NRL) may cause health problems for patients and health care workers. Persons may become sensitive to the protein in latex rubber. If allergy develops, symptoms may be as mild as watery eyes and respiratory irritation to hives, swelling, severe breathing problems or rarely death.

According to the NIOSH, 8 to 20 percent of healthcare workers who are regularly exposed to natural rubber latex (NRL) become sensitized. Reactions have risen with the increased use of powdered NRL gloves.

Which products contain latex?

It is hard to tell by looking at a product, if it contains natural latex or is made from a man made material. In general, dipped or stretchy rubber products like gloves, balloons and condoms contain a high percentage of natural latex rubber. Molded or hard rubber products have less latex. However, even things that are not made of latex may have a latex coating on them. Those who react to natural rubber latex may also be allergic to bananas. They may also have cross reactions to foods like avocado, kiwi, pear, potato, tomato and chestnuts.

Latex can be carried through the air on powder used in surgical and other type gloves. It is for this reason that products used in healthcare settings or on long term patients are often latex free and powder free.

East Georgia Regional Medical Center uses latex free and powder free products and equipment whenever possible. Hospital products which may also contain natural rubber latex include:

- Surgical and exam gloves
- Plungers on syringes
- IV tubing and adaptors
- Tourniquets
- Urinary catheters
- Blood pressure cuffs
- Ambu bags
- Stethoscopes

EXPOSURE

People generally develop an allergic response to natural rubber latex (NRL) after repeated exposure. There are various methods that the NRL allergens enter the body:

- Skin – Placed directly on skin via items like gloves or condoms.
- Nose, Mouth and Mucous Membranes – Enter via mucous membranes when airborne particles are inhaled or by contact with items such as urinary catheters, dental dams, or mouthpieces.
- Blood – Enter the blood stream via IV tubing/bags, syringe plungers and IV adapters.

SECONDARY CONTACT

Contact with an object which has been handled by someone wearing latex gloves or by an object containing latex. Three components are likely to influence the likelihood and exposed individual will react to a latex exposure: the degree of sensitivity of the individual, the amount of latex in the environment, and the route of exposure to the latex. Usually the more sensitive an individual is to latex proteins, the smaller the amount of latex needed to elicit a reaction.
EXAMPLES OF LATEX SENSITIVITY OR ALLERGY

Type IV – More Common
- These reactions develop over time and can occur 18 hours or more after contact
- Usually characterized by localized contact dermatitis
- Also results from the chemicals added to natural rubber latex (NRL) products
- People with skin breakdown due to contact dermatitis are more susceptible to a Type I reaction.

Type I – Most Severe and Least Common
- Immediate reaction, occurring within minutes of contact
- Is an extreme response by the immune system to the NRL allergens
- Results in symptoms ranging from skin redness, hives, swollen lips, and itching eyes to dyspnea, tachycardia, anaphylaxis, and in rare cases, even death.

What do I do if a patient or co-worker is potentially allergic to natural rubber latex (NRL)?
Assess and classify:

Take emergency actions to remove irritating source and protect the patient immediately. When the patient is safe:
- Identify if the person has ever become short of breath or experienced chest tightness or racing pulse during a medical or dental procedure.
- Ask if they have ever experienced skin irritation after wearing natural rubber latex gloves at work.
- Find out if they have had a reaction to other common items like balloons, condoms, or Band-Aids.
- Ask about food allergies: avocado, tomato, potato, chestnut, kiwi.

Intervene:
- When a reaction occurs, have the person seek medical attention immediately.
- Avoid further contact with items that contain natural rubber latex (NRL). Report the incident to other nursing staff and Risk Management.

Document:
- Label the patient’s chart and record.
- Put signs on the door and place allergy bands on the patient’s wrists.
- Educate the patient about natural rubber latex and document your teaching.

Prevent:
- Control the environment by using latex-free kits or supplies.
- Remove all natural rubber latex (NRL) items from the patient’s room.
- Completely wash and dry your hands with a mild soap each time gloves are removed.
- Ask Housekeeping to clean carpets and air ducts often to help keep the air NRL free and to not use latex gloves in cleaning.

Associates who suspect or know they are sensitive to natural latex rubber (NRL) should?
- Tell their manager.
- Inform Employee Health.
- Document the allergy with their physician or medical provider. Avoid areas where latex rubber is in use.
HIPAA PRIVACY Compliance

HIPAA – Health Insurance Portability and Accountability Act is a Federal law passed to protect a patient’s privacy.

- Requires that healthcare facilities tell a patient how his confidential information may be used.
- Requires that healthcare facilities take extra steps to make sure that confidential information is protected and not disclosed to people who should not have the information.
- Requires that healthcare facilities keep track of confidential information released to others.

Overview of Privacy

*Healthcare workers must handle patients’ confidential information with special care in order to protect the privacy of the patients and to comply with Federal law.*

Confidential or protected health information (PHI) may include information about a patient’s medical condition. It also includes any information that could be used to identify a patient, such as social security number, address, or telephone number. This information can be in any format (oral, paper, picture, or electronic). Patient’s have a right to have their privacy protected. To help protect a patient’s privacy:

- Close patient room doors.
- Discard paper that contains patient information in a shred box. **DO NOT** put this information in a trashcan.
- Do not discuss patients in elevators or other public spaces.

Minimum Necessary

A patient has the right to expect that no one, except those involved in his treatment, should see his confidential information. If you do not need the information to do your job, you should not read or access it in any way. Access to confidential, private information should be limited to the minimum amount an employee needs to do his job.

Make sure that staff members have access to the minimum amount of confidential information:

- Shield computer monitors from view of passers-by.
- Do not share computer passwords.
- Locate fax and copy machines in private, secure areas.
- Question anyone you feel might be looking at confidential information for the wrong reasons.
- Do not leave medical records or reports in areas where they may be seen by people who are not treating the patient. For instance, do not leave an open medical record on the counter top of a nursing station.

Privacy Notices

How a patient’s health information may be used by a healthcare facility is explained to a patient when he is admitted.

- All patients receive a Notice of Privacy Practices, which describes how their confidential information may be used.
- Patients have a right to request special privacy considerations. The hospital does not have to grant the request, and the patient may choose not to be treated at the hospital. The privacy status of a patient may be determined by consulting the computer listing of patients.
- Receiving a Privacy Notice, which explains how their confidential information may be used, helps patients understand their right to privacy.

Accounting of Disclosures

Patients have a right to request a list of people or companies who received copies of their medical records, except those records released for treatment, payment, or healthcare operations.
hospital must give patients an accounting of records released for the previous six years.

- All requests for copies of medical records should be forwarded to the Health Information Management Department.
- It is proper to send copies of medical records with patients who are being transferred for treatment at another hospital. Never send original records.
- The hospital must track all information released on patients, if the information was not released for further treatment, payment, or healthcare operations.

**Business Associates**
Under HIPAA, people who are not employees of a healthcare facility but use the facility’s protected health information to perform work for the facility, are considered Business Associates. They must sign a Business Associates Agreement that says they will abide by the Privacy Standards under HIPAA.

**Requests to View or Amend Medical Records**
- The medical record is the property of the hospital. However, patients have a right to view the information in their medical record.
- Patients have a right to request that entries in the medical record be changed if they feel that they are incorrect. The hospital will consider, but does not have to honor, these requests to amend the medical record.
- Patient requests to view medical records or have medical records changed or amended should be forwarded to the hospital Privacy Officer – The Director of Health Information Management.

**Notification Rule**
Beginning 09/23/09, Federal law requires us to tell patients if someone has snooped into or breached their information protected by HIPAA. We must also notify patients any time their protected health information is inappropriately disclosed outside of the facility, or if their information was stolen or breached. We are required by this new HIPAA law to notify the patient in writing and report this to the Federal government. At any one time, if there are more than 500 patients who have their records snooped into or if their PHI is disclosed in any way outside of our facility, we must notify every patient in writing and immediately notify the Federal government. We may be required to notify the local media if 500 or more patients are from the same state/area. Once a breach of PHI is discovered, the hospital has no more than 60 days to comply with the rule’s notification requirements, sometimes sooner.

Examples of types of information that you are not permitted to access, use or disclose without authorization from the patient include:
- Medical information
- Name, address, phone number
- Social security number, date of birth
- Photo of any part of the patient’s body, including x-ray images (whether or not they contain the patient’s name)
- Any information or data that could be used to identify the patient

Under the Notification Rule, a breach of PHI is defined as:
- Intentional acquisition,
- Intentional access,
- Intentional use, or
- Intentional and/or unintentional disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule which compromises the security or privacy of the PHI.
Examples of breaches of PHI:
- Lost laptop or PDA
- PHI left in the cafeteria, lounge, or public area
- “Snooping”
- Cell phone or personal camera pictures of the patient, patient’s body parts, or x-rays
- PHI faxed to the wrong fax number, emailed to the wrong address, or printed to the wrong printer
- PHI thrown into regular trash
- Information intended for one patient handed to another patient (not verifying your work).

Consequences and Penalties

- The Government may impose fines (up to $250,000) or jail sentences (up to 10 years) if a facility fails to abide by the HIPAA privacy standards.
- All healthcare workers sign a statement saying they agree to keep private information confidential.
- Violation of confidentiality may result in termination of employment.
- If you are found to be responsible for any type of HIPAA violation that the State Attorney General believes has threatened or in some way harmed a patient who is a resident of this State, you can be held responsible for your actions. The State Attorney General can bring a civil action in Federal court against you.

Summary

Healthcare workers have always tried to protect confidential patient information. Now Congress has passed a law called HIPAA – The Health Insurance Portability and Accountability Act – to help assure the privacy of patient information. HIPAA requires healthcare facilities to take extra steps to inform patients of how their confidential information will be used. HIPAA also requires healthcare facilities to train all employees on privacy and confidentiality; to take steps to make sure that only those people who need to see confidential information have access to it; to keep track of to whom information has been released; and to appoint a Privacy Officer to answer questions and deal with Privacy Issues. East Georgia Regional Medical Center is committed to maintaining patient privacy and confidentiality. As an employee, you should keep privacy and confidentiality in mind as you perform the functions of your job. You should report any violations of confidentiality to EGRMC’s Privacy Officer:

Shelley Harris, Hospital Privacy Officer (912) 486-1761

CONFIDENTIAL DISCLOSURE PROGRAM HOTLINE (800) 495-9510

CAUTION REGARDING ELECTRONIC TECHNOLOGY:

HIPAA regulations require that we safeguard the privacy and security of any protected health information. This includes transmission via email, cell phone, or any other electronic technology (i.e. FaceBook, MySpace, YouTube, etc.). The temptation to discuss unusual patient cases is great; however, this is strictly prohibited under HIPAA. Employees have been fired in several hospitals across the nation for taking pictures of patients or their x-rays with cell phones or writing something about a patient on FaceBook or MySpace. The information transmitted does not have to specifically identify the patient to make it a violation of HIPAA. If you have questions about acceptable methods of transmitting patient information, please contact Shelley Harris (ext. 1761) or Nakesha Rolle (ext. 1506).
HIPAA SECURITY Compliance

Overview of Security
Healthcare facilities must protect the confidential health information of its patients, which is stored on computers and transmitted electronically. The facilities must:
- Establish and enforce policies related to computer hardware and software containing electronic protected health information (ePHI);
- Control visitor access to buildings that house computer hardware and software; and
- Determine who has access to ePHI and monitor access of staff to ePHI.

What is ePHI?
Protected health information (PHI) is any health information that may identify the patient and that relates to the patient’s physical or mental condition, the health care services provided, or the payment for the health care services. ePHI denotes that the data is stored on a computer or provided electronically.

The hospital must ensure that:
- Reasonable security measures are taken to protect ePHI;
- Enforceable procedures are created and that the hospital's workforce are informed about these procedures upon employment and annually;
- Alleged security incidents and violations are investigated and addressed;
- Workforce members have appropriate access to ePHI in order to do their jobs; and
- Workforce members who do not need to have access to ePHI are prohibited from obtaining access.

Before workforce members are granted computer access, the appropriate background checks must be completed. When computer access is granted, the level of access to ePHI is determined by the individual’s job function. The user will be assigned the lowest level of access to ePHI required for the job function. Each user is assigned a unique user ID. The user ID, in combination with the individual’s chosen password, allows the individual to access the predetermined levels of ePHI. Each user must change his/her password every 90 days. When an individual’s employment is terminated, the user ID is promptly disabled.

Protection of Information Systems
In order to ensure that all the hospital's information systems meet the requirements of the HIPAA standards and are protected against malicious activity, the Director of Information Services is required to coordinate all computer information systems within the hospital. In order to appropriately protect all systems:
- No software can be downloaded onto hospital computers without advance consent and approval by the Information Services Director.
- The hospital has installed virus protection programs which are updated on a daily basis.
- The hospital’s computer systems are monitored on a routine basis for unauthorized access.
- The Director of Information Services will routinely send out security reminders and notify the workforce of known security threats (identifiable e-mails that should not be opened, etc.).
- No ePHI may be removed from the hospital on diskettes, memory sticks, CDs, etc. without the approval of the Security Official.
- The hospital has developed a contingency plan for responding to emergencies or other occurrences that damage systems that contain ePHI. The plan includes methods for recovering patient data.

As a further measure of protection for the computer system, the Information Services Department must monitor log-in attempts and report discrepancies. When a user unsuccessfully attempts to log in five successive times, the individual’s user ID will be disabled automatically. Computer access will be restored by the Information Services Department only after the individual’s identity has been confirmed.
verified by the department director or nursing supervisor. The user may be asked to provide his/her home address and last four digits of his/her social security number as additional verification.

Other measures of protection to ensure confidentiality and integrity of ePHI include password protected screensavers or automatic log off from the system after 15 minutes of inactivity.

**Security Incidents**
The hospital has implemented procedures to address and respond to security incidents. A security incident is defined as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

When a security incident occurs, the Security Official must conduct an investigation into the incident and recommend appropriate remedial action. As a part of a quarterly audit, the Security Official must review the records of employees and their family members, physicians and their family members, and certain other individuals to determine if there has been inappropriate access to the records. Examples of unauthorized or inappropriate access include viewing the record of a patient not under your care or viewing your own medical information. The proper method of obtaining your medical information is to request your record from the Medical Records Department and sign a release to obtain the information. Because these audits are based on user IDs, it is very important that you sign off your computer when you have finished your work and you do not share your password. If you do not sign off your computer or you share your password with someone, you could be disciplined for what that other individual did while using your user ID and password. Violations of policies and procedures by employees may result in disciplinary action, up to and including termination. In addition, employees can be subject to civil and criminal penalties imposed by the federal government with fines up to $250,000 and 10 years in prison.

**Access controls**
The hospital must implement access controls to the physical plant which relate to patients, visitors, staff and physicians.

The hospital’s plan requires:
- All patients must wear armbands.
- All employees, physicians, students, and other staff must wear identification badges.
- Individuals not wearing identification badges or armbands are designated as visitors and should not be allowed access to unattended areas where there is computer equipment or ePHI.
- Non-public entrances are locked, and those designated as employee/staff entrances require swipe access cards.
- Between the hours of 9:00 p.m. and 6:00 a.m., all entrances are locked with the exception of the emergency department entrance and Women’s Pavilion entrance. In the main building, a security guard is on duty in both the ER waiting area and at the outpatient surgery desk. After normal visiting hours, visitors in the main building must enter through the Emergency entrance. The Women’s Pavilion entrance is staffed by an admitting registrar and security guard at all times. The doors into the Women’s Pavilion patient areas are locked and access must be granted by the registrar.
- Employees should question visitors who wander into an area that contains ePHI and then assist them in getting to the correct location.

You should report any violations of security to the hospital’s Security Officer:
Nakesha Rolle, Risk Manager/HIPAA Security Officer (912) 486-1506
Emergency Medical Treatment and Labor Act (EMTALA)

The Emergency Medical Treatment and Labor Act (EMTALA) is an anti-discrimination law enacted to protect against the refusal of care to the uninsured. It requires that a person who seeks an examination or treatment for any medical condition in an emergency department must receive a screening exam to determine whether an emergency medical condition exists.

Medical Screening Exams (MSE):
- Examination required to determine whether a medical emergency does or does not exist;
- MSE must be performed within the capability of the hospital’s emergency department (ED), including ancillary services routinely available to the ED;
- A patient’s MSE may NOT be delayed to obtain registration or payment information;
- Triage is NOT equivalent to a MSE;
- Physician or any other qualified medical personnel deemed qualified by bylaws or hospital rules and regulations, with criteria approved by the Board of Trustees, may perform the MSE.

What is an Emergency Medical Condition (EMC)?
It is a medical condition that, if not treated immediately, could result in:
- Placing the patient’s health in jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ.
- For pregnant women, threat to the health of the mother or the baby if transfer cannot be completed before delivery.

What if there is no Emergency Medical Condition?
If, after the MSE, there is a determination that there is no EMC:
- EMTALA doesn’t apply.
- Hospital is not legally required to provide any additional examination or treatment.

If there is an Emergency Medical Condition:
- Hospital must provide stabilizing treatment.
- Follow prescribed procedures if the patient is transferred to another facility.
- If the patient is admitted for stabilization, EMTALA no longer applies.
- A pregnant woman experiencing contractions is considered stabilized when the women has delivered the child and the placenta.

Stable for Transfer vs. Stable for Discharge:
Stable for Transfer:
- The physician has determined that the patient will not have a material deterioration in his medical condition during transfer.
- The physician believes that the receiving facility has the capability to manage the patient’s condition.
Stable for Discharge:
- It is determined that the patient has reach the point where his continued care, including diagnostic work-up and treatment, could be reasonably performed as an outpatient or later as an inpatient, provided that he is given a plan for appropriate follow-up care and discharge.

Hospital Obligations:
Sending hospital:
- Determine appropriate mode, equipment, and attendant personnel for transfer.
- Obtain permission from receiving hospital.
- Document hospital’s acceptance.
Receiving hospital:
- Must accept transfer if it has available space, qualified personnel, and specialized capabilities needed to treat the patient.

**Biochemical Terrorism**

Biochemical Terrorism – Premeditated, unlawful threat or use of chemicals, microorganisms or their toxins to produce death or disease in humans, animals or plants. The act is intended to create fear and/or intimidate governments or societies in the pursuit of political, religious or ideological goals.

Terrorism can take other forms, including nuclear, ordinals (bombs, etc), cyber, etc. Statesboro and Bulloch County are located near many potential targets, such as the Baxley nuclear power plant, military installations, large cities, and are in close proximity to I-16. All of these increase our risk of experiencing a terrorist event.

**Notification Protocol**
The following notification protocol is to be implemented if a terrorist event is suspected to have taken place on hospital property or if patients, who may have been victims of a terrorist event are received:
- Notify your director or supervisor on duty
- The director or supervisor will make the decision to:
  - Notify the administrator on call.
  - Notify Bulloch County Public Safety by dialing 489-1661 or 9-911.
- The administrator on call will determine if an internal disaster needs to be called.
- The Bulloch County Incident Command Officer for terrorist events is the Bulloch County Sheriff.
- The Bulloch County Incident Command Officer for non-terroristic, naturally occurring events is the Bulloch County Public Safety Officer

**Chemical Terrorism**

Major categories of chemical agents:
- Blood – Specific agents include cyanide and cyanogens
- Blister – Sulfur mustard, nitrogen mustard
- Nerve – Sarin, VX
- Choking – Chlorine, phosgene
- Riot control agents – tear gas

Refer to the chemical contamination section of the Emergency Preparedness Plan located in the Environment of Care/Safety Manual. Additional information is available through the Emergency Department or Infection Control.

**Chemical Decontamination**

Decontamination of persons contaminated with chemical agents is necessary as part of their treatment and to protect others who may come in contact with them.

Major points of decontamination:
- EMS staff should perform decontamination at the site as much as possible.
- The decontamination shower outside the ER or a portable decontamination shower will be used for decontamination here at the hospital.
- Only designated personnel wearing protective attire can perform decontamination.
- Dry decontamination may also be used utilizing kits for that purpose.
Avoid bringing non-decontaminated persons into the hospital, if possible!!!

Treatment for Chemical Agents
- Antidotes for many agents are immediately available through the hospital pharmacy.
- Other antidotes would need to be obtained.
- Treatment includes supportive care: fluids, ventilators, etc.
- Additional information on decontamination and treatment, etc. for specific agents is available in the ER or by contacting Infection Control staff.

Biological Terrorism
- Biological agents are bacteria, viruses and toxins that can cause infection.
- Terrorists could spread these organisms through the aerosol route, through food and water, etc.
- Most infections are treatable.
- Decontamination is not required in most cases.
- Isolation may be necessary. They type of isolation required depends on the organism involved.

Isolation for Victims of Bioterrorism
- Negative pressure isolation rooms would be used for smallpox and other agents that are transmitted by the airborne route.
- Depending on the number of patients involved, patients may need to be cohort together in designated areas, such as the 4th floor.
- The usual isolation attire would be utilized for these patients. N95 (TB) masks would be needed for certain agents.
- Each department needs to maintain their inventory of isolation supplies in the event of an emergency.
- Strict adherence to isolation protocol will aid greatly in preventing the transmission of these illnesses.

Examples of Biological Agents
- Smallpox (Virus)
- Anthrax (Bacteria)
- Plague (Bacteria)
- Botulism (Bacterial Toxin)
- Tularemia (Bacteria)
- Hemorrhagic Fevers (Viruses)

Treatment and Prevention of Biological Agents
For bacterial agents, antibiotics may be used for treatment and can be effective if started in a timely manner.

- Antiviral medications can be used for treatment of some of the viral agents.
- Preventive treatment (usually in the form of vaccines) is available for some of the agents. These vaccines are not available to the general public at this time.

Smallpox Vaccine
- Smallpox vaccine is no longer a naturally occurring illness.
- Those previously immunized against smallpox are considered to be no longer immune.
- Enough Smallpox vaccine is now available so that all Americans could be immunized, if necessary.
- The vaccine, however, is not available to the general public and there are no current plans for mass immunizations.
- The vaccine does have some serious potential side effects.
- Those exposed to smallpox would be immunized if the illness was introduced into the U.S. population.
Bloodborne Pathogens and The Exposure Control Plan

OSHA Bloodborne Pathogens (BBP) Standard:

- Can be found in Title 29 of the Code of Federal Regulations @ 29 CFR 1310.1030
- The standard protects workers who can reasonably be anticipated to come into contact with blood or OPIM as a result of doing their job duties.
- EGRMC’s exposure control plan can be found on the EGRMC intranet. On the right hand side of the page click on the EGRMC policies link. Then you will click on the IC folder.

Bloodborne pathogens are infectious microorganism present in blood that can cause disease in humans. These pathogens include, but are not limited to hepatitis B virus (HBV), hepatitis C virus (HBC), and human immunodeficiency virus (HIV), the virus that causes AIDS. Workers exposed to bloodborne pathogens are risk for serious or life-threatening illnesses.

How bloodborne diseases spread:

They are all transmitted in the same way- through contact with blood or Other Potentially infectious Material. (OPIM)

Other potentially Infectious Material:

- Semen and vaginal secretions
- Any fluid or tissue containing visible blood
- Cerebrospinal fluid
- Pleural fluid
- Peritoneal fluid
- Pericardial fluid
- Amniotic fluid
- Saliva in dental procedures
- Non-intact skin or organs from living or dead humans

Common Ways of Transmission:

- Injuries involving needles
- Injuries involving other sharps, such as scalpels, broken glass or anything that can pierce, puncture or cut you skin.
- If blood or OPIM comes in contact with your broken skin or mucous membranes or your eyes, nose, or mouth.
- If you touch a contaminated objected or surface and then transfer the material to your eyes, nose, mouth or broken skin.

There are several important ways you can protect yourself from exposure to blood borne pathogens. These include:

- Standard precautions-
  Standard precautions are used at all times, and during the care of all patients- whether or not they are known to have an infection. These precautions apply when you may have contact with blood and OPIM.
- Engineering controls –
  Are tools that protect you from becoming infected they include hand washing facilities, sharps
  containers, regulated waste containers, and sharps safety devices.

- Work practice controls –
  Reduce the likelihood of an exposure by altering the manner in which the task is performed they
  include wearing the proper PPE, washing your hands, never storing food, drink or personal items
  in refrigerators, on shelves or other places where blood or OPIM are stored, cleaning up blood
  spills properly.

- Personal protective equipment-
  Gloves and other PPE protect you by creating a barrier between you and germs.

- Housekeeping-
  Follow the guidelines for cleaning up blood spills, dispose of regulated waste according to
  state/local laws, and use biohazard labels on containers for regulated waste.

- Administration of the hepatitis B vaccine-
  The hepatitis B vaccine is offered at no charge to employees. Any healthcare worker who has
  the potential to come into contact with blood and body fluids is offered the hepatitis B vaccine. It
  is a series of three injections, and a titer is drawn 4 to 6 weeks after the last injection to check for
  immunity. It is the employee’s responsibility to follow you with employee health and receive their
  vaccine in a timely manner. Please contact employee health (x1507)

Exposure Follow-up:

After washing /flushing the affected area, report the exposure to your supervisor and fill out an Associate
Accident Injury Report Form. Be sure to give as much detail as possible about the exposure. You will be
required to report to the ER. Please notify employee health and the workers comp coordinator.

If the exposure places the HCW at risk for hepatitis B or hepatitis C, these are the steps that will be
followed:

- If the source patient can be identified both the patient and the exposed HCW will be tested for
  Hepatitis B and Hepatitis C. The exposed HCW will be made aware of the test results.
- The CDC guidelines for post exposure prophylaxis will be followed.

If the exposure places the HCW at risk for HIV infection, these are the steps that will be followed:

- HIV testing will be offered to the associate. If the associate refuses testing, a declination form
  will be signed. If the associate agrees a base line HIV test will be done and follow up testing ,
  if necessary, will be done at 6 weeks, 12 weeks, 6 months and 1 year from exposure.
- If the source patient is known, the patient will be asked to consent to HIV testing. The patient’s
  results will be given to the associates after receiving counseling re: confidentiality. If patient
  refuses HIV test, with previously drawn blood and 2 physician’s signature, the test can be
  done without the patients consent.
- CDC guidelines for HIV post exposure will be followed. Medication may be offered which can
  help prevent infection with HIV. These medicines are most effective if started within2 hours of
  exposure.
Remember to:

- It is the employee's responsibility to follow up with Employee Health the next business day.
- Give as much information as possible about the exposure.
- Report all exposures immediately.

If you have any question regarding this section or blood borne pathogens, you may call the Infection Control Nurse, ext. 1542; Employee Health Nurse, 1507 or the nursing supervisor on duty for additional information.

Remember to order the following labs for exposures: (do not put into the computer system, call the lab)

**Source Patient:**
- a. HIV-STAT
- b. Hepatitis B surface Antigen
- c. Hepatitis C antibody

**Employee:**
- a. HIV-STAT
- b. Hepatitis B surface antibody quantitative
- c. Hepatitis C antibody
- d. Urine drug screen

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**Biohazardous Waste Management**

**Definition:** Includes pathological waste (tissues, etc.), biological waste, cultures and stocks of infectious agents, sharps, chemotherapy waste. Biological waste is waste that contains blood and body fluids to a degree that if it were compressed, it would release blood or body fluids (free-flowing). Examples: Suction canisters, dressings with significant amount of drainage, IV tubing that contains blood, etc.

Examples of nonbiohazardous waste---soft drink cans, paper towels used for drying hands, gauze with a drop of blood on it, etc.

Biohazardous Waste Includes:

- **Pathological waste/cultures and stocks:** Primarily handled by lab/OR staff---usually red-bagged.
- **Sharps:** Includes needles, lancets, scalpels, etc. Place into a sharps container which should be at the point of use. Activate the sharp's safety mechanism immediately after use. Don't recap used needles. Don't discard anywhere else. They should be replaced at ¾ full.
- **Biological Waste:** Liquid waste, such as urine in a bedpan, should be poured into a toilet taking care not to splash. If potential for splashing, wear PPE. For suction canisters, use solidifier, ensue non-leakage and place in a red bag. Other biological waste---Red bag.
- **Place all red-bagged waste in the appropriate biohazardous waste can or cart.**
- **Chemotherapy Waste:** Chemotherapy waste, including PPE used during administration, IV tubing, medication bags/bottles, etc. will
be placed in yellow containers marked “chemotherapy waste.” Environmental Services staff will transport and place in a biohazard container marked “Incinerate Only.”

Availability of biohazardous waste containers determined by needs of the department and public access to the department. Example: L&D needs multiple covered containers because of their patient population and public accessibility. OR will use uncovered containers, but bags will be changed out between each case.

Environment of Care

Life Safety:

- The hospital is a smoke-free facility and campus. Smoking is not permitted on hospital grounds, including personal vehicles located on hospital property.
- Most fire extinguishers within the hospital are type ABC. ABC extinguishers are for all types of fires.
- The kitchen has an automatic fire suppression system.
- To report a fire, DIAL 1911 and tell the operator the location. Pull stations tell the operator the general location of the fire.
- The code for a fire is **Code Red**. The operator will announce “All Clear” three times when the code is cleared.
- The method for fire response is:
  - R – rescue
  - A – alarm
  - C – contain
  - E – extinguish

- The method for using a fire extinguisher is:
  - P – pull
  - A – aim
  - S – squeeze
  - S – sweep

- Fire drills are conducted every month to ensure that all three shifts are involved in a drill each quarter.
- You must know the location of all pull stations, fire extinguishers and exits in or around your department.
- You must know your role in the event of a fire or drill.
- You must know what smoke zone you are in and all adjacent zones.
- The code for evacuation is **Code Purple**. There are three types of evacuations: Horizontal, Vertical, and Total. You need to know what transporting equipment is needed.
- Window keys are available at all nursing stations and team centers for emergencies.

Safety:

- Know your **Safety Officer: Mike Motes, Ext. 1651**.
- An electronic copy of the Environment of Care/Safety Manual can be found on EGRMC’s intranet under Policy and Procedures.
- The hospital has a Safety Committee that meets at least bimonthly.
- All safety hazards must be reported to your supervisor immediately.
Monthly hazard surveillance rounds are conducted ensuring that all clinical areas of the hospital are inspected at least semi-annually and non-clinical areas annually. Safety is EVERYONE’s responsibility (i.e., report spills, missing ceiling tiles, frayed cords, burned out lights, broken doors, etc.). Also observe warning signs or report anything that seems abnormal.

Become familiar with your departmental safety policies.
Never block exits, fire extinguishers, electrical panels or fire pull stations.
Do not store equipment in unauthorized areas, stairwells or above 18” from the ceiling.
Report accidents or unusual occurrences to your supervisor immediately.
Know ALL SAFETY CODES. To report all codes dial 1911 for the Operator.

Security:

Security is staffed twenty-four hours a day from Monday through Sunday.
Always be on the alert for unauthorized people wandering throughout the hospital.
Always wear your name badge.
After 9:00 p.m., all visitors should enter the hospital through the Emergency Department. Security will provide the visitor with a stick on pass.
To contact security, call the switchboard to request that security be paged.
If it is your responsibility, make sure your department is locked-up when leaving for the day.
Never wedge something in any door to hold it open.
Make sure you lock up your personal belongings in a locker or your desk.
If there is a visitor incident or accident, you must notify security and the nursing supervisor immediately. You must also complete an Event Report and forward it to Risk Management.
A number of areas are considered sensitive, which means that they are not open to the general public. Some of these areas have controlled access (keypads or swipe badge access). Do not tell visitors or unauthorized individuals the codes for these doors.

Emergency Preparedness:

The code for disaster is Code Black Internal or Code Black External.
The hospital Disaster Plan is located in the Safety Manual.
You must know your role in a disaster.
A minimum of two disaster drills is conducted each year.
Make sure that all callback information in your department is correct.
In the event that you are called in for a disaster, enter through the loading dock and then report to your department.
The code for a bomb threat is Code Yellow.
In the event that you receive a bomb threat, take as much information as possible and notify the hospital operator immediately.
The code for a tornado watch is Code Gray Alert and a tornado warning is Code Gray.

Medical Equipment:

All patient care equipment must be checked by Clinical Engineering before being used in the hospital.
Make sure equipment has an up-to-date PM sticker on it before use. PM requirements are different on each piece of equipment, but a good rule of thumb is no sticker should exceed one year.
Make sure equipment is fully functional before use. (i.e., no frayed cord, 3-prong plug, all indicators working properly, etc.)
Know how to properly operate equipment before using it.
Always tag defective equipment and send a work order to Clinical Engineering.
Never attempt to service equipment yourself.
Know procedures for emergency failure of equipment. (i.e., spare equipment, taking life-supporting measures).
Make sure any life supporting equipment is plugged into RED receptacles.
All equipment is continually monitored for user errors or unusual occurrences which are reported to the Safety Committee.

Utilities:
- The hospital has an emergency generator that is tested weekly.
- All exit lights, stairwell lights, red receptacles, every other light in the hallways; all elevators and several lights in each department are on emergency power.
- Know your department procedure for any utility loss. Each department should also have a utility failure flip chart that provides information on steps to follow in a utility loss.
- Know where the medical gas emergency valves are located in your department.
- House Supervisors, Clinical Directors, Engineering, Safety Officer, Cardiopulmonary designee and the fire department are the ONLY AUTHORIZED personnel who can shut off medical gas valves.
- Immediately report any utility loss to Plant Operations.

Hazardous Materials:
- SDS – stands for SAFETY DATA SHEET. Hard copy will be maintained in Materials Mgt.
- SDS – stands for MATERIALS SAFETY DATA SHEET.
- If your department’s copy of the SDS sheet is not readily available, the SDS sheet can be requested from the SDS Online Company by calling 1-888-362-7416 or visiting website hq.SDSonline.com/Health Management2137 (See sticker on telephone for instructions).
- You should know how to read a SDS sheet and be able to explain what kind of information is included.
- Make sure ALL CHEMICALS in your department are properly labeled and stored.
- Your department MUST have a SDS sheet on each chemical you use.
- Know where an eye wash station and protective equipment is located if you deal with chemicals or hazardous materials.
- Each department must have a hazardous materials list.
- Materials Mgt must also have a copy of the SDS sheet.
- CODE ORANGE is the code for any chemical or hazardous spill.
- Only biohazardous waste goes into RED biohazard bags.
- Needles and sharps go into sharps containers. All sharps containers must be emptied at ¾ full capacities.

Hospital Emergency Codes:
- Code Red – Fire
- Code Yellow – Bomb Threat
- Code Black – Disaster with influx of patients
- Code Gray Alert – Tornado Watch
- Code Gray – Tornado Warning
- Code Blue – Cardiac/Pulmonary Arrest
- Code Orange – Chemical/Biohazardous Spill or Radiation Accident
- Code Pink – Infant abduction
- Code Purple, H/V/T – Evacuation Horizontal/Vertical/Total


- Code Silver – Individual(s) has weapon/firearm & has intent to do harm
- Code Armstrong – Staff needs assistance
- Code Lockdown – Lockdown of all entrances
- All Clear – Code situation terminated

**The PBX Operator will page CODE situations as follows:**
- Code situation will be paged three (3) times slowly.

  Example: Code Blue ICU, Code Blue ICU, Code Blue ICU

- Once the emergency is over and normal operations can resume, the PBX operator will page an “All Clear” three (3) times.

  Example: Code Blue All Clear, Code Blue All Clear, Code Blue All Clear

**Rapid Response Team**

East Georgia Regional Medical Center utilizes a Rapid Response Team (RRT) to assist in the assessment and stabilization of any person who appears to be unstable, acutely ill or rapidly deteriorating. The goal is to help improve overall mortality and survival rates through early intervention. The Rapid Response Team is comprised of an ICU/CCU RN and a Respiratory Therapist. They can be contacted by paging 212-0589 and entering the patient’s room number or calling the operator at 1911. They should be called prior to contacting the physician. The Rapid Response Team can initiate life-saving interventions per protocol while waiting for the physician to respond. RRT algorithms include: anaphylaxis (acute allergic reaction), acute dyspnea or respiratory distress, chest pain, excessive blood loss/bleeding, symptomatic hypotension, loss of consciousness/change in level of consciousness, and acute or continuous seizures.

**Safe Medical Devices Act**

East Georgia Regional Medical Center complies with the Safe Medical Devices Act of 1990 and amendments through its Safe Medical Devices Act policy and procedure. The purpose of the policy is to reduce risk to patients and staff and ensure timely investigation, follow-up, and required reporting of adverse events involving medical devices. The following is a brief synopsis of the policy and procedure:

**Policy:**

*Any patient or staff death or serious injury that may have been caused or contributed to by a medical device is to be reported immediately to Risk Management. Appropriate actions shall be taken to prevent any additional injury.*

**Procedure:**

1. Anyone who becomes aware of equipment related adverse event shall take the following action:

   (a) If the device is electrical, turn the device off and unplug it from the power source, if possible.
   (b) Immediately notify the department director/charge person, who will initiate calls to begin the investigative procedures.
   (c) Do not remove the device or any accessories from the area. If possible, do not change control settings. Retain disposable devices or supplies and packaging, if possible.

2. The person witnessing the event should complete an Event Report.

3. The Risk Manager and other designated staff will complete an investigation to attempt to
determine if the event was caused by an equipment failure or user error. Upon authorization of the Risk Manager, Safety Officer, or Administrator-on-Call, the equipment and accessories will be locked in a secure place.

4. Contaminated implantable devices will be sent to the Laboratory for cataloging and safe storage.

5. No device will be released to the manufacturer or investigating agencies nor will it be discarded without approval from the Executive Director.

6. The Risk Manager and those investigating the incident will determine if the event shall be reported to the FDA and/or the device manufacturer. The Risk Manager will submit the required reports to the FDA and/or the device manufacturer within (10) working days of the event.

For the purposes of this policy, **serious injury** shall be defined as an injury or illness that:

- is life threatening;
- results in a permanent impairment of a body function or permanent damage to a body structure; or
- necessitates medical or surgical intervention to prevent permanent impairment of a body function or permanent damage to a body structure.

**Hazard Communication and The Right to Know**

The Occupational Safety and Health Administration (OSHA) has a requirement that you, as an Associate, have the Right to Know:

- the hazardous materials that you may be exposed to during your work;
- the dangers of the hazardous materials; and
- the protective measures you need to take to work safely with the hazardous materials.

**TRAINING**

East Georgia Regional Medical Center has a Hazardous Materials and Waste Plan in the Environment of Care Manual/Safety that describes how the hospital manages hazardous materials and waste. There are policies and procedures to tell you how to handle regular waste and biohazardous or infectious waste and how to handle spills of hazardous materials.

Associates receive basic training on hazardous materials during new Associate orientation. More specific training will be provided by your department director or supervisor, who will review with you the hazardous materials that you may use or be exposed to in your specific job and how to work safely with these materials.

You can also receive more information on hazardous chemicals that you may work with or be exposed if you:

- Read the label on the container.
- Read the Material Safety Data Sheet (SDS) for the chemical.
WARNING LABELS

You have a duty to read the warning labels on hazardous chemicals that you may use or be exposed to in your work. The warning label gives you information that will help you protect yourself. Not all labels are written the same way, but the label will give you the following information:

- **Identifying Information:**
  - Name of chemical
  - Name, address, phone number of manufacturer
  - Chemical code number

- **Signal Word (which tells the severity of the hazard):**
  - Caution (least severe)
  - Warning
  - Danger (most severe)
  - Poison (identifies highly toxic chemicals)

- **Information on Physical Hazards:**
  - Explosive
  - Flammable
  - Corrosive

- **Information on Health Hazards:**
  - Can cause irritation to the eyes, lungs, or skin
  - Can cause burns or illness of any kind

Labels may provide other information such as precautions; first-aid instructions; procedures to follow in case of fire, leaks, or spills; and handling, storage, and disposal details.

If you transfer a chemical to another container, it must be labeled with the name of the chemical, the name and address of the manufacturer, and the specific hazard warning.

**HOW CAN YOU PROTECT YOURSELF FROM CHEMICAL HAZARDS?**

You can prevent accidental exposure to hazardous chemicals by following these basic procedures:

- Practice safe work habits. Obey safety rules and do not take shortcuts when handling, using, storing, or transporting hazardous chemicals.
- Be informed. Hazard communication is for your protection. Know how to use the information available on chemical hazards.
- Use personal protective equipment. Make sure you have the right protective equipment and follow policies and procedures.
- Know emergency procedures. Learn how to use emergency equipment such as eyewash stations and emergency showers. Know emergency alarm signals and procedures.

**WHAT SHOULD YOU DO IF YOU DISCOVER A SPILL OF A POTENTIALLY HAZARDOUS MATERIAL?**

- If you know or can determine the identity of the hazardous material, consult the SDS, and obtain necessary personal protective equipment. If the identity of the material is unknown, treat it as highly hazardous.
- Remove any individuals who may have been contaminated by the spill.
- Notify the Safety Officer and Risk Manager.
Evacuate non-essential personnel from the area.
Avoid walking into or touching the material. Avoid inhalation of fumes.
Attempt to contain the spill by using absorbent material.
If the spill is small (less than 500 ml.) and the material is not toxic, clean up the spill following the directions of the SDS. If the spill is large or requires special equipment (i.e., spill kit), notify Environmental Services of the spill.
Complete an Event Report and forward it to Risk Management.

MATERIAL SAFETY DATA SHEETS (SDS)

When you need more information about a chemical, check the Material Safety Data Sheet (SDS) for that chemical. Your department will have a yellow notebook containing the SDS’s for the chemicals used in your department. If you cannot quickly locate the SDS for the chemical, you can call the SDS Company at 1-888-362-7416 to get the SDS sheet faxed to the nearest fax machine. You will need to know the following information when you make the call:
1. Product name and number
2. Manufacturer name
3. Manufacturer phone number
4. UPC code
5. Number for nearest fax machine.

When you consult an SDS because of a chemical spill, you need to pay particular attention to the sections on Hazard Identification, First Aid Measures, Accidental Release Measures, and Exposure Controls/Personal Protection.

Eye, Organ & Tissue Donation Key Referral Points

Who should call?
- The hospital staff is responsible for calling LifeLink of Georgia on all potential donors at or near the time of death to determine suitability.

What signifies a potential eye, organ/tissue donor?
- All deaths should be called in on the Hospital Donation Referral Line, 1-800-882-7177.
- Medical Examiner/Coroners cases are not automatic rule-outs - continue to call on all deaths.

When should I call?
- Upon death or when death is imminent. If the patient is brain dead and on life support, he may be a potential donor of organs, such as heart, lung, kidney, etc. If this is the case, call LifeLink as soon as possible and before the patient is removed from life support.
- Call first to evaluate medical suitability before the family is notified about their option to donate. LifeLink will ask for basic information, such as the patient’s age, diagnosis, and cause of death.
- LifeLink representatives are available 24 hours a day to assist you with any questions you may have or to evaluate a potential donor.

Why should I get involved?
- Georgia law requires hospitals to refer all potential donors to the appropriate recovery agency. You fulfill this by calling the Hospital Donation Referral Line.
- This is different from states that practice “required request,” which requires hospitals to ask families if they wish to donate.
By verifying medical suitability first, you will ensure that families are given the option to decide about only those eyes, organs, and tissues that can be donated.

Who asks for consent?

Once a call is made on the Hospital Donation Referral Line:

- If LifeLink says tissues or organs are suitable, LifeLink will:
  - Obtain release from coroner;
  - Communicate with attending physician;
  - Talk with the family and assist with the consent for organ and/or tissue and eye donation;
  - Coordinate the recovery in the hospital O.R.

- If Georgia Eye Bank says eyes are suitable, the hospital will be asked to obtain consent on solely eye donation cases.
  - If family says yes:
    - Have family sign consent;
    - Call Georgia Eye Bank to coordinate the recovery.
Age Specific and Cultural Competencies

Age and culture are part of what makes each person unique. Completing an annual review of age specific and cultural competencies is a JCAHO requirement. This information enables you to care for patients at every stage of life while meeting their needs and respecting their values. Age specific competencies increase your awareness of the development and age groups you work with. Cultural competencies involve your knowledge, understanding, and respecting the values, beliefs, and practices of others.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Growth and Development</th>
<th>Key care issues</th>
<th>Ways to provide care</th>
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</thead>
<tbody>
<tr>
<td>Infants/Toddlers</td>
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<tr>
<td>0-3 yrs</td>
<td><strong>Physical:</strong> growth is rapid, muscle skill development is important</td>
<td><strong>Communication:</strong> provide for sense of security; promote bonding.</td>
<td>Ensure safety and comfort at all times.</td>
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<td><strong>Mental:</strong> learn through senses; infants cry and make simple sounds;</td>
<td><strong>Health:</strong> stress need for immunizations and check-ups.</td>
<td>Parents should stay with child if possible.</td>
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<td></td>
<td>toddlers learn simple words/sentences</td>
<td>provide good nutrition, skin and oral care,. establish good sleeping patterns.</td>
<td>Explain procedures to parents and in simple terms to the child.</td>
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<td></td>
<td><strong>Social/Emotional:</strong> developing trust and sense of being loved; dependent on</td>
<td><strong>Safety:</strong> evaluate environment closely for safe play, exploring, and</td>
<td>Discuss concerns.</td>
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<td></td>
<td>others; playing builds social and other skills</td>
<td>sleeping.</td>
<td>Involve in general care and provide education as needed on all aspects of care.</td>
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<tr>
<td>Curious nature</td>
<td><strong>Communication:</strong> provide for sense of security; promote bonding.</td>
<td><strong>Safety:</strong> evaluate environment closely for safe play, exploring, and</td>
<td>Encourage the child to communicate.</td>
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<td></td>
<td><strong>Health:</strong> stress need for immunizations and check-ups.</td>
<td>sleeping.</td>
<td>Provide safe opportunities for play.</td>
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<tr>
<td></td>
<td>**provide good nutrition, skin and oral care. establish good sleeping patterns.</td>
<td><strong>Safety:</strong> evaluate environment closely for safe play, exploring, and</td>
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<tr>
<td></td>
<td><strong>Safety:</strong> evaluate environment closely for safe play, exploring, and</td>
<td>sleeping.</td>
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<td></td>
<td><strong>Discuss concerns.</strong></td>
<td>**Involve in general care and provide education as needed on all aspects of care.</td>
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<td></td>
<td><strong>Encourage the child to communicate.</strong></td>
<td><strong>Provide and teach about safe opportunities for play.</strong></td>
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<td></td>
<td><strong>Ensure safety and comfort at all times.</strong></td>
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<td></td>
<td><strong>Parents should stay with child if possible.</strong></td>
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<td></td>
<td><strong>Explain procedures to parents and in simple terms to the child.</strong></td>
<td><strong>Allow to discuss concerns.</strong></td>
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<tr>
<td></td>
<td><strong>Discuss concerns.</strong></td>
<td><strong>Encourage the child to communicate.</strong></td>
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<tr>
<td></td>
<td><strong>Involve in general care and provide education as needed on all aspects of care.</strong></td>
<td><strong>Provide safe opportunities for play.</strong></td>
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<tr>
<td>Young Children</td>
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<td>4-6 yrs</td>
<td><strong>Physical:</strong> slower paced growth; improving motor skills; dresses self;</td>
<td><strong>Communication:</strong> give praise, rewards, and clear rules.</td>
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<td></td>
<td>toilet trained</td>
<td><strong>Health:</strong> stress need for immunizations and check-ups.</td>
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<td><strong>Mental:</strong> improving memory; vivid imagination; like stories</td>
<td>provide good nutrition, skin and oral care. establish good sleeping patterns.</td>
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<td><strong>Social/Emotional:</strong> sense of independence develops; sensitive to feelings of</td>
<td><strong>Safety:</strong> evaluate environment closely for safe play, exploring, and</td>
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<td></td>
<td>others; fears separation or injury</td>
<td>sleeping.</td>
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<td><strong>discuss safety in simple terms with child.</strong></td>
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<td>Active</td>
<td><strong>Communication:</strong> clear and concise information; help child feel competent</td>
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<td></td>
<td>and useful</td>
<td><strong>Health:</strong> stress need to keep immunizations and check-ups on schedule.</td>
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<td>Encourage discussion and provide information on alcohol, tobacco, other drugs,</td>
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<td>sexuality, and other risky behaviors.</td>
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<td></td>
<td></td>
<td><strong>Safety:</strong> promote safety habits; stress conflict resolution</td>
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<td>Older Children</td>
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<tr>
<td>7-12 yrs</td>
<td><strong>Physical:</strong> slower paced until growth spurt at puberty</td>
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<tr>
<td>Are “doers”</td>
<td><strong>Mental:</strong> eager to learn, can accept rules and responsibility;</td>
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<td></td>
<td>recognize cause and effect; read, write, and do math; understand time</td>
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<td><strong>Social/Emotional:</strong> enjoys a variety of activities; want to “fit in” with peers, develops greater sense of self; wants independence, but still needs boundaries</td>
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<td><strong>Respect privacy.</strong></td>
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<td><strong>Use correct terms and explain procedures and equipment in advance.</strong></td>
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<td><strong>Allow child some input in care decisions.</strong></td>
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<td><strong>Build self-esteem and praise achievements.</strong></td>
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<td></td>
<td></td>
<td>**Guide child and parents in discussing and making lifestyle choices that are healthy and safe.</td>
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</tr>
<tr>
<td>Age Group</td>
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</tbody>
</table>
| Adolescents 13-20 yrs | Physical: grows in spurts; matures physically; able to reproduce  
Mental: develops abstract thinking, but may not think about long-term consequences  
choose own values; think about the future  
Social/emotional: developing an identity; challenges authority; has emotional swings; self-conscious; peer pressure concerns; begin close relationships; eating disorders may be a concern. | Communication: provide acceptance, privacy, and respect  
encourage teamwork.  
Health: encourage regular check-ups and updated immunizations.  
promote sexual responsibility.  
advise against substance abuse.  
encourage good nutrition, exercise, and proper sleep.  
Safety: discourage risk taking; encourage parental involvement and parameters. | Treat more like adult than a child, avoid authoritarian approach.  
Use visual aids in teaching and use correct terms.  
Show respect and provide privacy.  
Encourage to keep in contact with friends and family.  
Teach about healthy habits.  
Provide parents with info on normal adolescent changes and general care needs.  
Know the age at which the adolescent can legally authorize own treatment and when HIPAA applies. |
| Young Adults 21-39 yrs | Physical: have reached physical and sexual maturity; nutritional needs are for maintenance  
Mental: develop personal identity and self-reliance; utilize problem solving skills; establish a career  
Build connections | Communication: be supportive and honest; respect personal values  
Health: encourage regular check-ups; promote healthy lifestyle; inform about health risks; update immunizations  
Turn page over please | Assess stress levels and encourage communication about health issue and effect on family, career or finances.  
Educate on disease process and all aspects of care.  
Provide support for decisions made. |
| Young Adults 21-39 (continued) | Social/emotional  
Seeks relationships with others, may choose a mate and start a family. Establishes values and uses them to make life choices. | Safety: provide information on hazards at home or work; discourage risk taking.  
Encourage contact with family and friends for support. | |
| Middle Adults 40-64 yrs | Physical: begin to experience signs of aging, such as decreased endurance, menopause, and may develop chronic health problems.  
Mental: uses experiences to learn, create, and solve problems. Make seek further education and make a career change.  
May have early cognitive changes.  
Social/emotional: wants to stay productive and contribute; balances dreams with reality; plans retirement; may care for children and parents; begins to emotionally prepare for death. | Communication: keep a hopeful attitude; focus on strengths not limitations.  
Health: reassess dietary and exercise needs; encourage regular check-ups and preventative exams; address age related changes; monitor health risks; update immunizations.  
Safety: address age-related changes. | Assess stress levels and encourage communication about health issue and effect on family, career or finances.  
Educate on disease process and all aspects of care.  
Include education on advance directives.  
Provide support for decisions made.  
Encourage contact with family and friends for support. |
<table>
<thead>
<tr>
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<tr>
<td>Older Adults 65-79 yrs</td>
<td>Physical: ages gradually; higher risk of health problems; decline in physical abilities and senses. Mental: Can continue to be an active learner; may have reduced attention span; may remember things and make decisions more slowly. Social/emotional: take on new roles and activities; may experience depression; balances independence versus dependence; reviews life.</td>
<td>Communication: Treat respectfully; prevent isolation; encourage acceptance of aging. Health: monitor health closely; stress need for immunizations, screenings, and check-ups; reassess nutrition and activity status; encourage self care Safety: evaluate driving skills; promote home safety and evaluate for potential hazards; educate and protect against financial scams.</td>
<td>Adapt procedures to accommodate physical changes. Allow time for rest. Educate on disease processes, safe medication use, and home hazards. Teach in quiet environment, speak clearly, and use large print materials. Provide support for coping with impairments. Involve family in care needs. Encourage conversation about feelings of loss, achievements, and grief. Encourage socialization.</td>
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</tbody>
</table>

| Adults>80 Move to acceptance | Physical: steady decline in abilities; mobility becomes harder; increasing risk for chronic illness and major health problems. Mental: continues to learn at slower rate; may have reduced attention span; may have confusion which may signal illness or a medication problem. Social/emotional: accepts end of life and personal losses; may feel isolated or upset; may lose self-confidence; lives as independently as possible. | Communication: encourage expression of feelings/ thoughts; avoid despair; use humor; stay positive. Health: monitor closely and frequently; encourage self care with supervision; ensure proper nutrition; encourage activity and rest; update immunizations. Safety: try to prevent injury; ensure safe living environment. | Respect dignity. Provide for care needs slowly and respectfully. Assist in self-care. Monitor for age related risks. Encourage independence. Encourage social and physical activity. Support end of life decisions. |

**Assess every patient you deal with for possible physical impairments, emotional stresses, learning difficulties, language barriers, and cultural difference.**

To successfully care for the patient’s cultural needs, we must first understand our own culture and value system. To define culture we should consider our ethnic group, religious group, occupational group, and political group et cetera. Most of us would find that we have multiple group identities. Our ethnic background and religion generally have the most effect on our daily lives. We may have daily traditions and activities or food restrictions that may reflect a part of our identity. Our response to pain or willingness to seek medical attention may also be reflective on our cultural identity.

A key step in providing effective care is understanding the patient’s views and incorporating them into their care. It is very important to ask questions and have a basic knowledge of food preferences, religious beliefs and practices, views about birth and death, gender, sexual orientation, the presence of a disability, and their socio-economic status.

More specifically, we should discuss their thoughts on staying healthy, what they perceive as the cause of their condition or illness, what avenues of treatment would they agree to pursue and what outcomes do they expect, and what are their views on taking medications. It is most important to understand the role their culture allows in regards to others being involved in their care. Who do they consider family and how can these persons be involved in their care needs? Who in their community
may be called on for support? Are there “healers” in their cultural group and how will this affect the care provided in the facility?

Being aware of language and communication styles or issues is a priority area. Taking the appropriate steps to insure that you are able to communicate effectively with your patient is of utmost importance. Know what language your patient uses and utilize the cyracom or use laptop in nursing supervisor office for sign language line interpretation. if they are not fluent in English. Try not to use family members; they’re not likely to have medical knowledge and rules of respect may prevent certain discussions. Remember that presenting information in a variety of ways may enhance their ability to learn. Using pictures, diagrams, videos and asking for a return demonstration will improve their ability to understand. Be sure to ask questions that need more than a “yes” or “no” answer so that you can evaluate their comprehension of the material presented.

Remember to give each person your full attention—listen, observe, and provide quality healthcare with compassion and without compromise.

### Hierarchy of the Dying Person’s Needs

1. To share and come to terms with the unavoidable future. To perceive meaning in death.

2. To maintain respect in the face of increasing weakness. To maintain independence. To feel like a normal person, a part of life right to the end. To preserve personal identity.

3. To talk. To be listened to with understanding. To be loved and to share love.

4. To be given the opportunity to voice hidden fears. To trust those who care for them. To feel that they are being told the truth. To be secure.

5. To obtain relief from physical symptoms. To conserve energy. To be free from pain.

www.healthministries.info/module3/hierarchy.html
Ethics Committee

Policy:
The Ethics Committee is established to respond to the increasingly complex nature of ethical concerns arising in healthcare. The Ethics Committee is a multi-disciplinary hospital committee which is advisory in nature and does not have decision-making authority. The Committee exists to promote ethical standards in the hospital organization overall and in the delivery of patient care, and to provide a forum to hospital staff, medical staff, patients and families/legally designated representatives for identifying, clarifying, and resolving ethical issues. The functions, membership and responsibilities of the committee are listed below.

Meetings:
Meetings may be requested by any person associated with the care of the patient in question by contacting the Director of Quality Support at extension 1118 or the Nursing Supervisor during off hours. The Director or the Nursing Supervisor will contact the Administrator on call, who will speak with the physician and determine if a request should be made to the Chair of the Ethics Committee. The Chairman of the committee (or designee) shall be responsible for calling a meeting of the entire committee, if necessary. If a need is identified for the Ethics Committee Chairperson to call an emergency meeting, a reasonable meeting time and date will be set and all members will be contacted. When an ethical issue involving a patient is being discussed at a committee meeting, family members/legally designated representatives may attend if they wish.

Functions and Responsibilities:
- To serve as a consultation resource for the medical staff, hospital staff, patients and families/legally designated representatives in dealing with ethical questions related to hospitalization and treatment.
- To serve as an advisory body for the medical staff, hospital staff and Administration on the formulation of policies and/or guidelines dealing with ethical issues in healthcare.
- To provide an education forum for the discussion of ethical and moral questions and concerns which arise in the hospital, but which are not dealt with systematically by any other committee.
- To encourage and assist in the development of educational programs for medical staff, hospital staff, and for the community served by the hospital.
- To provide an opportunity for members of the committee and through them, other hospital and medical staff, to become sensitive to and knowledgeable about ethical issues.
- To review ethically problematic, significant issues for educational purposes.
Parking Layout
Hand Hygiene

Hand hygiene is the most effective way to prevent the spread of infection. In health care facilities, hand washing reduces the risk of infection for the patients, the staff and visitors. The Joint Commission has included hand hygiene as one of its patient safety goals and will be observing for close adherence to proper hand washing at all the appropriate times during their survey visits to our hospital. Good hand hygiene habits should be instincual to health care workers to keep patient’s safe. Make good hand hygiene a habit. Hand hygiene must be done well and often to be effective.

- Health care workers should use hand hygiene before direct patient contact, after removing gloves, before inserting invasive devices, after contact with the patient’s non-intact or intact skin, body fluids, mucous membranes or wound dressings, after contact with inanimate objects in the patient’s immediate environment and after contact with specimens or contaminated equipment. Also, wash after using the bathroom, after coughing or blowing your nose and before and after eating.
- WASH HANDS BEFORE LEAVING A PATIENT’S ROOM OR OTHER PATIENT CARE AREA!

- Soap and water or an alcohol based hand sanitizer product provided by the hospital may be used.
- If hands are visibly soiled, soap and water, not alcohol, must be used.
- When using an alcohol based hand sanitizer, apply product to all surfaces of hands and rub vigorously until hands are dry.
- Dispensers of alcohol hand sanitizer have been installed throughout the hospital, especially in areas where sinks are not readily accessible.
- The dispensers for the alcohol based products must not be installed over carpeting, electrical outlets or switches or in egress or exit access corridors.
- The alcohol based product must be stored in a one hour fire rated room.
- When using soap and water, wet hands, apply soap and apply friction to all surfaces of hands for at least 15 seconds, rinse well, dry with a paper towel and use the towel to turn off the faucet.
- Lotions are provided by the hospital which are compatible with the hand washing products and that will not interfere with the integrity of the gloves.
- Artificial nails, gel polishes and extenders are not allowed when performing direct patient care and work in an areas that you have direct contact with patients or patients environment.
- Natural nails must be no longer than ¼ inch for those providing direct patient care.
- Wear gloves for contact with non-intact skin, contact with any body substances or mucous membranes.
- Remove gloves after caring for a patient and use hand hygiene. Do not wear the same gloves for the care of other patients. Do not wear gloves out of a patient’s room or other patient care area. Do not wash gloves.
- Change gloves during patient care if moving from a contaminated body site to a clean body site.
- Soap and water only for C-diff infections.
COMMUNITY CARES
Standards of Behavior

Community Cares is a culture of service and operational excellence. We know that excellent patient care helps provide better quality outcomes. The Community Cares culture connects 10 standards of behavior to daily actions that can help us maintain a high benchmark of service and operational excellence and deliver great patient care.

Our Community Cares culture also nurtures each employee by developing a sense of purpose, providing worthwhile work and giving each of us the opportunity to make a difference in the patients we care for.

By living these standards in our daily activities, together we are building a stronger future for our organization. Our goal is to create great places for employees to work, physicians to practice medicine, and patients to receive care.

10 STANDARDS OF BEHAVIOR:

Demonstrating that SAFETY is an uncompromisable core value and the foundation of our promise to each other, our patients and the communities we serve.

We will always maintain customer PRIVACY and confidentiality.

We will have a positive ATTITUDE about the customers we serve.

Our goals of COMMUNICATION is mutual understanding.

Make customers COMFORTBALE while they wait.

Be RESPONSIVE to every patient and family member.

If a customer complains, do not be defensive – use ACT: Apologize, Correct, Thank

Take pride in our personal APPEARANCE, our facility and surroundings.

COMMITMENT TO CO-WORKERS is very important.

Every employee should feel a SENSE OF OWNERSHIP toward his/her job.

AIDET stands for:

Acknowledge- acknowledge the patient by name using eye contact and a smile

Introduce- introduce yourself by name and describe what you are doing for the patient

Duration- give an estimated time you will be in with your patient

Explanation- explain what you are going to do for the patient.

Thank-you- Thank the patient for choosing East Georgia Regional Medical Center and end with, "Is there anything else I can do for you? I have the time."
AIDET is a powerful but simple key word technique that allows anyone to connect with a patient or customer to let him know they are in great hands. Using AIDET helps decrease anxiety and engages the patient in their care process to improve quality and safety outcomes.

**CLINICAL HOURLY Rounding**

Hourly rounding has been proven to improve our patients perception of the care they receive. Research demonstrates hourly rounding decreases the use of call lights, increases patient satisfaction, decreases patient falls, develops trust between the patient and hospital staff, and has proven to anticipate the patient’s needs. East Georgia Regional Medical Center complies with the culture of safety through hourly rounding.

**The three P's of hourly rounding are: 1. Pain  2. Position  3. Potty.** Each of these components are to be checked any time a care giver enters a patient room. While in the patient room, the white board should be checked and updated as needed. Each white board must have the names of care givers, date, and plan of care for the day. Before leaving each patients room every caregiver must ask the patient, “is there anything else I can do for you? I have the time.” When entering the patient room a safety assessment must be done to include: is the water pitcher, tissue box, call light, phone, TV remote, and trash can within reach of the patient?

**PATIENT EXPERIENCE**

Handoff communication is whenever one caregiver is relinquishing care to another care giver. This can be lunch breaks, change of shift, and movement of the patient from one area to the next. Patient flow addresses input- where the patient enters our system, throughput- daily operations, and output- the ability of the system to move the patient to the next disposition. Daily interdisciplinary communication occurs to help the discharge process. Patients reviewed in this process include but are not limited to the following: Length of stay over 3 days, Identified barriers to discharge, new admissions, and private pay patients. When the interdisciplinary team communicates well, our patients receive a higher quality care and improved satisfaction with the hospital team.
RECOGNIZING AND REPORTING ABUSE, NEGLECT, AND EXPLOITATION

Unfortunately the abuse, neglect, and exploitation of both adults and children knows no economic, geographic, gender, ethnic, religious or age specific boundaries. This growing problem in our society is fueled by many factors and has significant economic and human costs. As a member of the staff of EGRMC this is of particular importance because you are a MANDATED REPORTER. A 1988 Georgia State Law required mandatory reporting if there is reason to suspect that physical injuries have been inflicted by other than accidental means or that someone has been exploited or sexually abused by a caretaker, family member or other person not related to the abused person.

Those who are required by law to report suspected abuse, neglect or exploitation:
1. Physicians, interns or residents
2. All hospital or medical personnel
3. Dentists
4. Licensed Psychologist, students completing internships for licensure
5. Podiatrist
6. Professional counselors, social workers, marriage and family therapists
7. School teachers, counselors, administrators, social workers, psychologists, visiting teachers
8. Child welfare agency personnel (includes placement agency, childcare institution, maternity home, boarding home, family day-care or day care center
9. Child counseling personnel
10. Child service organization personnel
11. Law Enforcement

Signs to look for include, but are not limited to:
1. Withdrawn or overly aggressive
2. Bruised or other marks of physical violence
3. Unable or unwilling to discuss physical findings
4. Lack of appropriate supervision
5. Significant weight loss and other signs of malnutrition
6. Poor hygiene, soiled or inappropriate clothing
7. Not receiving needed medical attention
8. Inappropriate interaction with family members
9. Seclusion from others (absent from school, not attending church or other normal activities.

How to Report:
1. Notify your immediate supervisor
2. Notify the patient’s physician
3. Notify the Georgia Department of Family and Children Services at 871-1333; Adult Protection Services referral fax 770-408-3001 or call 1-866-552-4464 press 3; and at 764-9911 nights and weekends (Statesboro Police)

You must provide:
1. The name and address of the potential victim
2. The name(s) of his/her caretakers
3. The nature, extent and history of the injury (neglect or exploitation) and the reason given
4. Any evidence of previous abuse
5. Your name and address
6. Any other information which may be helpful

YOUR REPORT WILL BE KEPT CONFIDENTIAL AND INVESTIGATED.
HANDLING AND DEFUSING AGGRESSIVE AND VIOLENT BEHAVIOR

Managing aggressive and violent behavior has become an essential skill pertinent to all healthcare providers. The Crisis Prevention Institute’s Nonviolent Crisis Intervention ® program is considered to be the gold standard by the Joint Commission for interventional techniques and is the program recognized by EGRMC. The objectives are to provide staff with the skills to:

1. recognize and control their anxieties, maintain professionalism
2. educate on techniques effective in approaching and reducing the tension of an agitated person
3. educate on the alternatives (NONVIOLENT) if a person loses control and becomes violent
4. provide knowledge of nonverbal, paraverbal, verbal and nonviolent physical intervention skills to allow the staff to maintain the best possible CARE, WELFARE, SAFETY, AND SECURITY for all involved, even during the most violent moments.

Risk factors that may contribute to the potential for situations to occur include:

1. Long waits that increase frustration levels
2. Failure to keep the patient/family informed
3. Failure or delay in meeting their needs
4. Lack of training for staff in recognizing and managing escalating hostile and assaultive behavior
5. Weapons being brought into the facility due to the lack of screening devices
6. Availability of drugs or money
7. Unrestricted movement of the public
8. Potential presence of drug and alcohol abusers who may be prone to violent behavior
9. Presence of criminals with or without law enforcement assistance
10. Increased use of ER to care for acutely disturbed or violent individuals

CPI Crisis Development Model
Aggressive Behavior or acting out behavior may generally be demonstrated in two ways, verbal and physical. Verbal acting out intervention should be verbal and physical acting out may require non-violent physical intervention, but only as a last resort.

According to the CPI Crisis Development Model the following model should be followed:

<table>
<thead>
<tr>
<th>Crisis development/Behavior levels</th>
<th>Staff Attitudes/Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxious behavior noted</td>
<td>1. Be supportive/informative</td>
</tr>
<tr>
<td>2. Defensive (losing rationality)</td>
<td>2. Be directive</td>
</tr>
<tr>
<td>3. Acting out behavior</td>
<td>3. Non-violent physical crisis intervention</td>
</tr>
<tr>
<td>4. Tension Reduction</td>
<td>4. Therapeutic Rapport</td>
</tr>
</tbody>
</table>

Anxious behaviors may be subtle and include pacing, tapping, talking to self/others, flushing or withdrawing. Staff may have a gut feeling about the person. Being supportive/informative certainly includes listening, being non-judgmental and empathetic.

Defensive behaviors often include yelling/ cursing and verbally challenging staff. Unfortunately these behaviors are often learned in today’s culture. Staff should set limits, give choices (positive first and in a limited number) and recognize the need for structure.

Acting out behavior means that the person has lost control of self, is physically acting out, and is a danger to themselves and others. Non-violent physical crisis intervention should be used only as a last resort and by staff members that have received classroom training in these techniques. Please note that the only safe restraint is the one that is not used. This intervention should be short lived.
Tension Reduction is the decrease of physical and emotional energy. The person may relax, become more cooperative, cry or apologize. The re-establishment of therapeutic rapport is most important at this time. Re-establish good lines of communication and convey your willingness to give the acting-out person another chance.

CPI calls this model an integrated experience, meaning that the staff often feels the same feelings as the acting-out person. Professionalism on the part of the staff is of utmost importance.

Communication Skills
Communication is an art and includes much more than just the words we use. Our nonverbal behavior is 55%, paraverbal skills are 38% and words are only 7%.

Nonverbal behavior includes our awareness of personal space and our body language. CPI suggests 1.5-3 feet of space between you and the acting out person. When personal space is invaded, anxiety increases. Our body language (facial expressions, posture, and movement) can be a contributing cause for acting out behavior.

Paraverbal skills are the vocal part of speech-excluding the words. It is how we say what we say and conveys our attitude to anyone we are talking with.

Tone: sincere, respectful, and avoiding inflections of fear, superiority, etc.
Volume: appropriate for setting
Cadence: rate and rhythm of speech

Communication is a two-way process. Maintain a professional attitude by not allowing your own perceptions to get in the way of your responsibilities or by not allowing your personal prejudices to influence the way you communicate.

Minimize communication problems by:
- Taking time to communicate
- Check to make sure you are understood. Be direct and explicit. Avoid emotive language (“power” words)
- Encourage and give feedback
- Hold conversation in an appropriate time and place
- Utilize an interpreter if appropriate
- Reduce background noise. It is a major distracter.
- Awareness of intrusion of personal space

Team Intervention
EGRMC’s emergency code for Aggressive/Suspicious behavior is CODE ARMSTRONG. Security and Plant Operations staff responds to the code. Team intervention is important because it promotes safety for all involved, professionalism and safer from a legal standpoint.

In addition to knowledge of the CPI Model, staff should be aware of the following:

Suspicious behavior
Suspicious behavior may include:
- Presence in sensitive or inappropriate areas
- Poor eye contact
- Refusal to interact
- Lack of appropriate identification
- Inability or unwillingness to answer questions about their reason to be in the facility

Associates should report any activity that is not part of the normal environment or anyone that is acting in a suspicious manner. Reporting should take place no matter how innocent it might seem at the time. We must take all threats seriously. It is extremely important that you follow your instincts about
situations. Security should be made aware of these situations as quickly as possible. **PREVENTION IS THE KEY!**

**Additional Defusion Strategies**
Staff should seek to defuse the situation using the CPI Crisis Development Model while also being focused on their own safety. Calmly seek the assistance of others. **Do not allow your access to the exit to be blocked by the person.** Strategies to incorporate include:

- **Appear confident**
- **Move slowly and display calmness**
- **Try to identify what is causing the issue or feeling**
- **Create space between yourself and the person**
- **Speak slowly, gently, clearly, and in a low tone**
- **Avoid staring**
- **Show that you are listening—feel respect for the person, not the behavior**
- **Avoid arguing and confrontation. Don’t tell them what to do**
- **Steer toward a more productive way to express feelings**
- **Calm the person before trying to solve the problem**
- **Don’t lie to them, be honest and create trust**
- **Avoid sudden movements that may startle or be perceived as an attack**
- **Avoid audiences— an audience may escalate the situation**
- **Weapons do change the scenario. Remain calm. Still try to talk them through the situation**
- **NEVER THREATEN!**

All Associates of the facility are responsible for preventing workplace violence and recognizing a potential situation BEFORE it escalates. Understanding a patient, family, or visitor’s concerns, anticipating their needs and following up on their concerns is the first step to prevention. There is no specific profile of a person who will become aggressive and create a situation in the facility. There is a delicate balance between customer service and insuring a safe environment. Remember the words **CARE, WELFARE, SAFETY, and SECURITY.**

All threats (verbal or situational) should be taken seriously. Recognizing aggression and preventing it from escalating into actual physical violence must be the goal of all Associates.
INFECTION CONTROL

The basic goal of an Infection Control Program is to prevent the spread of infections and to eliminate the spread of microorganisms from one person to another. Patients sometimes acquire infections while hospitalized. These are referred to hospital acquired infections. Hospital personnel seldom acquire infections from patients. The reason that patients, rather than staff, are more susceptible to infection is that the patient’s general state of health and ability to fight infection is very low. In addition, many patients undergo invasive procedures which can allow entry of bacteria into the body.

MRSA

What is MRSA?

Staphylococcus aureus (pronounced staff-ill-oh-KOK-us AW-ree-us), or “Staph” is a very common germ that about 1 out of every 3 people have on their skin or in their nose. This germ does not cause any problems for most people who have it on their skin. But sometimes it can cause serious infections such as skin or wound infections, pneumonia, or infections of the blood. Antibiotics are given to kill Staph germs when they cause infections. Some Staph are resistant, meaning they cannot be killed by some antibiotics. “Methicillin-resistant Staphylococcus aureus” or “MRSA” is a type of Staph that is resistant to some of the antibiotics that are often used to treat Staph infections.

How do I get an MRSA infection? People who have MRSA germs on their skin or who are infected with MRSA may be able to spread the germ to other people. MRSA can be passed on to bed linens, bed rails, bathroom fixtures, and medical equipment. It can spread to other people on contaminated equipment and on the hands of doctors, nurses, other healthcare providers and visitors.

Can MRSA infections be treated? Yes, there are antibiotics that can kill MRSA germs. Some patients with MRSA abscesses may need surgery to drain the infection.

Vancomycin Resistant Enteroccus (VRE)

What is VRE? VRE refers to vancomycin-resistant enterococcus. The enterococcus is a germ or bacterium that lives in the intestinal tract and in the female genital tract. Most of the time, the enterococcus does not cause a problem. This is called colonization. Occasionally, the enterococcus can cause an infection of the urinary tract, bloodstream, or skin wounds. Vancomycin is an antibiotic that can be used to treat those infections. However, some enterococcus germs are no longer killed by vancomycin and are known as vancomycin-resistant enterococcus or VRE. These germs are often resistant to many antibiotics in addition to vancomycin.
How can the spread of VRE be prevented in the hospital?

- Caregivers should clean their hands with soap and water or an alcohol-based hand rub before and after caring for every patient.
- Hospital rooms and medical equipment should be cleaned and disinfected after use.
- In some cases, healthcare provider may also use gowns and gloves to help prevent spread
- Healthcare providers should take special measures (isolation precautions) to prevent the spread of infection to others.

Are certain people at risk of getting a VRE infection?

The following people are at an increased risk of becoming infected with VRE:

- People who have been previously treated with the antibiotic vancomycin or other antibiotics for long periods of time.
- People who are hospitalized, especially when they receive antibiotics for long periods of time.
- People with weakened immune systems such as patients in intensive care units, or in cancer or transplant wards.
- People who have undergone surgical procedures, such as abdominal or chest surgery.
- People with medical devices such as urinary catheters or intravenous (IV) catheters that stay in for some time.
- People who are colonized with VRE.

Surgical Site Infections

What is a Surgical Site Infection (SSI)?

A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place. Most patients who have surgery do not develop an infection. However, infections develop in about 1 to 3 out of every 100 patients who have surgery.

Some of the common symptoms of a surgical site infection are:

- Redness and pain around the surgical site
- Drainage of cloudy fluid from the surgical wound
- Fever

To prevent SSIs, doctors, nurses, and other healthcare providers:
• Clean their hands and arms up to their elbows with an antiseptic agent just before the surgery.

• Clean their hands with soap and water or an alcohol-based hand rub before and after caring for each patient.

• Hair removal immediately before surgery using electric clippers if the hair is in the same area where the procedure will occur. Patients should never be shaved with a razor.

• Wear special hair covers, masks, gowns, and gloves during surgery to keep the surgery area clean.

• Patients should be given antibiotics before surgery starts. In most cases, antibiotics should be given within 60 minutes before the surgery starts and the antibiotics should be stopped within 24 hours after surgery.

• Clean the skin at the site of your surgery with a special soap that kills germs.

Catheter Associated Bloodstream Infections

What is a catheter-associated bloodstream infection?

A “central line” or “central catheter” is a tube that is placed into a patient's large vein, usually in the neck, chest, arm, or groin. The catheter is often used to draw blood, or give fluids or medications. It may be left in place for several weeks. A bloodstream infection can occur when bacteria or other germs travel down a “central line” and enter the blood. If you develop a catheter-associated bloodstream infection you may become ill with fevers and chills or the skin around the catheter may become sore and red.

What are some of the things that hospitals are doing to prevent catheter-associated bloodstream infections? To prevent catheter-associated bloodstream infections doctors and nurses will:

• Choose a vein where the catheter can be safely inserted and where the risk for infection is small.

• Clean their hands with soap and water or an alcohol-based hand rub before putting in the catheter.

• Wear a mask, cap, sterile gown, and sterile gloves when putting in the catheter to keep it sterile. The patient will be covered with a sterile sheet.

• Clean the patient's skin with an antiseptic cleanser before putting in the catheter.

• Clean their hands, wear gloves, and clean the catheter opening with an antiseptic solution before using the catheter to draw blood or give medications. Healthcare providers also clean their hands and wear gloves when changing the bandage that covers the area where the catheter enters the skin.

• Decide every day if the patient still needs to have the catheter. The catheter will be removed as soon as it is no longer needed.

• Carefully handle medications and fluids that are given through the catheter.
Catheter Associated UTI

What is “catheter-associated urinary tract infection”?  

A urinary tract infection (also called “UTI”) is an infection in the urinary system, which includes the bladder (which stores the urine) and the kidneys (which filter the blood to make urine). Germs (for example, bacteria or yeasts) do not normally live in these areas; but if germs are introduced, an infection can occur.

If you have a urinary catheter, germs can travel along the catheter and cause an infection in your bladder or your kidney; in that case it is called a catheter-associated urinary tract infection (or “CA-UTI”).

Catheter care

Healthcare providers clean their hands by washing them with soap and water or using an alcohol-based hand rub before and after touching catheters.

The catheter drainage tubing and bag should not be separated thus keeping a closed system to prevent infections. The specimen collection port should be used to collect specimens. This helps to prevent germs from getting into the catheter tube.

The catheter is secured to the leg to prevent pulling on the catheter. The catheter tubing should remain free of kinks, knots and twists.

Keep the bag lower than the bladder to prevent urine from back flowing to the bladder. Do not allow the bag to sit directly on the floor.

Empty the bag regularly. The drainage spout should not touch anything while emptying the bag. Catheters are put in only when necessary and they are removed as soon as possible. More information can be found in the Patient Information and Education Guide (Handbook).

PLEASE COMPLETE AND SUBMIT QUIZ FOR ARI BOOK
Answer questions by placing True (T) or False (F) in the blank lines. Some questions require a letter answer, “a, b, c, d, e”.

1. EGRMC’s mission statement is to provide quality healthcare in a safe and compassionate environment.
2. The term “cultural diversity” incorporates cultural differences based on race, color of skin, and national or ethnic origin.
3. Associates must notify their supervisor when under any medication that may limit their ability to perform their job duties.
4. Contractors/volunteers are covered under the Drug Free Workplace Policy.
5. EGRMC will conduct drug and alcohol testing for new hires only.
6. The EGRMC Compliance Officer is
   - Elmer Polite
   - Shelley Harris
   - Nakesha Rolle
7. The code of conduct provides formal guidance regarding the ethical behavior that is expected from all employees to ensure compliance with applicable laws.
8. When lifting, you should bend with your knees and not your back.
9. What causes MSD (Musculoskeletal Disorder)?
   - Repetition
   - Forceful exertions
   - Awkward postures
   - Contact stress
   - Vibration
   - All of the above
10. If you are involved in an accident or are injured while on-the-job, you must report the Accident/injury immediately.
11. A drug screen is required for every injury.
12. You should note in the medical record that an Event Report has been completed.

13. An **event report** should be completed when there is an incident or accident which is not consistent with the desired care of patients or operations of the hospital.

14. If contacted by an attorney regarding a patient incident, it is ok to talk to them without permission from the Risk Manager.

15. A **patient grievance** is a formal/informal written or verbal complaint made to the hospital by the patient or family member.

16. Patient complaints should be routed to the Patient Advocate.

17. An **Adverse event** is an unexpected event that caused or may cause a negative effect on patient care.

18. A **sentinel event** should be reported immediately to the workers compensation coordinator.

19. Joint Commission 2015 Safety Goals include:
   a. improving the accuracy of the patient identification
   b. improving the effectiveness of communication among caregivers
   c. improve the safety of using medication
   d. improve the safety of clinical alarm systems
   e. reduce the risk of healthcare associated infections
   f. all of the above

20. Georgia’s informed consent law requires that a patient undergoing surgery with certain types of anesthesia, amniocentesis, and diagnostic procedures involving injection of contrast materials be informed, in terms he can understand, certain information related to his diagnosis and proposed procedure.

21. Forensic Personnel (law enforcement personnel) are required to have an orientation of the building.

22. A hostile work environment might include off-color language, lewd or suggestive remarks or jokes, sexually explicit posters, and pictures.

23. We measure quality of care by observing staff in their roles, reviewing medical records, monitoring patient outcomes and patient satisfaction and by comparing the quality of care provided with the cost of the healthcare provided.

24. Hospital products which may contain **natural rubber latex** are:
   a. urinary catheters
   b. ambu bags
   c. surgical and exam gloves
   d. all of the above

25. What does **HIPAA** stand for?
   a. Health Insurance Portability and Accountability Act
   b. Health Information Policy Alert Association
   c. Health Insurance Payment Account Act
26. Federal law requires us to tell patients if someone has snooped into their information protected by HIPAA.

27. At EGRMC, the Privacy Officer is:
   a. Shelley Harris
   b. Nakesha Rolle
   c. Rhonda Jones

28. At EGRMC, the Risk Manager is:
   a. Shelley Harris
   b. Nakesha Rolle
   c. Rhonda Jones

29. Individuals authorized to have access to ePHI (electronic protected health information) must have a
   a. Unique user ID.
   b. Password that is changed every 90 days.
   c. Background check.
   d. All of the above.

30. Emergency Medical Treatment and Labor Act (EMTALA) is an anti-discrimination law enacted to protect against the refusal of the uninsured.

31. A patient’s medical screening exam may **not** be delayed to obtain registration or payment information.

32. Biochemical Terrorism is a premeditated, unlawful threat or use of chemicals, microorganisms or their toxins to produce death or disease in humans, animals or plants.

33. Bloodborne pathogens are disease causing microorganisms that require using standard precautions.

34. Biohazardous waste includes pathological waste, biological waste, cultures and stocks of infectious agents, sharps, and chemotherapy waste.

35. The hospital is a smoke-free facility and smoking is not permitted on hospital grounds.

36. The Code for evacuation is:
   a. Code Yellow
   b. Code Purple
   c. Code Gray

37. The code for a Bomb threat is:
   a. Code Orange
   b. Code Silver
   c. Code Yellow

38. The code for disaster is:
   a. Code Red
   b. Code Black Internal
   c. Code Purple
39. The code for someone who has entered building with a weapon with the intent to harm.  
a. Code Red  
b. Code Black  
c. Code Silver  

40. **Rapid Response Team (RRT)** is used to assist in the assessment and stabilization of any person who appears to be unstable, acutely ill, or rapidly deteriorating.  

41. All patient care equipment must be checked by **Clinical Engineering** before being used in the hospital.  

42. At EGRMC, the **Safety Officer** is  
a. Mikes Motes  
b. Pat Patterson  
c. Nakesha Rolle  

43. SDS stands for Safety Data Sheet. (Material Safety Data Sheets)  

44. The **hospital staff** is responsible for calling Lifelink in Georgia on all potential donors at or near the time of death to determine suitability.  

45. The person witnessing the adverse event should complete an Event Report before the end of their shift.  

46. Dial 1911 for the operator to report all codes.  

47. The Occupational Safety and Health Administration (OSHA) has a requirement that you, as an Associate, have the right to know:  
a. the hazardous materials that you may be exposed to during your work;  
b. the dangers of the hazardous materials; and  
c. the protective measures you need to take to work safely with the hazardous materials.  
d. All of the above  

48. Which one of the following statements about handwashing is correct.  
a. The amount of time is not important as long as your hands are clean.  
b. Hands should be wet first, then apply soap and use friction for at least 20 seconds, rinse and dry.  
c. Only wash when visibly soiled.  

49. We are expected to **exceed the expectations** of those we serve—not just meet them.  

50. What are the 3 P’s of hourly rounding:  
a. Pain, position, play  
b. Pain, position, patient safety  
c. Pain, position, potty  

51. All hospital or medical personnel are required by Georgia Law to report any suspected or actual case of abuse, neglect or exploitation.  

52. CPI stands for Crisis Prevention Institute.  

53. MRSA (Staph) is transmitted thru exchange of body fluids and thru bed linens, bed rails, or medical equipment.
### East Georgia Regional Medical Center
#### Annual Required Inservice Evaluation

<table>
<thead>
<tr>
<th>Topic</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>This booklet contained adequate information about the topic addressed.</td>
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<tr>
<td>The objectives stated in this book were met.</td>
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<tr>
<td>How effective was the material related to your job?</td>
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<td>The booklet was easy to read and understand.</td>
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<tr>
<td>Contact names and numbers were made available to address any questions or concerns you might have had.</td>
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<tr>
<td>Are there any ways you can suggest to improve this presentation?</td>
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</tbody>
</table>

**Comments:**

***Please return form to Human Resources.***
I. Compliance Program

Introduction
East Georgia Regional Medical Center has developed and implemented a Compliance Program that is designed to deter, detect, and prevent fraud, abuse, and mistakes.

Examples of potential fraud, abuse, and mistakes include the following:
1. Billing for goods or services that were not provided.
2. Billing for goods or services that are not documented or not sufficiently documented.
3. Billing for goods or services that were not medically necessary.
4. Providing a referral source anything of value in exchange for referrals.
5. A financial relationship between a hospital and a referring physician, physician group, or immediate family member of a referring physician, without a written agreement.
6. Paying a referring physician, physician group, or immediate family member of a referring physician above fair market value for services rendered.
7. Charging a physician less than fair market value rent for space or equipment.

Written Standards, Policies, and Procedures
The Compliance Program structure and requirements are set forth in the Compliance Manual and Compliance Policies and Procedures. Both of these documents are available on the hospital intranet. In addition, a paper copy of the Compliance Manual can be obtained from the Director of Human Resources, Michael Black.

Oversight
Nakesha Rolle is the Facility Compliance Officer responsible for making sure that the Compliance Program has been implemented and is operating in accordance with the requirements of the Compliance Manual and Compliance Policies and Procedures. The Hospital Compliance Officer works in conjunction with a Divisional Compliance Team and reports to the Senior Vice President of Corporate Compliance and Privacy Officer on all compliance related matters.

Training
In order to successfully deter, detect, and prevent potential fraud, abuse, and mistakes, it is critical that all individuals working in the hospital, including medical staff members, are aware of the existence, purpose, elements, and requirements of the Compliance Program. Consequently, we have developed this Compliance Program Overview to introduce and/or remind you of the elements and requirements of East Georgia Regional Medical Center's Compliance Program. In addition, you may contact the Facility Compliance Officer, Nakesha Rolle at (912) 486-1506, at any time should you have any questions or concerns.

Audits
Each year, a risk assessment is performed to identify risk areas that can be proactively monitored and audited. A Compliance Work Plan is developed based upon the risk assessment and the Compliance Work Plan describes the mandatory internal and external auditing and monitoring activity. Significant portions of the Compliance Work Plan audits relate to validating that services are adequately documented and medically necessary. In addition, all financial relationships with physicians, physician groups, and immediate family members of physicians are audited to verify that any transfer of remuneration is pursuant to a written agreement that is supported by evidence that the financial relationship is fair market value.

Anonymous Reporting Mechanisms
As part of East Georgia Regional Medical Center’s Compliance Program, we have contracted with an outside vendor to provide a mechanism, the Confidential Disclosure Program Hotline, for associates to
Clinical Students
Compliance & HIPAA Program Overview Certification

anonymous report suspected misconduct 24/7. The Disclosure Program Hotline number is: 1-800-495-9510. All matters reported through the Disclosure Program Hotline are emailed to the Senior Vice President of Corporate Compliance and Privacy Officer for the hospital’s parent company. The Senior Vice President of Corporate Compliance and Privacy Officer reviews the reports and determines the appropriate person to investigate the concern.

In addition, associates can also anonymously report suspected misconduct by sending their concerns to a confidential post office box at the following address: Corporate Compliance and Privacy Officer, Community Health Systems, 4000 Meridian Boulevard, Franklin, TN 37067. Similar to communications through the Confidential Disclosure Program Hotline, all communications via mail are reviewed by the Senior Vice President of Corporate Compliance and Privacy Officer and then forwarded for investigation.

Investigations
All reports of suspected misconduct must be entered into the hospital’s compliance log and investigated. The Facility Compliance Officer will oversee all investigations and is responsible for involving when necessary, legal counsel and/or subject matter experts.

If the Facility Compliance Officer cannot perform the investigation due to a conflict, then the Senior Vice President of Corporate Compliance and Privacy Officer will determine who will conduct the investigation. If the investigation reveals fraud, abuse, or mistakes, then these conclusions must be reported to the Senior Vice President of Corporate Compliance and Privacy Officer and an appropriate corrective action plan must be established to address all noted deficiencies.

Conclusion
The success of our Compliance Program depends on each and every East Georgia Regional Medical Center associate helping to establish and maintain a culture that is focused on our mission of providing compassionate high quality healthcare services that improve the quality of life for our patients, physicians, and communities that we serve and showing zero tolerance for illegal, unethical, or otherwise inappropriate behavior.

II. Code of Conduct
The parent company of East Georgia Regional Medical Center has developed a Code of Conduct that provides all who are associated with East Georgia Regional Medical Center with guidance to perform their daily activities in accordance with the organization’s ethical standards and all federal, state, and local laws, rules and regulations. The Code is an integral component of the organization’s Compliance Program and reflects our commitment to achieve our goals within the framework of the law through a high standard of business ethics and compliance. It is the obligation of all colleagues of East Georgia Regional Medical Center to be knowledgeable about and adhere to the Code. Compliance with the Code is mandatory. Failure to comply with any of the provisions of the Code of Conduct may result in disciplinary action up to and including termination for employees and cancellation of contractual or business relationships with physicians, contractors, and agents. Violations of portions of this Code relating to federal healthcare benefit programs may lead to severe consequences including, but not limited to, civil monetary penalties and/or exclusion from federal healthcare benefit programs for employees, physicians, contractors, agencies, facilities, or the parent company. You may review the Code on the hospital’s intranet site, www.myintranet.hma.com. If you have questions about the Code, please contact Nakesha Rolle, Facility Compliance Officer at (912) 486-1506.
Clinical Students
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III. HIPAA Program

To be in compliance with the HIPAA regulations, all healthcare providers should be knowledgeable about HIPAA policies and procedures.

Key Message Points Relating to HIPAA compliance include:

- The HIPAA Privacy Rule establishes national standards to control the use and disclosure of what is known as Protected Health Information (PHI).
  - PHI is any health information that is collected from the patient or created or received by a health care provider or facility that relates to the past, present or future physical or mental health or condition of a patient that could potentially identify that individual.
  - Unsecured PHI: All PHI we deal with is unsecured. Paper records are unsecured.
  - Secured PHI: PHI is secured if it is encrypted by NIST standards or has been destroyed.
  - Disclosure: PHI brought outside the organization

- The Privacy Rule gives patients the right to:
  - Receive a Privacy Notice
  - Inspect and get a copy of their PHI
  - Amend their PHI if incorrect
  - Request restrictions on disclosures of PHI
  - Request alternative means of communication
  - Obtain accounting of non-routine disclosures of PHI

- The obligation of the hospital’s workforce and medical staff is to:
  - Use or disclose PHI only for work related purposes
  - Limit uses and disclosures to the “minimum necessary” to achieve those work purposes
  - Exercise reasonable caution to protect PHI under their control
  - Understand the HIPAA policies and follow them
  - Try to remedy any privacy problems or to report them to the Facility Privacy Officer of East Georgia Regional Medical Center. The Facility Privacy Officer is Shelley Harris, who can be reached at (912) 486-1761.
  - Recognize that the hospital will not retaliate or discriminate against any patient, member of the workforce, or medical staff member who exercises their right to express a privacy or other HIPAA concern

Do not:

- Throw PHI in the trash or leave on the copier – use a shredder or dispose of paper-based PHI in the secured trash receptacles located throughout the facility
- Share your password to any computer system. Your password is your “key” and you will be held responsible for others that view information.
- Use your personal cell phone or camera to take pictures of patient’s body parts, X-rays, or other PHI.

Be aware that:

- Audits are done regularly to see who accessed PHI in our systems. Every associate, physician, and VIP admitted to the hospital will have their account reviewed for inappropriate access.
- The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) empowers individual State Attorneys General to investigate and recover damages from
**Clinical Students**  
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*INDIVIDUALS* in federal court (anti-snooping measure). The new law mandates civil monetary penalties for certain violations and can include fines and jail time for the *INDIVIDUAL*.

- The HITECH Act also requires written notification to patients (as of 9/23/09) of inappropriate access of their unsecured PHI and notification to the Federal Government and local media if 500 or more patients are affected.
  - Exceptions from notifying the patient or Federal Government about breaches:
    - Breaches that were not intentional and did not disclose information outside of the facility. (Note – outside the facility includes HIPAA information found in the facility by a non-employee or individual covered by our HIPAA policy.)
    - If a stolen laptop is protected by encryption software approved by the Federal Government.

Physicians/AHPs and students are expected to follow facility policies concerning privacy and security. The HIPAA and HITECH regulations provide a range of penalties for non-compliance depending on the context of the violation and the offender’s intent. For individuals who knowingly release information inappropriately, the penalties could include jail time, loss of licensure, and/or significant financial penalties.
Compliance and HIPAA Program Certification

I have received and read the Clinical Students Compliance and HIPAA Program Overview and have had the opportunity to ask questions, request a copy of the Compliance Manual, and discuss the Compliance and HIPAA Programs with the Facility Compliance Officer, Nakesha Rolle, and Facility Privacy Officer, Shelley Harris.

I am aware that as a clinical student at East Georgia Regional Medical Center, I agree to report even suspected HIPAA issues to the Facility Privacy Officer, Shelley Harris, and suspected misconduct to the Facility Compliance Officer, Nakesha Rolle, or through one of the anonymous reporting mechanisms.

Unless otherwise noted below, I do not have knowledge of any illegal, unethical, or otherwise inappropriate conduct at East Georgia Regional Medical Center.

___________________________________   _______________________
Clinical Student Signature                      Date

___________________________________
Print Clinical Student Name
HIPAA Workforce Confidentiality & Information Security Agreement

I understand the facility or business entity (the “Company”) in or for which I work, volunteer or provide services (contractual or otherwise) has a legal and ethical responsibility to safeguard protected health information (“PHI”).

In the course of my employment, assignment, or affiliation with the Company, I understand that I may come into contact with PHI. I will access and use this information only when it is necessary to perform my job-related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet.

1. I will act in the best interest of the Company and in accordance with its policies, procedures, and Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
3. I understand that I have no right to any ownership interest in any intellectual property, ideas, inventions, or work product developed during work time by me during my relationship with the Company.
4. I will practice good workstation security measures such as positioning screens away from public view, logging off the system when not in use, and securely storing removable media when not in use.
5. I will only access or use records, documents, systems, or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
6. I shall:
   a. use only my officially assigned user ID and password.
   b. use only approved licensed software.
   c. use devices with virus protection software.
   d. report theft or loss of mobile devices (cell phones, USB drives, laptops, etc.) that store PHI immediately.
7. I am personally responsible for transactions under my user ID and password.
8. I shall not:
   a. share or disclose user IDs or passwords, make them discoverable to others, ask others to share their passwords, or utilize another individual’s passwords.
   b. use tools or techniques to break or exploit security measures.
   c. connect to unauthorized networks through the Company’s systems or devices.
   d. knowingly include, or cause to be included, any false, inaccurate or misleading entry in any record or report.
   e. Use a workstation without logging out another user.
9. I will not disclose or discuss any PHI with others, including friends or family, who do not have a business need to know it.
10. I will not in any way use, access, copy, release, sell, loan, alter, remove, or destroy any PHI except as properly authorized.
11. I will not make unauthorized transmissions, inquiries, modifications, or purgings of PHI.
12. I will practice secure electronic communications by transmitting PHI only to authorized entities, in accordance with approved security standards.
13. I will only access electronic systems to review patient records for which my job responsibilities have a legitimate need to access for treatment, payment, or healthcare operations.
14. I will notify my manager or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy or security policies, or any other incident that could have any adverse impact on PHI.
15. Upon termination, I will immediately return any documents or media containing PHI to the Company.
16. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
17. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, termination of authorization to work within the Company, in accordance with the Company’s policies, and/or legal action against the organization and/or myself.

The following statements apply to non-employed physicians and independent contracted entities and/or persons using Company systems containing patient identifiable health information:

1. I will ensure that only appropriate personnel in my office will access the Company’s electronic systems and I will annually train such personnel on issues related to patient confidentiality and access.
2. I will accept full responsibility for the actions of my employees who may access the Company’s electronic systems and PHI.

I acknowledge that I have read this Agreement and I agree to comply with the terms and conditions stated above in order to obtain authorization for access to protected health information.

<table>
<thead>
<tr>
<th>Signature (Employee, Consultant, Contractor, Office staff, Physician)</th>
<th>Facility Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name</td>
<td>Department</td>
<td></td>
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</tbody>
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Rev. 09/2013
STATEMENT OF CONFIDENTIALITY

I, the undersigned, understand that in the course of my employment by EGRMC confidential information will be disclosed (or made available) to me, and I agree and acknowledge that such confidential information is disclosed in confidence and with the understanding that it constitutes valuable business information developed by EGRMC at great expenditure of time, effort and money. I agree that I will not, without the express prior written consent of EGRMC, use such confidential information for any purpose other than the performance of the duties of my position.

I further agree to keep strictly confidential and hold in trust all confidential information and not disclose or reveal such information to any third party without the express prior consent of EGRMC. Upon termination of my employment with EGRMC for any reason, I will immediately return all material constituting or containing confidential information, and I will not thereafter for any purpose, use, appropriate, or reproduce such information or disclose such information to any third party.

For purposes of this Statement of Confidentiality, “confidential information” shall be defined as any and all of EGRMC’s systems, specifications, designs, documents and other materials, including but not limited to policy and procedure manuals, public information/education programs, quality assurance/standards compliance programs, financial data and feasibility studies, regulatory and other applications, development and expansion plans and proposals, records, business plans, status reports, and surveys and studies conducted by or on behalf of EGRMC.

I further understand that any and all information and/or communication concerning all individual patient(s) is confidential. I agree not to disclose any information concerning any former or present patient. I also agree not to discuss any patient’s status and/or treatment with another patient or with any staff, other than those specifically designated with a right-to-know. I understand that unauthorized disclosure of confidential information may result in my immediate termination, and that EGRMC reserves the right to pursue any legal or equitable remedies available to it, including but not limited to an action for monetary damages and/or for injunctive relief.

Signature: ___________________________ Date: ________________

Print Name: ___________________________
STUDENT AFFILIATION AGREEMENT – ADDENDUM 4

STUDENT SUBSTANCE POLICY CONSENT FORM

Name of School: ___________________________
Name of Facility: __________________________

Facility policy prohibits Students (as well as applicants, employees and contractors) from using “Substances” including, but not limited to, illegal drugs and legal prescription drugs without a current, legal and valid prescription. Alcohol may not be used in a manner that will cause Student to be impaired while at the Facility. Students shall be tested for Substances as directed by the School or the Facility.

The Substance Policy

The Students are seeking Facility experience that is not granted to the general public.

It is Facility policy to maintain a drug and alcohol free environment.

By choosing to access the Facility through the program, the Student must agree to follow the Facility’s substance abuse policy, including Substance testing.

Any Student who chooses not to agree to this policy has chosen not to be in the program.

No Student shall be in the program who:

- Has chosen not to comply with the Facility’s or School’s directives;
- Is unfit for duty; and/or
- Has not passed a Substance test within the twelve (12) months preceding Student’s provision of Patient Care Services.

The School shall:

- Cause each Student to complete Addendum 4 Student Substance Policy Consent Form;
- Provide the Facility with a copy of each Student’s completed Consent Form or request Student to provide the completed Consent Form to the Facility;
- Conduct testing of Students through a licensed laboratory if School is responsible for Substance testing; and
- Provide to the Facility copies of each Student’s test result, for every test, if School is responsible for Substance testing.

Substance Testing may also be required by the Facility:

- When a Student is injured at the Facility;
- When a drug is not accounted for per Facility policy;
- For oversight of a Student who has previously completed a Substance rehabilitation program;
- For a Student who has been absent from the School or program for more than 30 days (except for regularly calendared school breaks); and
- When a Student appears to be unfit for duty.
Student Consent, Disclosure and Release

I choose to:

- Agree with and follow the Substance Policy.
- To provide any specimen(s) and to authorize the School and Facility and any associated persons and/or entities to conduct tests for alcohol and drugs and to allow them to access and utilize Specimen and test information as needed pursuant to the Substance Policy and process.
- Release the School and the Facility and any associated persons and/or entities from any and all claims, causes of action, damages, or liabilities whatsoever arising out of or related to the Substance Policy and process.

Student Choice to Consent or Not Consent

I have read the above and I choose to (check one)

☐ Consent

or

☐ Not consent (not to remain or be in the program)

Student and Witness Signatures

Student:        Witness:

______________________________                 ______________________________
Signature        Signature

_______________________________               ______________________________
Printed Name                                                       Printed Name

_______________________________               ______________________________
Date                      Date

Additional Consent for Students under the Age of 18

As the parent and/or guardian of the Student named above, I hereby consent to and authorize the School and Facility and affiliated persons and/or entities to proceed as outlined above.

Parent and/or Guardian’s Signature Date

______________________________
Student’s Printed Name                 ______________________________
                                             Date
Welcome to East Georgia Regional Medical Center. We look forward to providing you with an informative and beneficial clinical opportunity during your educational experience. Please complete the following information for our records.

*Please print to insure legibility.*

NAME ________________________________________________________________________

DATE OF BIRTH _________________________________ GENDER M_____ F_____

ADDRESS _____________________________________________________________________

______________________________________________________________________________

PHONE NUMBERS WITH AREA CODES ______________________________________________

______________________________________________________________________________

**EMERGENCY CONTACT INFORMATION**

NAME __________________________________________ RELATIONSHIP ________________

PHONE NUMBERS WITH AREA CODES ______________________________________________

______________________________________________________________________________

ADDRESS _____________________________________________________________________

______________________________________________________________________________

SCHOOL ______________________________________________________________________

PROGRAM _____________________________________________________________________

INSTRUCTOR __________________________________________________________________

SEMESTER/ACADEMIC YEAR ______________________________________________________

HOURS OF WORK _______________________________________________________________

June 2013 vlc