Phone 541.844.1328 Fax 541.636.3416
1144 Gateway Loop, Suite 136 - Springfield, OR 97477
EMT.Associates@comcast.net
www.emtassoc.com

2024

EMT Associates

CNA2

Application Packet

Fill out packet per instructions and make an appointment with EMT Associates to submit your COMPLETED packet, documentation & payment

CNAInfo@emtassoc.comcastbiz.net
541-844-1328

ALL REQUIREMENTS MUST BE COMPLETED BY DEADLINE

WRITE IN BLACK INK ONLY

Phone 541.844.1328 Fax 541.636.3416
1144 Gateway Loop, Suite 136 - Springfield, OR 97477
EMT.Associates@comcast.net
www.emtassoc.com

WELCOME

Thank you for choosing EMT Associates for your CNA 2

Here are some housekeeping items that may be helpful to you in preparing to register for this course.

Class Times:

Please come to register with EVERYTHING listed on the checklist no later than 3:30pm on the registration deadline. If you need to obtain a BLS CPR card, or do not have a current BLS CPR card, please let us know ahead of time and we will set up a class for you before clinicals. The fee is $90. We also offer the Two Step PPD [TB Test] for $25/per test. Please contact the office to schedule

Clinical Scrub requirements are black or navy blue pants and a maroon top. Your maroon scrub top is included with your tuition

Classroom temperature is variable — so dress in layers. There are coffee shops and restaurants within walking distance

****Clinicals begin after classroom completion. They may be any combination of 4 days in coordination with Peacehealth's availability. We may have day or evening options... Therefore it is IMPORTANT for you to allow your schedule for an additional 7 days beyond the scheduled dates****

Please be aware class will be canceled if less than 4 students register. This is rare, but we want students to know of the possibility in advance. A full refund will be given if we cancel.

We hope this will be a great experience for you in furthering you career. We look forward to meeting you!

Below are contact numbers for any question of concerns:

CNA 2 Program Director	Mary Ann Vaughan	(541) 430-7149	Mavemtrn@comcast.net
CNA 2 Program Coordinator	Skorpiaa	(541) 844-1328	Skorpiaa.N@emtassoc.comcastbiz.net
CNA 2 Clinical Instructor	Mary Carpenter	(541) 912-2761	

Welcome to Class on behalf of EMT Associates!

Phone 541.844.1328 Fax 541.636.3416
1144 Gateway Loop, Suite 136 - Springfield, OR 97477
EMT.Associates@comcast.net
www.emtassoc.com

From I-5: Take exit 195-A. Stay in the far right hand lane. At the Gateway Street light turn right. Follow Gateway Street to the second light and turn right. This will put you on Gateway Loop. Gateway Office Plaza is the 4th driveway on the right, in front of Selectemp. Follow the driveway straight back and to the left.

From Beltline HWY E: Follow Beltline to the end. Get in the far right hand lane. At the Gateway Street light turn right. Follow Gateway Street to the second light and turn right. This will put you on Gateway Loop. Gateway Office Plaza is the 4th driveway on the right, in front of Selectemp. Follow the driveway straight back and to the left.

Parking: Students may park in the Gateway Office Plaza parking lot. Use West door.

Phone 541.844.1328 Fax 541.636.3416
1144 Gateway Loop, Suite 136 - Springfield, OR 97477
EMT.Associates@comcast.net
www.emtassoc.com

EMT ASSOCIATES

CNA2 REGISTRATION

INTENDED COURSE START DATE: _ _ / _ _ / _ _

STUDENT INFORMATION				
Last Name:	First Name:		M.I.	☐ Male ☐ Female
Date of birth:	Age:	SSN:	CNA Certification #:	
Current mailing address:				
City:	State:	ZIP Code:		
Home Phone:	Cell Phone:	Other Phone:		
E-Mail Address:				
Are you a US Citizen? ☐Yes ☐No If no, How long have you lived in the us?	Have you lived outside of the state of Oregon for 6 months or more in the last two years? ☐Yes ☐No			
Is English your Primary Language? ☐Yes ☐No If English is your secondary language, what is your primary language?				

Race / Ethnicity [Optional]:

☐ Hispanic or Latino or of Spanish Origin	☐ American Indian or Alaska Native	☐ Bi-Racial/Multi-Racial
☐ Black or African American or of African Origin	☐ Asian	☐ Other
☐ Caucasian	☐ Native Hawaiian or Other Pacific	☐ I Prefer Not To Say

EMERGENCY CONTACT INFORMATION			
Emergency Contact 1:			
Last Name:	First Name	Phone:	Relation:
Emergency Contact 2:			
Last Name:	First Name:	Phone:	Relation:

EMPLOYMENT INFORMATION (IF APPLICABLE)			
Employer Name:			
Employer Name address:			
City:	State:	ZIP Code:	Phone:

OTHER INFORMATION
Please print your name as you wish it to appear on your certificate:
How did you hear about us?

Phone 541.844.1328 Fax 541.636.3416
1144 Gateway Loop, Suite 136 - Springfield, OR 97477
EMT.Associates@comcast.net
www.emtassoc.com

EMT Associates CNA 2 Course
Enrollment Agreement, Disclosure Statement, and Policies Document

COURSE BEGINNING DATE: _____ COURSE END DATE: _____

ADMINISTRATION OF EXAMS

1. Daily quizzes in the classroom may be given covering the material in a written or oral format.
    a. Grading will be pass/fail.
2. Clinical demonstration is graded on a pass/no pass.
3. The final exam will be given on the last day of class.
    a. Exam will be monitored.
    b. Exam will be an individual effort.
    c. No cheating will be tolerated on exams.
        i. Any cheating or falsification of documentation or skills will result in immediate dismissal without refund, a failing grade, as well as reported to OSBN.
    d. The student who scores 75% or below will be given the opportunity to take another written final exam after they receive remediation. They will be allowed to retest at the discretion of the instructor.
    e. Appeals will be handled by the program director whose decision will be final.
4. Grading scale is as follows:
    a. A = 90% to 100%
    b. B = 80% to 89%
    c. C = 75% to 79%
    d. D = 65% to 74%
    e. F = below 65%

STUDENTS MUST SATISFACTORILY COMPLETE CLASSROOM PRIOR TO CLINICALS

ATTENDANCE

5. Students are required to attend 100% of:
    a. Classroom/Lab Hours
        i. 60 Hours
    b. Clinical Hours
        i. 28 Hours
6. Punctuality is important.
    a. You are expected to be on time for all classroom and clinical times.
        i. If you are going to be absent or tardy you must call your instructor as soon as possible.
        ii. If you miss 30 minutes or more of class time you must make up the time as scheduled with your instructor.

    b. Make up Time:
        i. Make up time will be charged at fee of **$50.00** per hour, due on the day of your scheduled make-up time.
        ii. All make-up time must be completed within the program hours with instructor approval. See iii.
        iii. In cases of extensive make-up time, you time must be completed within 4 months with director approval. Please see refund policy.

3. When working in the clinical area please meet your instructor in the designated area.
    a. **It is against OSBN and EMT Associates policy for you to be on the floor unless your instructor is present.**

BEHAVIORIAL EXPECTATIONS

1. Respect and Courteous
    a. Students will be respectful and courteous to all instructors, clinical supervisors, fellow classmates, clients, visitors, and site staff.
2. Honesty
    a. Honesty is required!
    b. Any cheating or falsification of documentation or skills will result in immediate dismissal without refund, a failing grade, as well as reported to OSBN.
3. Student will actively participate and cooperate with others in both lab and clinical experiences.
4. Drug and alcohol use is prohibited and will result in immediate dismissal without refund, a failing grade, as well as reported to OSBN.
5. Smoking is only allowed in designated areas.
6. Cell phones must be turned OFF during classroom/lab time.
    a. You will however use your cell phone to contact your instructor in the clinical setting.
7. As guests in the clinical site, we will be subject to their behavioral expectation and dress codes.
    a. You will review these expectations prior to clinicals, and sign you acknowledgement as part of your required file forms.
    b. Clinical dress code includes:
        i. All facilities require top in the color chosen by the clinical site and closed toed shoes.
        ii. Some facilities may require tattoos to be coved at all times and/or facial piercings to be removed during clinical time.
8. Professional demeanor is expected at all times in the classroom and clinical sites.
    a. This includes clean hair, neatly trimmed facial hair, control of body odor, no use of aromatic products (perfume, strong lotions, etc.)
9. HIPPA Confidentiality will be observed at all times.

COURSE REQUIREMENTS

1. **Prerequisites: must be turned in 14 days before class begins.**
    a. Personal Verification
        i. Unencumbered Oregon CNA 1 certificate.
            1. Your name is listed and Active on the registry.
        ii. Drivers License
        iii. Active Health insurance
            1. **Peace Health REQUIRES that you have current health insurance coverage during your clinical time. We have made arrangements with Collura Benefits Consulting for reasonably priced health insurance. If needed, please contact him at 541-654-0598. He is located at 1126 Gateway Lp, St 116, Springfield, OR 97477 E-mail: SALCOLLURA@COLLURABENEFITS.COM
        iv. Active American Heart Association BLS CPR Card
    b. Background Check and Drug Screen
        i. Must be initiated prior to the first day of class
        ii. Must be done at Any Lab Test Now
            1. Other companies will NOT be accepted
    c. Clinical Rotation Forms Completed
        i. Clinical Application

ii. Confidentiality Agreement
iii. Quiz

d. Vaccination Records
   i. MMR
   ii. Varcilla
   iii. Tdap
   iv. Hepatitis B
   v. Two Step TB Test
      1. 1st TB Test needs to be read within 48 to 72 hours or it needs to be redone.
      2. 2nd TB Test should be done 3-4 weeks after the first complete TST, but no sooner than 7 days after the first test. Test needs to be read within 48 to 72 hours or it needs to be redone.
      3. If your test reads positive you must obtain one of the following:
         a. Negative chest x-ray report within the last 6 months
         b. Negative QuantiFERON TB Gold in-tube (GFT-IT) Lab
   vi. Annual Influenza Vaccine
      1. October 1 until March 30 – MUST HAVE DOCUMENTATION FROM PROVIDER
      2. Per our clinical site, you do have the option of declining the vaccine you have provider documentation of one of the two medical contraindications:
         a. A severe allergic reaction to eggs or other vaccine components (anaphylaxis)
         b. A history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination

2. Classroom/Lab

di. Attend 100% of classroom/lab time – 60 Hours as defined by EMT Associates and OSBN.
dii. Syllabus
   i. Day 1 – 8:00AM to 6:30PM
      1. Topics Covered:
         a. Interpersonal Skills
         b. Communication
         c. Pain Assessment
         d. Documentation
         e. Person Centered Care
      2. Skills Practiced:
         a. Communication
         b. Manual and Electronic Vital Signs
         c. Orthostatic Blood Pressure
         d. Pain Assessment
         e. Documentation
         f. Abbreviations and Medical Terms
         g. Role Play Person Centered Care
   ii. Day 2 – 8:00AM to 6:30PM
      1. Topics Covered:
         a. Circulatory System
         b. Respiratory System
         c. Nervous System
      2. Skills Practiced:
         a. Telemetry and 12 Lead EKG
         b. Incentive Spirometer
         c. CPAP
         d. Sx Nose and Oral Pharynx

iii. Day 3 – 8:00AM to 6:30PM
    1. Topics Covered:
        a. Mental Health
        b. Immune System
        c. Infection Control
    2. Skills Practiced:
        a. Personal Protective Equipment
        b. Obtaining rectal and nasal swabs
        c. Setting up a sterile field
iv. Day 4 – 8:00AM to 6:30PM
    1. Topics Covered
        a. Digestive System
        b. Promoting Nutrition and Hydration
        c. Endocrine System
        d. Diabetes
    2. Skills Practiced
        a. Oral Suction
        b. Tube Feedings
        c. Ostomy Care
        d. CBG
        e. NG disconnection and reconnection
        f. Hemocult
v. Day 5 – 8:00AM to 6:30PM
    1. Topics covered:
        a. Integumentary System
        b. Musculoskeletal System
        c. Promoting Functional Abilities
    2. Skills Practiced
        a. Traction
        b. Cast Removal
        c. CMP Machine
        d. Hot and Cold Compress
        e. Use of Adaptive Devices
        f. Changing Wound Vac Canisters
vi. Day 6 – 8:00AM to 6:30PM
    1. Topics Covered
        a. Care of the Surgery Patient
        b. Urinary System
        c. Reproductive System
    2. Skills Practiced
        a. Empty, Measure, and Record Output of JP and Hemovac
        b. SCD's
        c. UC from Catheter Port
        d. Discontinue Foley
        e. Bladderscan

c. Students are expected to actively participate in all classroom/lab activities.
d. Assignments are to be completed.
    i. Home work as assigned.
    ii. Small group participation
e. Quizzes (pass/fail)
f. Skills check list (pass/fail)
g. Final exam (75% or more as per Administration of Exams policy).

3. **Clinical Experience**
    a. Attend 100% of classroom/lab time – 28 Hours as defined by EMT Associates and OSBN.
    b. Students are expected to actively participate in all clinical experiences.
    c. Skills checklist (pass/fail)

4. **Maintain patient confidentiality per HIPPA standards.**

5. **No disciplinary actions of dishonesty.**

BACKGROUND CHECKS

1. Background checks will be evaluated per the clinical site policies and procedures.

2. **Criminal history check:**
    a. Application to be submitted to Any Lab Test Now.
    b. EMT Associates will accept all results from Any Lab Test Now.

3. **Drug screen:**
    a. Application to be submitted to Any Lab Test Now.
    b. EMT Associates will accept all results from Any Lab Test Now [under special circumstances We will accept results from an approved Lab]

4. Drug screen and background fees are the responsibility of the student. EMT Associates has no input as to the policies of the company conducting the screening. Any disagreement in findings is between the student and the company providing the service.

5. All results will be released to EMT Associates which will hold the information in confidence. Students will be notified if their background check does not meet the clinical site policies and procedures.

6. Failure to pass the drug screen or background check will result in a refund of tuition if paid prior to the beginning of class.

DRESS CODE

1. Good personal hygiene
    a. Controlled body odors
    b. Good oral hygiene
    c. Short, neat, clean fingernails. NO acrylics
    d. No odor of tobacco
2. No perfume/cologne or highly scented lotions or deodorants
3. Conservative makeup
4. Long hair must be contained. Please wear it up, pulled back in braids or pony tail.
5. Limited jewelry
    a. Watch with second hand encouraged
    b. Engagement ring/wedding band and small post earrings are allowed
    c. Facial rings/loops/studs are not allowed per hospital policy.
6. Uniform required for clinical.
    a. Maroon scrub top
    b. Black or navy blue pants.
    c. Shoes cannot have open heels or toes.
7. Photo name tag to be worn at all times in the clinical practice site.
8. Clean, neat casual dress is appropriate for classroom and lab
    a. (Uniforms are not required in the classroom)

Meals and Breaks

1. Classroom/Lab
    a. There will be two fifteen minute breaks.
    b. Lunch break is 30 minutes.
    c. There are restaurants nearby, or you may bring your own to class.
        i. There is a refrigerator and microwave on site.
2. Clinical Area
    a. There will be two fifteen minute breaks.
    b. Lunch break is 30 minutes.
    c. You are required to take you break when your CNA does.
    d. If you plan to leave the building you MUST inform your instructor.

PARKING

1. Classroom
    a. There is free parking at the Gateway Office Plaza.
2. Clinical
    a. Parking is available in the employee parking lot at the south end of RiverBend with parking permit.
    b. You will be given a form called VEHICLE PARKING REGISTRATION. Return completed form to Security and Parking Services to receive your temporary parking permit. This department is located in the main lobby of RiverBend.

Safety in the Clinical Setting

1. Do not get a patient up by yourself. You must work with your assigned preceptor
2. Wear PPE as appropriate
3. Hand washing for all possible C-Diff is mandatory
4. Gel – before and after patient care
5. Never wear gloves out of the room - clean or dirty
6. Use Gait Belt when transferring or ambulating a patient, unless contraindicated

TUITION AND CLASS FEES

- Tuition
  - Includes non-refundable registration fee of $150, textbook, face shield or safety goggles & 1 surgical mask daily for class — $995
- Drug Screen and Background Check — $ 115
- Vaccines and TB Test — $ 25 - $100 *Approximately

TOTAL: $1,090 - $1,200

There's a $25 fee to reissue course completion certificates*

1. No refunds available for absences, but makeup sessions may be arranged for valid reasons such as: Illness, family emergency, prearranged absence per attendance policy.
   a. Make up Time:
      i. Make up time will be charged at fee of $50.00 per hour, due on the day of your scheduled make-up time.
      ii. All make-up time must be completed within the program hours with instructor approval. See iii.
      iii. In cases of extensive make-up time, you time must be completed within 4 months with director approval. Please see refund policy.
2. Refunds
   a. **100% refund if written cancellation is received 3 business days prior to start of class**
   b. **NO refund on the first day of class or if you no show to class**
   c. **NO refund if you are dismissed from class per Administration of exams policy**
3. Drug screen and background fees are the responsibility of the student. EMT Associates has no input as to the policies of the company conducting the screening.
   a. Drug Screens are to be obtained per the Drug Screen Policy.
   b. Background Checks are to be obtained through the Criminal History Checks Policy.
   c. Failure to pass the drug screen or background check will result in a refund of tuition if paid prior to the beginning of class.

Phone 541.844.1328 Fax 541.636.3416
1144 Gateway Loop, Suite 136 - Springfield, OR 97477
EMT.Associates@comcast.net
www.emtassoc.com

OSBN [Oregon State Board of Nursing] CONTACT INFORMATION

If for any reason you have a complaint against our program or clinical training site which has not been satisfactorily resolved by your instructor, Program Coordinator or the Director, you may file a complaint on-line at the Oregon State Board of Nursing website: https://www.oregon.gov/osbn/pages/complaint.aspx

You Have The Option To Submit Your Complaint Confidentially

You may contact the Oregon State Board of Nursing by emailing:
oregon.bn.info@osbn.oregon.gov
OR
You may mail a letter to the following address:
Oregon State Board of Nursing
17938 SW Upper Boones Ferry Rd
Portland, OR 97224
OR
Office: 971.673.0685 [8a - 12p ONLY]

Phone 541.844.1328 Fax 541.636.3416
1144 Gateway Loop, Suite 136 - Springfield, OR 97477
EMT.Associates@comcast.net
www.emtassoc.com

Student Acknowledgment of EMT Associates CNA 2 Course Enrollment Agreement, Disclosure Statement, and Policies Document

I, _____ have received, read and understand the disclosures statement,
(Print Name)

enrollment agreement, and program policies of EMT Associates.

_____ _____
Signature Date

_____
Print Name

Phone 541.844.1328 Fax 541.636.3416
1144 Gateway Loop, Suite 136 - Springfield, OR 97477
EMT.Associates@comcast.net
www.emtassoc.com

Consent To Release

This is a consent for release of information about: _____
Name Of Student

_____ _____
Social Security Number Date Of Birth

I authorize _____
Name Of Provider Agency

to release the following specific information: _____

_____

_____

This information may be used only for the purpose of: _____

_____

_____

I understand I have the right to see this information at any time. I understand that I can revoke this consent in writing to both the person giving and the person receiving the information. Any information already released may be used as stated on the consent. I understand the requested or provided information is needed to determine eligibility for housing and/or social services. This consent is valid only until: _____
Date Consent Expires

This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked in writing sooner. By my signature below, I affirm that I have read this release or it has been read to me, and I understand its content

_____ _____
Student's Signature Date

_____
Student's Mailing Address

_____ _____
Consent Witnessed By Staff Signature If Different From Witness

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit further disclosure without specific written consent from the person to who it pertains.

PeaceHealth

Confidentiality Agreement

During the course of my work/services with PeaceHealth, its affiliated entities, or entities that have been granted access to PeaceHealth confidential information (collectively referred to as "PeaceHealth"), I may develop, use, maintain, or have incidental contact with or access to patient information, employee information, and/or business information that is confidential.

I understand and agree that:

- Information related to patients, caregivers (employees), providers, financial data, and/or any other information pertaining to PeaceHealth business or proprietary information in any form including paper records, oral communication, email, audio or video recordings, and electronic displays ("Confidential PeaceHealth Information") is the property of PeaceHealth and is to be considered strictly confidential unless specified otherwise.
- The obligations set forth in this agreement as well as applicable policies continue beyond the end of my relationship with PeaceHealth.
- This agreement is valid for all individuals with access to PeaceHealth information.
- When my relationship with PeaceHealth is terminated, I will not retain or transfer any PeaceHealth information in any form unless provided permission to do so by PeaceHealth's Vice President for Organizational Integrity.
- Subject to PeaceHealth's Policy for Reporting and Investigating Concerns or Suspected Violations (Document #101.38.36), violation of this Agreement, PeaceHealth policies, policy compliance rules, and procedures regarding the confidentiality, privacy, and security of Confidential PeaceHealth Information may constitute grounds for corrective action, up to and including:
    - Loss of medical staff privileges,
    - Termination of access to PeaceHealth information systems,
    - Termination of the contract or other terms of affiliation, and
    - Civil and/or criminal liabilities and penalties.
- I will access only the Confidential PeaceHealth Information needed to perform my work-related responsibilities.
- I may NOT access personal health information related to myself.
- I may NOT access personal health information related to my family members.
- I am NOT authorized to access or review the personal health information of my family members except for legitimate work-related purposes.
- I will electronically review only the type of information permitted through my established user account. I will not make use of another person's user account to gain greater access.

I understand that violations of PeaceHealth's policies and procedures include, but are not limited to:

- Accessing, using, or disclosing Confidential PeaceHealth Information that is not within the scope of the services I provide to PeaceHealth, or otherwise not permitted by written policy.
- Leaving confidential information in any form in an unsecured place or environment.
- Failure to properly secure a computer workstation when leaving the immediate vicinity.
- Disclosing computer system user ID and password combinations to any unauthorized person for any reason or using another person's computer system user ID and password combination.
- Discussing Confidential PeaceHealth Information in a public place or with persons not authorized to receive such information.

I understand and agree that I am solely responsible for knowing, understanding, adhering to and complying with the terms of the above agreement as well as applicable PeaceHealth policies, policy compliance rules, and procedures regarding the confidentiality, privacy, and security of Confidential PeaceHealth Information, and the Notice of Privacy Practices adopted by PeaceHealth.

First Name MI Last Name *(please print)*

Affiliation with PeaceHealth:

☐ Employee ☐ Medical Staff Member ☐ Clinic/Physician Office Name:_____ ☐ Volunteer or Board Member

☒ Intern or Student ☐ Vendor or Contractor ☐ Other_____

Signature Date

Signature of Legally Responsible Person
(Required if above individual is under age 18) Date

Relationship of Legally Responsible Person to above individual

Effective: January 2019

Orientation Test

For Contracted/Agency Caregivers and Students

Name:_____Agency/School:_____Date:_____Score:_____

Instructions:

Caregiver/Student:

Please review the PeaceHealth Orientation Workbook then complete this open book test.
Return the completed test to your agency or school.

Agency/School:

Score the test using the Answer Key provided. Record the score in the space above.
The caregiver or student must score 100% prior to starting their assignment at PeaceHealth.
Retain this document was for a minimum of 7 years – PeaceHealth will require a copy upon request.

Questions

1. The four core Values of PeaceHealth are:
   a. Safety, Just Culture, Communication and Respect
   b. Respect, Stewardship, Collaboration and Social Justice
   c. Communication, Collaboration, Respect and Stewardship
   d. Social Justice, Just Culture, Collaboration and Respect

2. Compliance Reporting is the duty of any caregiver if they have a concern regarding hospital practices.
   a. True
   b. False

3. Which of the following is true about **ICARE**, PeaceHealth's standardized communication model?
   a. **ICARE** stands for **I**ntroduce, **C**onnect, **A**cknowledge, **R**espond and **E**xplain
   b. Use **ICARE** to build trust and develop a personal connection with patients
   c. Explain things in a way the patient understands, avoid use of medical jargon
   d. All of the above

4. Where can you locate PeaceHealth policies?
   a. Through my agency or school
   b. In a manual on my unit
   c. By going to Crossroads and clicking the drop-down menu under "My Tools"
   d. By going to Crossroads and clicking the drop-down menu under "System Resources"

5. Which of the following PeaceHealth extensions do you call (from *most* facilities) to report an emergency situation, including unlocked doors or suspicious persons, items or activities?

   a. 4111
   b. 6111
   c. 7111
   d. 9111

6. While in a PeaceHealth facility, what are your responsibilities during an emergency?

   a. Wear your ID badge at all times
   b. Remain on duty until excused
   c. Report to your supervisor/preceptor immediately for directions, assignment and questions
   d. All of the above

7. Closing all doors during a Code Red represents which step in **RACE**?

   a. Rescue
   b. Alarm
   c. Contain
   d. Evacuate

8. Where can you find information about chemicals/hazardous substances used on your unit?

   a. Safety Department
   b. Safety Data Sheet (SDS)
   c. Employee Health
   d. Emergency Management Team

9. Code 99 refers to:

   a. Aggressive individual
   b. Active threat situation involving a weapon (not an active shooter)
   c. Bomb threat
   d. Hazardous materials spill

10. Code Roam refers to:

    a. Infant/Pediatric abduction
    b. Active shooter
    c. Missing patient
    d. Aggressive individual

11. Code Gray refers to:

    a. Aggressive individual
    b. Missing patient
    c. Bomb threat
    d. Hazardous materials spill

12. In the event of an active shooter incident, what option should you consider *next* if it were unsafe to run away?

a. Run
b. Hide
c. Fight
d. Call 911

13. Only those caregivers who have received approved intervention training can respond to a Code Gray.

a. True
b. False

14. You are interacting with a patient with a known history of violence who is threatening to leave the hospital. What are appropriate actions to take? Select all that apply.

a. Continue to provide the necessary care or service, even if it means risking your personal safety
b. Attempt to stop the patient by placing yourself between the patient and the exit
c. Allow the patient to leave but contact Security and the Charge Nurse/Nurse Team Lead immediately
d. Call (or ask someone else to call) a Code Gray

15. Who is responsible for the Culture of Safety at PeaceHealth?

a. Patient and family
b. All PeaceHealth Caregivers, including contracted staff, students and volunteers
c. PeaceHealth Executives
d. Risk Management

16. When is it necessary to complete a variance report?

a. For all safety-related incidents, including harm or the potential for harm
b. For only incidents that result in injury to patient
c. For only incidents that result in injury to PeaceHealth caregivers
d. For only incidents that result in injury to either patients or caregivers

17. In the event of an injury/exposure, report it immediately to:

a. Security
b. Human Resources
c. Employee Health
d. Supervisor/Manager on site

18. Patient identification is critical to providing safe patient care and ensuring the patient receives the right care or service, in the right place, and at the right time. Which of the following statements is true?

a. When a patient has been transferred from another facility and has an ID band from that other facility, it must remain on the patient's wrist during their hospital stay at PeaceHealth
b. Patients must be positively identified using two approved identifiers every time you provide care or service
c. If an ID band must be removed, the person who removes it is responsible to ensure that the patient is reidentified and a new ID band is placed
d. b. and c.

19. What is the key expectation for preventing the spread of infection?

a. Performing hand hygiene
b. Wearing a mask in all patient rooms
c. Wearing gloves whenever touching a patient
d. Isolating all patients

20. The 5 Moments of Hand Hygiene include washing/cleaning hands before touching a patient and washing/cleaning hands after touching patient surroundings.

a. True
b. False

21. You do not need to perform hand hygiene if you wear gloves.

a. True
b. False

22. You must wash your hands with soap and water (rather than using an alcohol-based hand rub) whenever caring for, or entering the room of, a patient who has *C. difficile*.

a. True
b. False

23. Which of the following actions help to prevent the spread of infection?

a. Hand Hygiene
b. Wearing appropriate personal protective equipment (PPE)
c. Cleaning/disinfecting high-touch surfaces and patient equipment
d. All of the above

24. COVID-19 is an infectious disease spread mainly through person-to-person contact. It is important for you to:

a. Stay home if you are sick
b. Refer to the KNOW Coronavirus site on Crossroads for current policies and procedures
c. Follow PeaceHealth's PPE requirements
d. All the above

25. If you are a ***clinical*** caregiver who will provide *hands-on patient care*, please answer Question 25 ***A***.
If you are a ***non-clinical caregiver*** who may need to enter a patient room, skip to the Question 25 ***B***.

A. For clinical caregivers:

The Center for Disease Control (CDC) standard sequence for donning PPE is:

a. Gown, gloves, goggles/face shield, and respirator/mask
b. Gloves, gown, goggles/face shield, and respirator/mask
c. Goggles/face shield, respirator/mask, gown, and gloves
d. Gown, respirator/mask, goggles/face shield, and gloves

B. *For non-clinical caregivers who may need to enter a patient room:*

What should you do if you see an isolation sign outside of the patient's room

a. Knock on the door and enter the room
b. Open the door to the room but remain outside – tell the patient you won't be able to come into their room because they have an infection
c. Check with the patient's nurse, the Charge Nurse or Nurse Team Lead for instructions regarding next steps
d. Walk away and inform your supervisor that you couldn't complete your work because the patient is in isolation

Orientation Handbook for Clinical (Non-Nursing) Contracted Caregivers & Students

Our Mission

We carry on the healing mission of Jesus Christ by promoting personal and community health, relieving pain and suffering, and treating each person in a loving and caring way.

At PeaceHealth, the fulfillment of our Mission is our shared purpose. It drives all that we are and all that we do. To those who embrace the spirit of these words and our commitment to exceptional medicine and compassionate care, we offer the opportunity to learn and grow as a member of the PeaceHealth family.

Our Values

Respect
We respect the dignity and appreciate the worth of each person as demonstrated by our compassion, caring, and acceptance of individual differences.

Stewardship
We choose to serve the community and hold ourselves accountable to exercise ethical and responsible stewardship in the allocation and utilization of human, financial, and environmental resources.

Collaboration
We value the involvement, cooperation, and creativity of all who work together to promote the health of the community.

Social Justice
We build and evaluate the structures of our organization and those of society to promote the just distribution of health care resources.

Our Vision

Every person receives safe, compassionate care; every time, every touch.

Created by Clinical Education
Updated 5/16/2023

Table of Contents

PeaceHealth's Mission, Values and Vision 1
PeaceHealth Nursing and Healthcare Teams 4
Overview of Crossroads and Policies 6
PeaceHealth's Compliance Reporting Process 7
Security 8
General Safety and Emergency Management 8
Emergency Codes 9
Workplace Violence Prevention 11
Clinical Excellence and Culture of Safety 14
Patient Identification 19
PeaceHealth's Clinical Excellence Initiatives 21
Prevention of Hospital Acquired Pressure Injuries (HAPI) 21
Prevention of Catheter Associated Urinary Tract Infections (CAUTI) 21
Prevention of *C. difficile* Infections 21
Prevention of Central Line Associated Bloodstream Infections (CLABSI) 22
Prevention of Falls with Injury 22
Prevention of VTE 22
Restraints 23
Suicide Precautions 24
Medical Emergencies, Rapid Response Team, and Code Blue 24
INTELLI-OX+™ Oxygen Tanks 25
Point of Care Testing: Glucometer 25
Preventing Needlestick and Other Sharps-related Injuries 26
Hand Hygiene 27
Bloodborne Pathogens 31
Transmission-Based Precautions 31
Personal Protective Equipment 32

PeaceHealth Nursing and Healthcare Teams

Nursing Vision

PeaceHealth Nursing is a highly respected team of caring, compassionate, and courageous professionals nationally recognized for holistic, evidence-based care through advocacy, innovation and collaborative relationships with our patients, families, caregivers, and our communities.

We are pleased that you have joined us at PeaceHealth – you are a valuable member of the healthcare team! During your orientation, you will learn more about the practices that:

- Support daily work.
- Ensure consistent care based on professional standards.
- Are grounded in evidence and best practice and help us:
  - Demonstrate how we care for patients
  - Provide holistic care
- Influence the patient's experience.
- Contribute to improved patient outcomes.

Communication with Patients and Families

PeaceHealth is implementing a standardized communication model called **ICARE** to create a memorable engagement at every point of interaction with the patient/family.

Introduce
...you and others; explain roles

Connect
...in a personal way

Acknowledge
...inconveniences; Ask permission

Respond
...to the patient; listen and respond with thorough explanations

Explain
...in a way the patient understands; help set expectations

When using ICARE, you should:

- Develop your personal style to build a personal connection with patients.
- Use the ICARE communication model to build trust with patients.

This video can help you find ways to make a connection:
56 Seconds to Create a Connection - PressGaney (wistia.com)

Communication Boards

Communication Boards are in each patient's room. They keep patients, families, and care team members informed; encourage the patient and family to participate in care decisions; and communicate daily goals and nursing interventions that are part of the patient's Care Plan.

Your Preceptor will introduce you to the Communication Board and the required documentation components. Be careful not to use medical jargon on the Communication Board: it is there to facilitate communication with the patient/family so it is important to use language that they can understand.

Purposeful Hourly Rounding

(for Nursing Students, Nursing Assistants/Nursing Assistant Students)

Purposeful Hourly Rounding (PHR) is a process that structures the time the caregiver spends with the patient by using an actual or mental checklist of procedures to promote optimal outcomes in a clean, comfortable, and safe environment. It has been shown to promote safety, enhance clinical outcomes and advance the patient's care.
For PHR to be effective, it is important to collaborate with other members of the care team (such as the nurses you are working with), to ensure it happens ***hourly.*** Establish who will hourly round (and when) at the start of your shift.

Upon entering the room, perform Hand Hygiene, introduce yourself again, and explain that you are there to perform rounding. Connect with the patient and include them in the rounding process in a meaningful way.

Our Standard Work for PHR incorporates the "Six Ps" to help you remember areas of focus:

Fall	precautions maintained
Bed	locked and in low position
Room	free of clutter
Bed/Chair Alarm	on if appropriate
Call Light	within reach
Pumps	assess batteries, bags and lines

Restraints*: We monitor any patient in restraint or seclusion in alignment with regulatory requirements and the patient's individual needs.*
What this means:

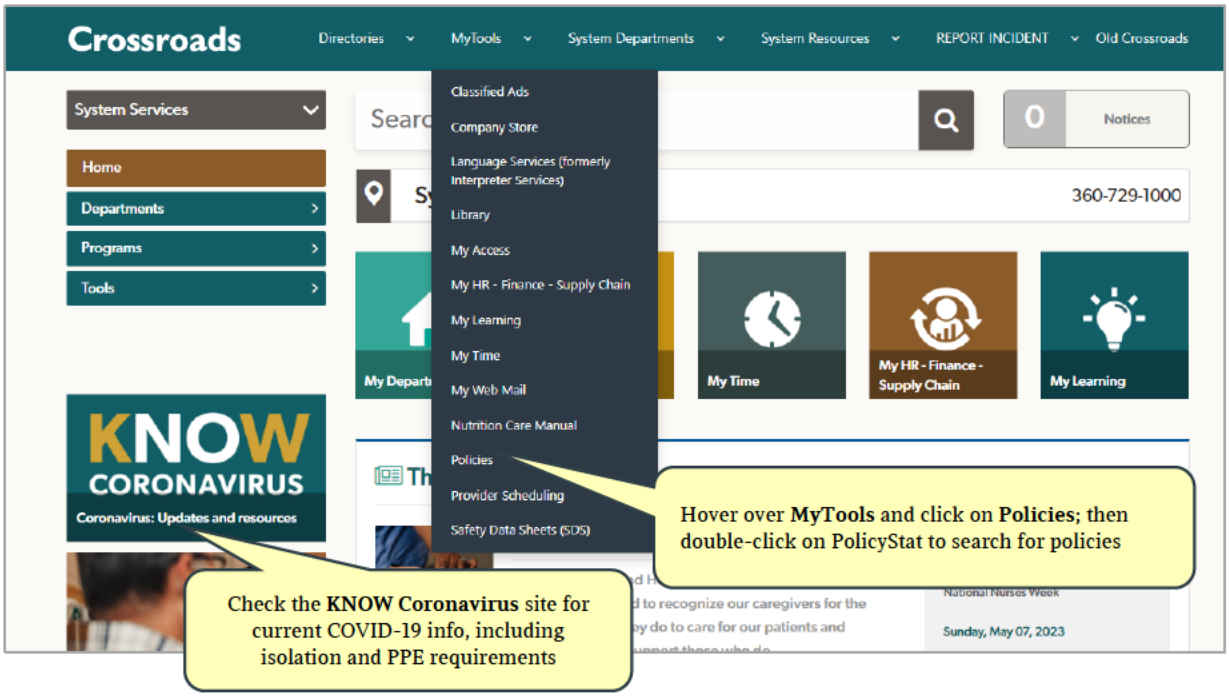
- *Nonviolent restraints:* ***monitored*** *every 2 hours via purposeful hourly rounding; documented by end of shift*
- *Violent restraints:* ***monitored*** *every 15 minutes*

Overview of Crossroads and Policies

Your daily work is guided by policies and procedures, steeped in evidence-based practice and with a commitment to Clinical Excellence. In your role, it is important for you to know how to access the tools that you need to practice safely and effectively.

Crossroads is PeaceHealth's intranet and where you will find important resources such as policies and reference documents.

To access policies, procedures, and reference documents



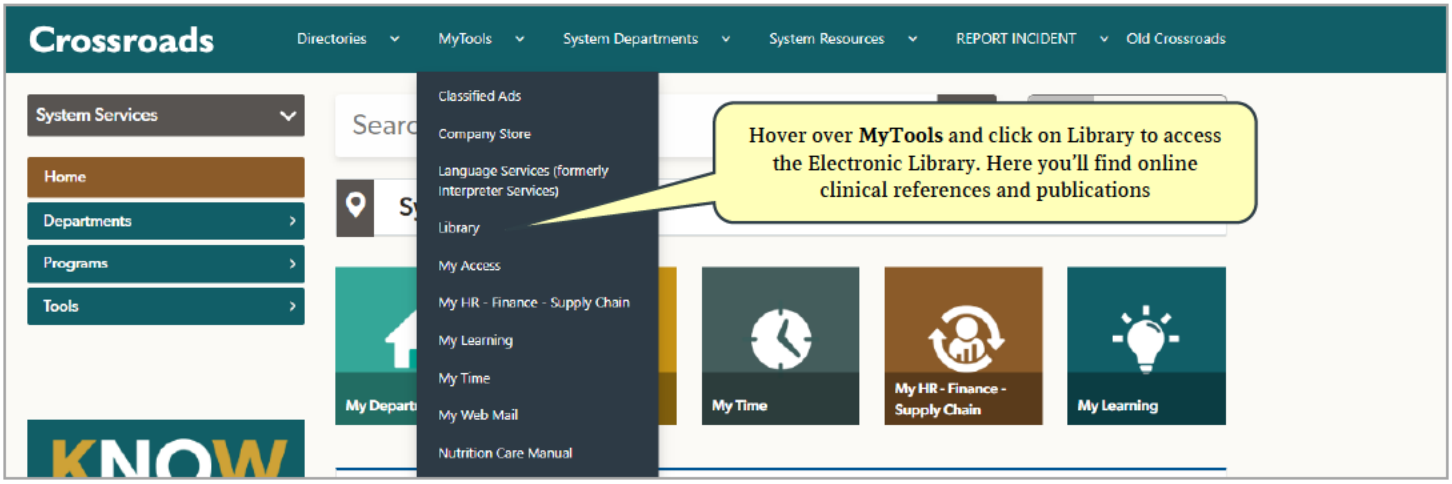
Policies to Review

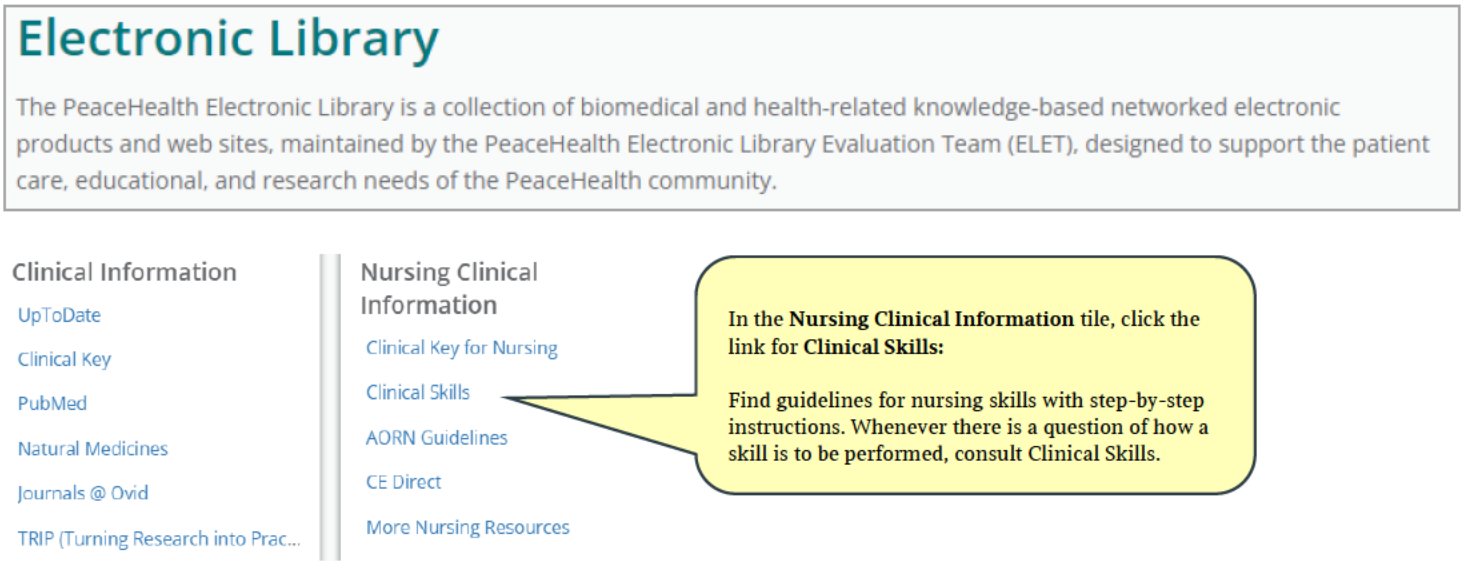
Below is a list of important policies and procedures for you to review:

- Attendance and Punctuality
- CareConnect Downtime
- Caregiver Identification
- Chain of Command
- Code Status (DNR)
- Dress and Appearance
- Identifying and Reporting Patient Abuse, Neglect, Exploitation or Misappropriation of Property
- Isolation Procedure
- Leaving Against Medical Advice
- Patient Belongings Policy/Procedure
- Patient Identification Policy
- Patient Lookup Policy
- Patient Visitation Rights and Privileges
- Procedural Verification Process
- Restraint and Seclusion
- Serious Safety Event
- Suicide Risk Screening Policy/Procedure
- Tobacco-Free, Smoke-Free Campus
- Training and Competency
- Workplace Violence Prevention

You may be instructed by your Unit/Department Manager, Supervisor, Clinical Nurse Educator, or Preceptor to review additional policies and procedures that are pertinent to your role. Many procedures are located in Clinical Skills.

Clinical Skills can be accessed via the Electronic Library





PeaceHealth's Compliance Reporting Process

When you have a concern, you have a duty to report it or to ask questions. Likewise, the Unit/Department Manager or House Supervisor/Coordinator has a duty to follow-up without retaliation. Reporting a compliance concern or problem should be as natural as picking up the phone to report a leaky pipe or a frayed carpet. When you have a question, or want to report a concern, we encourage you to refer to the following resources:

- The Unit/Department Manager or House Supervisor/Coordinator
- The Organizational Integrity Officer
- The PeaceHealth Integrity Line: (877) 261-8031 (an independent, confidential service open 24/7 except holidays)
- Online PeaceHealth Integrity Line at https://peacehealth.alertline.com

Security

The Security team is here 24x7. All caregivers are expected to report emergency situations, as well as suspicious activity, in clinical areas, common area spaces, and outside on the property (e.g., building, grounds, and parking areas). If you see something, say something!

- Emergency situations (see Emergency Codes)
- Suspicious or out of place person
- Suspicious, unattended bag or package
- Doors left unsecured

Be sure you know the correct emergency phone number to call for your facility:

- **For *most* facilities, it is extension 7111. When calling from your cell phone or a number outside the facility, first dial the area code (if needed) and prefix for your facility, followed by 7111.**
- ***Your facility may have a different emergency number*. During your first week, ask your manager, educator, or preceptor about the correct phone number to call to report an emergency.**

General Safety and Emergency Management

Electrical Safety

All electrical equipment brought into the facility by staff or patients (radios, hair dryers, fans, etc.) must be approved for use by a qualified staff member and have a dated and sticker attached.

Any electrical equipment purchased for patient care use must be inspected by Clinical Engineering/BioMed prior to use. All patient care equipment has a sticker indicating when it is due for preventative maintenance. If you find a piece of equipment that is overdue for preventative maintenance, do not use it. Ask the supervisor or other department resource to submit a work order to have it inspected.

If you suspect a patient care device is damaged or not working properly:

- Unplug the device and remove it from service
- Affix an "Out of Service"" tag
- Place it in the designated area for pick-up
- Contact Clinical Engineering/BioMed

Chemical Safety/Hazard Communication

A Safety Data Sheet (SDS) reference guide for all chemicals is available to you under the "Right to Know Act." Find out what chemicals are use in the area where you are working. SDS are posted on Crossroads under "My Tools." Review the SDS before handling any hazardous chemicals. In case of a spill:

- Act quickly!
- Wear Personal Protective Equipment (PPE)
- Contain the spill
- Notify Security if the spill is considered significant as noted in the Safety Data Sheet (SDS)
- Work with your supervisor to determine appropriateness of safe re-entry into area
- Complete a variance report in Safe2Share
- Report to the Emergency Department if exposed to a hazardous chemical
- Dispose of clean up materials following SDS and departmental guidelines

Emergency Management Plan

In the event of an emergency your responsibilities include:

- Remain on duty until excused
- Report to clinical supervisor/preceptor immediately for directions, assignment, and questions

During an emergency, remember to:

- Use stairways. DO NOT USE ELEVATORS!
- Know where exits are and what the posted evacuation plan is for your area
- Limit use of phones as much as possible
- Wear ID badge

If not on site during and emergency:

- Report to work at next scheduled time, unless otherwise directed
- Report to work if specifically instructed by an emergency text message, pager, or phone call

Emergency Codes

Please learn the following codes that are initiated by dialing the emergency number for your region/facility.
When calling from inside *most* facilities, the emergency extension is 7111.

Code Black (Bomb Threat)	▪ If you receive or identify a potential Code Black scenario, contact the emergency notification extension 7111 or call 911 (whichever is applicable to your building). ▪ Suspend use of radios and cell phones. ▪ Assist with reporting and search efforts as directed.
Active Shooter / Active Assailant **(REMEMBER: Run/Hide/Fight)**	An "active shooter" is an individual actively engaged in killing or attempting to kill people in a confined area; in most cases, active shooters use firearm(s) and there is no pattern or method to their selection of victims. How to respond to an Active Shooter/Active Assailant: ▪ Evacuate (RUN) – If safe to do so, move to a safe location. ▪ Hide Out (HIDE) – If unsafe to move, shelter in place and take actions to barricade the sheltered location. ▪ Take Action (FIGHT) – As a last resort and only when your life is in imminent danger, take an aggressive action to overcome the shooter. ▪ Notify (CALL) – As soon as it is safe to do so, call extension 7111 or 9-1-1.
Code 99 (Weapons Incident, Not an Active Shooter)	A Code 99 is an active threat situation involving a hostage, weapon, and/or less than lethal device. It may be identified by caregivers, patients, and/or visitors. If you encounter or suspect an active threat situation involving a hostage, weapon, and/or less than lethal device, activate a Code 99 by calling 7111.
Code Gray (Aggressive Individual)	Initiate a Code Gray when de-escalation techniques by unit caregivers have failed. ▪ If in a main hospital, call 7111 and ask the operator to page Code Gray. Provide operator with the location including unit/department, room number, or closet intersecting location. ▪ If in an offsite clinic or area, contact 911 for initial response. Contact Security after 911 has been notified.

	Security, the House Supervisor/House Coordinator, and Code Gray responders are expected to immediately respond to the Code Gray announcement, if available. Only those caregivers who have received approved intervention training are allowed to respond. The House Supervisor/House Coordinator and Security will assess the situation and determine if further assistance from local Law Enforcement is required.
Code Orange (Hazardous Materials Spill)	A Code Orange is called for a release (spill) that is uncontrolled or substantial. Staff working with hazardous materials are trained on spill response procedures. Before attempting to clean up any internal hazardous substance release, you must know what the material is. If an incidental spill or leak occurs, do the following: ▪ Notify your supervisor. ▪ Follow the spill cleanup directions found on the Safety Data Sheets and obtain the appropriate spill cleanup kit, if applicable. ▪ Obtain and don appropriate personal protective equipment. ▪ Ensure that all substances are absorbed, removed, etc. and placed in a labeled container that is adequate for storing the waste debris. ▪ Contact the Safety Department to identify the best disposal method.
Code Red (Fire)	**R**ESCUE: Rescue all persons in immediate danger, giving priority to patients, and move them to a safe area. Close doors behind you. **A**LARM: Activate the nearest fire alarm pull station AND report the fire by calling 7111 or 911 (whichever is applicable to your building). Notify dispatch and give exact location of the fire or smoke and describe extent of fire, if known. **C**ONTAIN: Close all doors. **E**XTINGUISH OR **E**VACUATE.
Code Amber (Infant / Pediatric Abduction)	Unit/department specific response training will be provided during your orientation. Clinical staff members assigned to work in a PeaceHealth inpatient labor and delivery, nursery, neonatal intensive care, and pediatric units/departments are provided additional training on unique mitigation, prevention, response, and recovery activities for their area. This training is reinforced through drills.
Code Roam (Missing Patient)	If one of your patients/clients is missing, call Security at 7111. In hospital buildings, notification of all onsite caregivers will occur through the use of a Code Roam overhead page. ▪ There will be a search of the facility by designated caregivers in an effort to locate the patient/client. ▪ Local law enforcement will be notified if the missing patient or client is at risk of harm to themselves or others.
Trauma Alert	In the hospital, a Trauma Alert is activated in the ED so that the Trauma Team is alerted to begin receiving patients. You will hear and overhead announcement (example: "Trauma Alert; Trauma Team report to the Emergency Department"), repeated x3.

Code Triage (Critical Incident/Leadership Briefing)	Activating a Code Triage should be done when there is knowledge or validated information of a major compromise to hospital business operations. Reasons to activate a Code Triage are, but not limited to, events such as Mass Casualty Surge Event, major facility compromise, life safety event in or near the hospital. ▪ Leaders will respond to Incident Command for further instructions. ▪ Leaders will communicate the information and mitigation strategies back to their unit/department staff.
Rapid Response Team (RRT)	Call Security at 7111 to activate the RRT if a patient, visitor, or caregiver has: ▪ Respiratory Rate (RR) < 8 or > 30 breaths per minute. ▪ Threatened airway or persistent change in oxygen saturation (SpO2) < 90% with O2. ▪ Acute change in level of consciousness (LOC), lethargy or seizure. ▪ Signs or symptoms of stroke. ▪ Heart Rate (HR) < 40 or > 120bmp. ▪ Systolic Blood Pressure (SBP) < 90 mmHg or > 200mmHg. ▪ Urinary output < 50 ml in 4 hours. ▪ Change in patient coloration: lips, face, or limbs pale, dusky or blue. ▪ Family or staff member worried about patient's status/condition. ▪ New onset or unrelieved acute pain.
Code Blue	In the hospital, call Security at 7111 to activate a Code Blue if a patient, visitor, or caregiver is not breathing or and/or does not have a pulse. ▪ Provide details, including name of patient, unit/department, location (room number, hallway, etc.) and whether this is an adult or pediatric patient. ▪ You will hear an overhead announcement (example: "Code Blue, ICU"), repeated x3. ▪ A Code Blue team trained in Advanced Cardiac Life Support will respond.

Check with your supervisor for directions regarding code initiation specific to your assigned unit/department.

Workplace Violence Prevention

It is the policy of PeaceHealth to provide a safe and non-intimidating work environment. PeaceHealth is committed to taking any act of violence seriously and prohibits all conduct, either verbal or physical, that is abusive, threatening, intimidating, or demeaning.

The responsibility for a workplace free of violence and aggression is a shared responsibility - a vital partnership between all who practice and/or provide service for PeaceHealth.

Patient Belongings and Weapons Screening

PeaceHealth has implemented a weapons screening procedure at most facilities. Where this is in place, all patients (with the exception of NICU patients) are screened for weapons upon entry to the facility. The weapons screening procedure is limited to disclosure by the patient or the patient's representative, UNLESS they fall into a category that requires their belongings to be secured. In other words, we cannot inspect or store patient belongings without appropriate cause. Find out if your facility has a weapons screening procedure in place and, if so, learn what your role is in the process.

Identifying Known Aggressive or Potentially Violent Persons

Prior to patient interaction, look for FYI flags (in CareConnect) that may indicate a history of or potential for violence. These include a Special Treatment Plan FYI flag or a Security Alert FYI flag:

In addition, the patient's door will have a magnet or sign indicating there may be a potentially harmful situation with the patient and/or family. See examples at right. If you see this magnet or sign, contact the primary nurse or Charge Nurse/NTL prior to entering the patient's room to learn about interventions put in place to prevent patient aggression towards caregivers. If you feel that an FYI flag and a magnet/sign is needed for your patient, please contact your Charge Nurse/NTL, Nurse Manager, or House Supervisor/Coordinator.

When caring for or interacting with a known aggressive or potentially violent person, consider engaging Security as a precautionary measure.

Recognize when a Person is Entering into Crisis and their Behavior is Escalating

PeaceHealth provides training licensed by the Crisis Prevention Institute (CPI)® - the training is available through MyLearning online modules as well as instructor-led classes. The core philosophy behind this training program is to maintain the best CARE, WELFARE, SAFETY, and SECURITY of everyone involved in crisis situations.

Understanding the phases of the Crisis Development Model, and recognizing behaviors associated with each, is the first step in crisis prevention and keeping yourself and others safe. Your responses and actions might positively or negatively contribute to escalating or de-escalating a crisis. Below are the phases and appropriate caregiver response.

Anxiety: during this first phase of the Crisis Development Model, you may observe a change in behavior or anxiety, nervousness, and repetitive nonverbal behaviors (such as pacing, crossed arms, grinding teeth, biting lip or fingernails, clenching fists, etc.). Your response is to be supportive. Offer the person a chance to explain, listen, and acknowledge their feelings/concerns. Use an empathetic, non-judgmental approach.

Defensive: during this phase, the individual begins to lose rationality. You may notice that the person becomes belligerent, asks challenging questions, or releases anger verbally (i.e., raising their voice, shouting) or nonverbally. Your response is to be directive, provide clear instructions, and set expectations. Request their cooperation and use some of the de-escalation techniques below.

Risk Behavior: during this phase, the individual loses control, resulting in physical behavior that could pose a risk to self or others. Your response is to call for help. Call a Code Gray or ask for someone else to call for you.

Tension Reduction: after a crisis, the person will experience a decrease in physical and emotional energy. The person regains rationality and their physical energy drops. They may begin to cry or apologize. Your response is to establish therapeutic rapport and try to re-establish communication with the person. Demonstrate empathy, avoid blame, and give reassurance.

De-escalation Techniques

- ✓ Assess the situation. If you see signs or symptoms of a person entering into crisis, intervene early.
- ✓ Identify triggers that cause the person to escalate.
- ✓ Maintain a calm, professional demeanor and voice.
- ✓ Be aware of yourself (your tone, attitude, position, posture, facial expressions, and nonverbal behaviors).
- ✓ Avoid being argumentative or emotional. If you find yourself becoming emotional, leave the situation and ask another caregiver to intervene.
- ✓ Be empathetic to the person's situation.
- ✓ Use problem solving with the individual.
- ✓ Be clear: use simple language.
- ✓ Offer choices.
- ✓ Give the individual time to think.
- ✓ Don't respond to challenges and power struggles.
- ✓ Set clear behavioral expectations, to include the consequences.
- ✓ Sometimes you have to agree to disagree.
- ✓ (Depending on your facility) Activate the Action Response Team (ART) early on so you can develop a plan of care for this patient.
- ✓ Activate a Code Gray if the situation escalates.

If met with verbal or physical aggression…

- Don't crowd the individual – respect their personal space and "comfort zone"
- Reconsider the task that you were about to perform: is this the right time to do it or can it be postponed?
- Be aware of your surroundings
  - Are there objects the person could use to hurt you or themselves?
  - Do you have a safe path to exit the room and get help if needed?
- Never place yourself between the person and the door if they are trying to leave
  - Let them go
  - Call Security at x7111 and the patient's physician immediately

Code Gray Process

Call a Code Gray when the potential for imminent danger to self or others is high and/or de-escalation attempts are unsuccessful:

1. Personal Safety is a top priority! Remove yourself and others from an unsafe situation
2. Get Help:
   - Follow your Chain of Command (Charge Nurse/NTL, Nurse Manager, House Supervisor/Coordinator)
   - Call (or delegate call to) Security at #7111 to initiate Code Gray. Provide details such as location, situation, who's involved, etc. Stay on the line until Security ends the call (if possible)
3. Secure the Environment:
   - Close doors to other patients' rooms and secure the perimeter as appropriate
   - If safe, remove items that could be used as a weapon (i.e., scissors or other sharps, eyeglasses, jewelry, name tags, food trays, etc.)
4. When the Code Gray Team arrives:
   - The identified Team Leader will debrief responders re: the situation and delegate roles/responsibilities
   - The Team will develop a plan and implement response
5. The nurse will notify the patient's physician; document; complete a Safe2Share; communicate to next shift
6. Debrief the Code Gray:
   - Is everybody OK? Check in the moment. Initiate a Safety STOP if appropriate
   - Is an Action Response Team (ART) meeting needed?
   - How well did we follow the process? Any learnings for next time?

If you or a co-worker are injured because of workplace violence…

- Notify your Manager, Supervisor or Charge Nurse/Nurse Team Leader right away
- Call a Safety STOP or have someone call one for you
- Seek medical attention as appropriate
- Complete a variance report as soon as you are able – there is a dedicated icon in Safe2Share for this
- Mobilize resources for emotional support, including Employee Assistance Program, Pastoral Care, Workplace Violence Prevention Committee, etc.

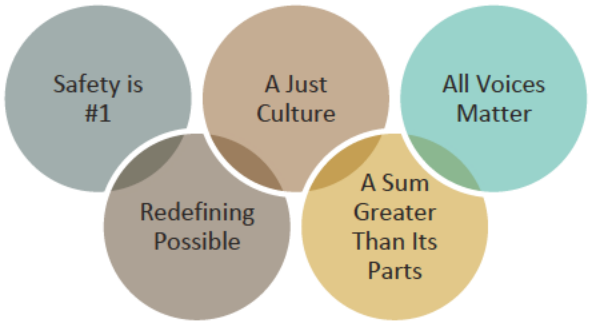
Safe2Share tile for reporting Workplace

Workplace Violence Prevention Resources on Crossroads

Many facilities have a Crossroads page dedicated to Workplace Violence Prevention. Ask your Preceptor or Nurse Manager how/where to locate resources for your hospital.

Clinical Excellence and Culture of Safety

Organizations with a Culture of Safety maintain a commitment to safety at all levels, from frontline caregivers to managers and executives.



In fulfillment of our shared mission, we work together at every level to achieve our priorities in Clinical Excellence – raising the bar to achieve 100% Perfect Patient Care, Always–Every Touch, Every Time. Safety is priority #1 and is everyone's job.

Just Culture

Just Culture is a values-supportive system of shared accountability. It is a culture that holds organizations accountable for systems they design and for how they respond to staff behaviors fairly and justly. There are four components of a Just Culture:

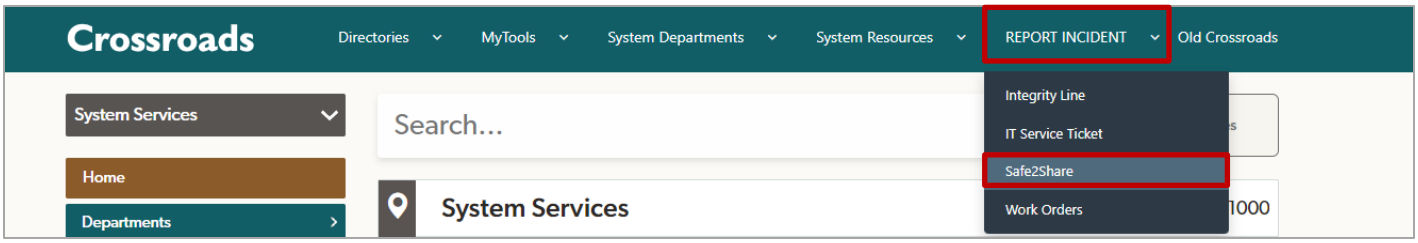
Managing Behavioral Choices:

- **Human error** - inadvertent action; inadvertently doing other than what should have been done such as a slip, a lapse, or a mistake (e.g., dosage calculation error). These behaviors may lead to a consultation.
- **At risk/drift behavior** - choice that increases risk where risk is not recognized or is mistakenly believed to be justified. Makes us more prone to human error (e.g., skipping an important step in a process). These behaviors may lead to a consultation or coaching.
- **Reckless behavior** - choosing to consciously disregard a substantial and unjustifiable risk (e.g., texting while driving impaired or intoxicated). These behaviors will lead to disciplinary action.

The more we understand contributing factors to medical errors and mistakes, the more successful we will be in eliminating risk. That is the rationale behind having a variance reporting system, an escalation pathway, and the Safety STOP program in place.

Variance Reporting

Safe2Share is PeaceHealth's variance reporting system. You can access it from Crossroads via the drop down under Report Incident:



- A variance report must be filed when there is a safety-related incident, including harm (or the potential for harm) to a patient, visitor, or caregiver.
- Variance reports must be to be completed promptly.
- The person most directly involved in an incident, or the person who first discovers the incident, is responsible for completing the variance report.
- Variance reports may be submitted anonymously.
- Variance reports are highly confidential and are not to be copied for any reason.
- The information contained in the variance report may be used only for risk management purposes and may not be used for any other purpose including peer review or employee corrective action.
- Variance reports are not a part of the patient medical record, and no mention of a variance report should be documented in the medical record. Only the facts of an incident involving a patient are to be recorded in the medical record.

In the event of a safety incident, including a "near miss:

- Follow the Pathways for Escalating Hospital Safety Concerns.
- Call a Safety STOP for serious safety events (i.e., the "29 Never Events") to mobilize support, identify and implement countermeasures, and eliminate preventable harm.

Pathways for Escalating Hospital Safety Concerns

Pathways for Escalating Hospital Safety Concerns

At PeaceHealth, all caregivers are empowered to speak up *any time* there is a safety issue. To ensure the right resources are deployed and concerns receive the quickest, most appropriate response it is critical that caregivers **use one or more of the escalation pathways that fit the situation**.

Call Rapid Response Team or Code

When there is a **patient emergency**.

Use standard processes.

Use chain of command

- When there is an immediate threat requiring **medical intervention** or
- Standard of care is not being met or
- **Medical attention** and/or clarifying orders are needed.

Follow your facility's chain of command procedure. (Crossroads>MyTools>Policies).

Reach out to a leader

To address an **operational issue** that is presenting a barrier to daily readiness/patient flow, including:

- Transfers/admission/discharge.
- Delays in resolving earlier service tickets for biomed, TSP or facilities.
- Broken equipment.
- Staffing.
- Supplies.
- Policies.

Options:

- Talk with charge nurse, team lead, manager or house supervisor/ coordinator.
- Share an improvement idea.
- Submit a service ticket or work order (TSP, biomed, facilities).
- Call the Integrity Line: 877-261-8031.
- Escalate through the tiered-huddle system: Unit huddle>facility huddle> network/division huddle>system huddle *(Ask for status update after 48 hours).*

Call a

Safety STOP

When there is a safety event involving **harm or the threat of imminent harm** to a patient or caregiver. All caregivers are empowered to call a Safety STOP.

1. Initiate a Safety STOP by calling the operator or code phone line.
2. Notify on-duty charge nurse/supervisor immediately.
3. All involved remain in the area until dismissed by the responding team.
4. Participate in the investigation as requested.

Safe2Share Report

In addition to escalating through one or more of the above pathways, **complete a Safe2Share report for *all* safety issues: Crossroads>Report Incident.**

Safety STOP

29 "Never Events"

100% Perfect Care, Zero Harm **National Quality Forum Serious Reportable Events in Healthcare**	
Surgical or Invasive Procedure Events	▪ Surgery or other invasive procedure performed on the wrong site ▪ Surgery or 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 ▪ The use or function of a device in patient care, in which the device is used or functions other than as intended ▪ 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, or resulting from: ▪ 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) ▪ Unsafe administration of blood products ▪ A fall while being cared for in a healthcare setting ▪ The irretrievable loss of an irreplaceable biological specimen ▪ Failure to follow up or communicate laboratory, pathology, or radiology test results or ▪ 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 ▪ Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting ▪ Artificial insemination with the wrong donor sperm or wrong egg
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 ▪ A burn incurred from any source in the course of a patient care process in a healthcare setting ▪ The use of physical restraints or bedrails while being cared for in a healthcare setting or ▪ 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
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

Patient Identification

Proper patient identification is an essential component of patient safety. We want to ensure each patient is in the right place and receiving the proper care. **It is PeaceHealth policy that, in accordance with safe patient care practices, patients must be positively identified with two approved identifiers (first and last names and DOB) every time caregivers provide care.** Key elements of the Patient Identification Policy include:

- All patients have ID bands placed upon admission by Patient Access or clinical caregivers.
- For patients transferred from another facility, the armband(s) from the other facility must be removed.
- Prior to placing the ID band, the caregiver verifies information by asking the patient to state and spell their first and last name and date of birth (stating the birth month by name, not by number); the patient's response is then compared to the information on the ID band.
- If patient's name or date of birth needs to be corrected because they were entered incorrectly at time of admission, contact Patient Access for support to correct.
- If an ID band must be removed, the person who removes it is responsible to ensure that the patient is re-identified, and a new ID band is placed.
- Every caregiver is required to check patient identification prior to providing services. Examples include:
  - Upon admission, transfer and change of shift
  - When collecting specimens (labeling in the presence of the patient whenever possible)
  - When administering medications or blood products
  - Prior to an invasive or diagnostic procedure
  - Prior to transport to/from a procedure
  - Prior to handing documents containing identifying information (e.g., paper prescriptions, After Visit Summary, consent forms) to a patient

Patient identification bands include:

- A patient label with bar codes used for patient identification, medication/blood administration and specimen collection.
- Standardized color clips used as visual clues.

Nursing validates the correct band and clips are placed on the patient:

- On admission:
  - During initial assessment, the nurse assesses factors associated with:
    - ✓ Fall risks
    - ✓ Allergies
    - ✓ Latex Allergy
    - ✓ Limb Alert (restricted extremity)
    - ✓ Do Not Resuscitate (DNR)

- At the beginning of the shift and at time of transfer (during Bedside Shift Report and hand-off):
  - Any changes in orders and/or status that may impact the band or clip color(s), the nurse will either:
    - ✓ Add a new clip
    - ✓ Remove the old band and replace it with a new one that has the correct clips attached

				
Allergies to: ▪ Drug(s) ▪ Food ▪ Environmental	Allergy to latex	Fall alert Implement fall bundle interventions	Restricted extremity movement, (i.e., mastectomy, fistula, or new pacemaker placement)	Order for Do Not Resuscitate (DNR)
Continue reviewing allergies with patient	Place sign on door	Educate patient and/or family to call for help getting out of bed	Restricted IVs, BPs, or blood draws (i.e., fistula)	Confirm provider's orders concerning code status: Full Code or Do Not Resuscitate (DNR)
Refer to EHR for specifics	Indicate allergy on patient's Communication Board	Indicate risk on Communication Board Label patient's door	Continue placing signs at the head of the patient's bed or on their door	

Another clip needs to be added	A clip needs to be removed
▪ Confirm the change with the patient (family) and with the medical record ▪ Retrieve the correct color clip ▪ Apply the clip to the patient's wrist band ▪ Educate the patient and family to the new clip ▪ Include the change in hand-off communication with other caregivers	▪ Confirm the change with the patient (family) and with the medical record ▪ Retrieve a new wrist band and add ALL the correct color clips needed ▪ Remove the old band from the patient's wrist ▪ Apply the new band to the patient ▪ Educate the patient and family to the change ▪ Include the change in hand-off communication with other caregivers

Patient Identification Resources and References

- Patient Identification Policy
- Patient Look-up Policy / Procedure

PeaceHealth's Clinical Excellence Initiatives

100% Perfect Care, Zero Harm

Prevention of Hospital Acquired Pressure Injuries (HAPI)

(for Nursing Students, Nursing Assistants/Nursing Assistant Students)

Nursing Students, Nursing Assistants / Nursing Assistant Students and play an important role in preventing pressure injuries by:

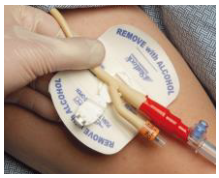
- Helping a patient to ambulate if they are able.
- Turning and repositioning a patient when they need assistance.
- Using caution when transferring a patient to a bed/gurney to reduce the chances of "shearing" the skin.
- Keeping a patient's skin clean and dry.
- Minimizing the use of bed linens.
- Assisting with feeding to promote nutrition.
- Reporting any changes in the patient's skin to their nurse IMMEDIATELY.

Prevention of Catheter Associated Urinary Tract Infections (CAUTI)

(for Nursing Students, Nursing Assistants/Nursing Assistant Students)

Nursing Students, Nursing Assistants / Nursing Assistant Students play an important role in preventing CAUTI by:

- Assisting a nurse during catheter insertion.
- Checking to ensure the securement device and red seal are in place.
- Ensuring there are no kinks or dependent loops in the catheter tubing.
- Clipping the green clip to the sheet.
- Ensuring the drainage bag is always lower than the level of the bladder but never touching the ground.



- Emptying drainage bags (using a clean container labeled with the patient's name):
  - Q shift
  - Prior to patient transport
  - Whenever the volume is ≥ 1000 ml
  - Use clean container labeled with pt. name to empty bag
- Measuring/recording I/O's.
- Performing peri-care and catheter care.
- Notifying the patient's nurse if the patient has an elevated temperature or is reporting any pain.
- Discontinuing a catheter when instructed by the nurse.
- Helping patients with toileting after a catheter has been removed.

Reducing Incidence of *C. difficile* Infections

(for Nursing Students, Nursing Assistants/Nursing Assistant Students)

Patients are sometimes inappropriately tested for *Clostridium difficile (a.k.a. 'C. diff)* infection, leading to misdiagnosis and unnecessary treatment. Treatment with antibiotics can cause untoward side effects, prolong a patient's hospital stay and increase the cost of their care. Notify the patient's nurse if the patient has any loose or liquid stools and describe its appearance. The nurse can then consult with the patient's provider regarding testing for *C. diff.*

Prevention of Central Line Associated Bloodstream Infections (CLABSI)

(for Nursing Students, Nursing Assistants/Nursing Assistant Students)

Central Line Associated Bloodstream Infections (CLABSI) occur when organisms enter the patient's bloodstream through or around a central line. You may be asked to perform daily CHG bathing for patients with a central line.

Prevention of Falls with Injury

(for ALL caregivers)

Fall prevention strategies include nursing assessment tools, Universal Fall Precautions, Individualized Fall Interventions, and other tools/processes aimed at keeping patients safe.

Many caregivers play a crucial role in preventing patient falls by:

- Looking for falls risk identifiers: Communication Board in room, DMS board or huddles, ID band color coding for moderate- or high-risk, etc.
- Reminding patients to call for assistance before getting up.
- Never passing by a call light without responding.
- Helping patients with toileting.
- Participating in Purposeful Hourly Rounding, including a Patient Safety Check each time.
- Maintaining a clean, safe environment, free of clutter and tripping hazards.
- Ensuring the patient has assistive devices (eyeglasses, cane, etc.), phone and call light within reach.
- Keeping bed in lowest position with siderails up.
- Placing/repositioning floor mats, if requested by patient's nurse.
- Ensuring the bed/chair alarm is on, if indicated.
- Assisting with mobility as directed by the patient's nurse.
- Assisting the patient with toileting and showering.
- Notifying the patient's nurse of any changes in the patient's condition.
- Reporting a patient fall IMMEDIATELY.

When getting a patient out of bed, press the "alarm silence button. **Do not turn off the alarm!**

Safe Patient Handling (SPH)

(for all caregivers who will mobilize patients)

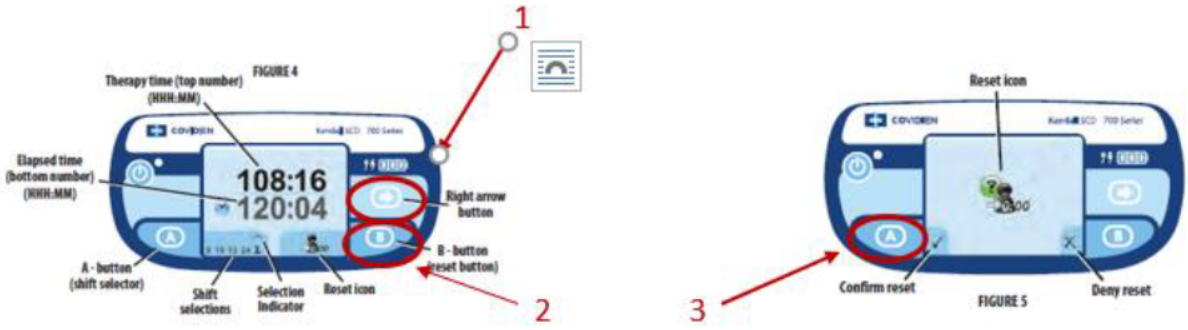
Across the globe, caregivers and patients are injured each year in the process of patient transfer or ambulation. Patients can fall while we are moving them. In addition to causing pain and suffering, this can lead to other complications that lengthen their recovery and prolong their hospital stay. For a caregiver, even a minor injury can result in needless discomfort, decreased ability to perform ADLs, and loss of time from work. Serious injuries can result in permanent pain and disability. Most of these injuries are PREVENTABLE by exercising good body mechanics and using Safe Patient Handling (SPH) lift equipment and slings correctly. During your orientation you will learn about the SPH lift equipment available at your facility. Be sure to use the lift equipment appropriate to the patient situation – the BMAT can help you determine the right type of lift equipment to use. **Never use equipment that you are unfamiliar with and have not been trained to use.** Ask your Preceptor or a unit based SPH "Super User" to show you how to use it and to validate your competency.

VTE Prevention

(for Nursing Students, Nursing Assistants/Nursing Assistant Students)

PeaceHealth has implemented evidence-based strategies for the prevention of venous thromboembolism (VTE), also known as blood clots. These strategies include:

- Mobilizing patients to prevent blood clots.
- Sequential Compression Device (SCD) monitoring:
  - Best practice for SCD wear-time: ≥ 18 hours per day
  - Compliance monitoring software is available on SCD machines



1. Press the right arrow button to access the wear time (the top number is the wear time and the bottom number is the elapsed time)
2. Press the B button to clear
3. Press the A button to confirm

Restraints

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, require a provider's order, and must be discontinued at the earliest possible time. Restraints are only used as a last resort when all other alternatives have been tried and failed. Alternatives to reduce the need for restraints include:

Physical	Environment	Emotional
Manage pain and discomfort	Provide calm environment	Encourage family participation in care
Ensure adequate sleep; discourage sleep during the day	Adapt the environment to needs	Provide familiar items and routines
Treat underlying medical condition	Early and Progressive Mobilization	Provide simple activities for diversion, e.g., folding washcloths
Provide sensory aids	Protective Care Staff to engage patient with activities and mobilization	Utilize spiritual and volunteer services
Prevent/treat delirium	Reassess need for (or disguise) the irritating agent	Involve social work for discharge planning
Ensure hydration and toileting needs are met	Structure and Routine	Frequent status updates and clear expectations

If restraints are necessary:

- Follow the Restraint policy - note the different requirements for patients in Non-Violent Restraints vs. Violent Restraints.
- Monitor the patient for signs of physical and psychological distress – if present, notify the nurse IMMEDIATELY and implement first aid (if appropriately trained).
- Document monitoring in the appropriate Flowsheet in the EHR.
- Notify the patient's nurse IMMEDIATELY if there are any changes in the patient's condition.

Suicide Precautions

(for Nursing Students, Nursing Assistants/Nursing Assistant Students)

You may be asked to be a "sitter" for a patient who is at risk for suicide. Work with the patient's nurse to remove any items from the environment that could be used by the patient to injure themselves or others:

- All patient belongings
- Plastic bags (replace with paper bags)
- Detachable monitor cables (not in use)
- Oxygen tubing (not in use)
- Oxygen tanks
- All unused equipment or electrical cords
- All extra linen or gowns
- All non-attached hand sanitizer
- Non-attached patient soap dispensers
- SaniCoths / bleach wipes and containers
- All other chemicals
- Unsecured sharps containers
- All other sharps (i.e., scissors)
- Extra chairs
- Clothes hangers
- Patient telephone/cords
- All loose items on stands or overhead tables
- Glass or metal silverware

Monitor the patient closely – never leave them unattended. Report any changes in behavior to the nurse IMMEDIATELY.

Medical Emergencies, Rapid Response Team and Code Blue

Review the non-clinical and clinical emergency codes used in your facility. Be sure you know how to activate a code and how to respond in the event of an emergency.

Many facilities have a Rapid Response Team (RRT): a group of specially trained clinicians who are available to respond to potentially life-threatening situations involving a patient, family member/visitor or caregiver. They can evaluate the individual and determine the next course of action to take. Activate the RRT for:

- Respiratory Rate (RR) < 8 or > 30 breaths per minute.
- Threatened airway or persistent change in oxygen saturation (SpO2) < 90% with O2.
- Acute change in level of consciousness (LOC), lethargy or seizure.
- Signs or symptoms of stroke.
- Heart Rate (HR) < 40 or > 120bmp.
- Systolic Blood Pressure (SBP) < 90 mmHg or > 200mmHg.
- Urinary output < 50 ml in 4 hours.
- Change in patient coloration: lips, face, or limbs pale, dusky or blue.
- Family or staff member worried about patient's status/condition.
- New onset or unrelieved acute pain.

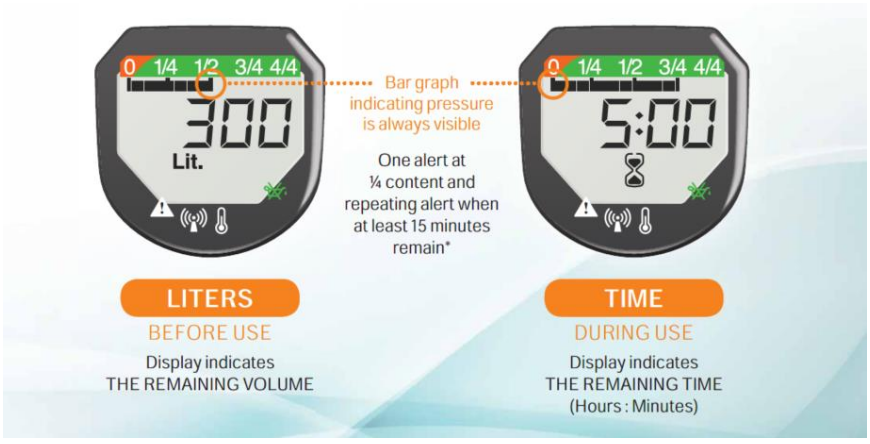
Remember: if you're worried about a patient, family member/visitor or caregiver, activate the Rapid Response Team. It is never a bad call if someone is in distress or meets the clinical criteria above. The RRT can be a resource if you are not sure what to do or who to call.

Be prepared to respond in the event of a Code Blue:

- Identify the location of the Code Cart on your unit.
- Review the contents of the Code Cart so you can quickly find supplies/equipment during a Code Blue.
- Know how to use the defibrillator and pads.
- Actively participate in Mock Code exercises on your unit.

INTELLI-OX+™ Oxygen Tanks

We use INTELLI-OX+™ O_2 tanks at PeaceHealth facilities. The digital display allows you to see a bar on how much volume of gas in is the cylinder, in addition to a digital read out. Instead of PSI, it reads liters left in the cylinder. The regulator calculates and displays the remaining time in the cylinder for the patient's specific liter low. There are repeating visual and audible alerts at ¼ content remaining and at 15 minutes of the selected flow rate remaining. The 15-minute alert will repeat every 15 seconds until the cylinder is empty or turned off. **Note: the alert is quiet and may be difficult to hear! Do not rely on an alert to let you know when a tank is running low: monitor the tank closely during use.**



REMINDER: Follow your facility's procedures to ensure safe storage of O_2 and all medical gas cylinder tanks.

Point of Care Testing: Glucometer

(for Nursing Students, Nursing Assistants/Nursing Assistant Students)

Nurses and other caregivers often perform testing at the patient's bedside (a.k.a., "point of care"). Regulatory agencies and PeaceHealth policy require that you be trained and competency-validated to perform this testing to ensure the accuracy and reliability of results.

Capillary blood glucose testing, using the NOVA meter, is one of the most common tests done in the hospital.

1. Login using you employee ID#.
2. Scan the bottle of test strips and the patient ID band.
3. Select the sample site on the side of finger pad.
4. Clean the site with an alcohol prep wipe; dry with gauze.
5. Use a lancet to poke the side of the finger:
   - Do not "milk: the finger.
   - Wipe away 1st drop of blood.
   - Apply steady pressure for 2nd drop of blood.
6. In the horizontal position, place strip to the side of the blood drop and allow fill by capillary action.
7. Review test results.
   - If the results don't seem right to you, are inconsistent with the patient's clinical picture, or represent a critical high or low value, tap "Reject" and obtain a second sample to confirm.
8. Disinfect the glucometer using a disinfecting wipe and allow appropriate contact time per instructions on the cannister.
9. Dock the glucometer to upload results to the patient's record.

Expires:
6
months
after
opening

Expires:
3
months
after
opening

Preventing Needlestick and Other Sharps-related Injuries

Sharps injuries can have short- and long-term effects. Most sharps injuries are preventable! Follow these simple steps to keep you and others safe:

- Visually inspect the patient care area for loose needles in the linen, on counters, sinks, computer keyboards, around and in trash cans, etc.
- AVOID:
  - recapping contaminated needles. Use a one-handed scoop method if needed.
  - passing uncapped needles or other sharps to other caregivers.
- NEVER stick your hand into a sharps container or fill a sharps container past the fill line.

Evaluate	Inspect	Inspect	Check
Look to make sure all sharps are fully contained in the sharps container prior to emptying and replacing	Carefully inspect bed linens prior to changing Inspect food tray prior to removal	Inspect computer station prior to cleaning	Check for sharps on floor prior to cleaning

If you do sustain a needlestick or other sharps-related injury:

- Clean the wound with soap and water. If splashed in your eyes, irrigate with water using the eyewash station.
- Report the incident immediately to your Manager/Supervisor or, if after hours, the House Supervisor or House Coordinator.
- Complete a variance report in Safe2Share.
- Within 2 hours of exposure. Contact Employee Health. If more than 2 hours have passed, contact the House Supervisor or House Coordinator.
- Participate in follow-up care as directed by Employee Health.

Hand Hygiene

Hand hygiene is a key expectation in patient safety and a PeaceHealth Clinical Excellence Initiative for reducing healthcare associated infections. It is the responsibility of every caregiver to utilize appropriate hand hygiene practices- every time, every touch.

At PeaceHealth, our hand hygiene program follows the World Health Organization (WHO) and Centers of Disease Control (CDC) standards to "wash-in" or gel when entering a patient room and "wash-out" with either gel or soap and water when leaving. We also use soap and water any time our hands are visibly soiled. These standards help reduce the potential for hospital outbreaks.

Hand Hygiene Technique with Alcohol-based Hand Sanitizer

(for when hands are NOT visibly soiled)

Rub the hands together, covering all surfaces of the hands and fingers with antiseptic rub.

Duration of the entire procedure: 20-30 seconds

Apply a palmful of the product in cupped hand, covering all surfaces;

Rub hands palm to palm;

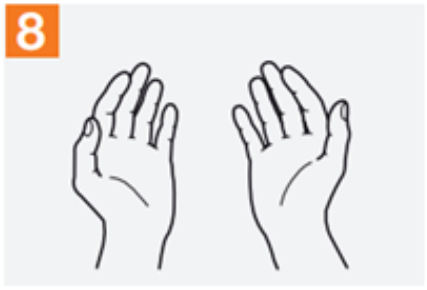
Right palm over Left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

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

Rotational rubbing, backwards & forwards with clasped fingers of Right hand in Left palm and vice versa;



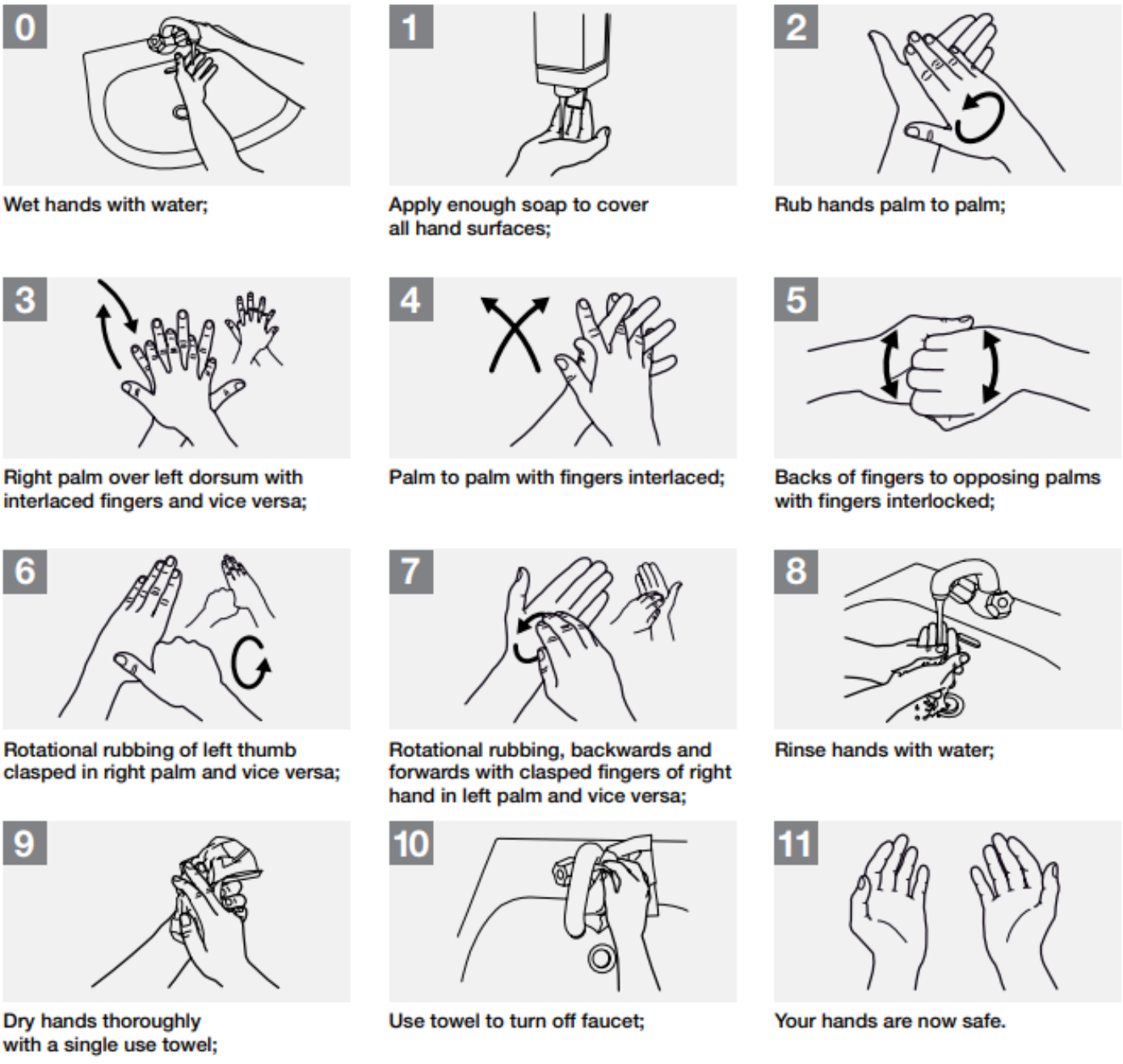
Once dry, your hands are safe.

Hand Hygiene Technique with Soap and Water

(use when hands are visibly soiled or when caring for a patient on Contact Enteric Precautions)

Apply friction making sure you perform all listed movements. Don't forget to clean around and under fingernails.

Duration of the entire procedure: 40-60 seconds



REMEMBER: you must ALWAYS wash your hands with soap and water when caring for a patient on Contact Enteric Precautions (e.g., a patient with a *C. difficile* infection).

BioVigil

Everyone who provides direct patient care or enters patient rooms is expected to wear BioVigil badges. BioVigil is an electronic hand hygiene reminder system, to ensure our clinicians and caregivers always have clean hands. The badge turns green (clean), yellow (reminder to wash) or red (stop and wash now) to show the caregiver's hand hygiene status.

If a badge loses power, the hand will go dark. If a badge is broken, the hand will turn red.
If you suspect that your badge isn't working, **return it to the base station.** The base stations run continuous diagnostics and will not allow an unhealthy badge to be checked out.

Recording Hand Hygiene Events with use of Hand Sanitizer:

- Bring a closed, cupped hand to the badge while there is still some moisture from the sanitizer.
- The badge detects the alcohol, the shadow of the hand, and the presence of the hand.
- It is not necessary to touch the badge- hover about ½ inch from it.
- Avoid oversaturating the badge with sanitize

Recording Hand Hygiene Events at the Sink:

- Approach the sink and begin washing. The sink beacon detects the presence of the badge.
- After 20 seconds the badge will chirp and light blue, indicating time requirement is met. Finish washing if still in progress.
- Present a closed, cupped hand to the badge. The badge detects the shadow and presence of the hand.
- If no hand is presented to the badge, the hygiene event will not be recorded.

NOTE: The badge will light blue if a person stands at the sink for 20 seconds.
If this occurs, the badge will return to its previous state 10 seconds after leaving the sink.

Reminder:

- If no hygiene event is recorded for a room entry or exit, the badge reminder will begin.
- The badge light turns yellow and beeps and/or vibrates for a total of 60 seconds.
- At the end of the 60 second hygiene reminder the light turns red.

Quick Entry/Rounds:

- Enter patient room (reminder may begin); leave within 60 seconds and reminder will stop.
- If a caregiver leaves one room, performs hand hygiene, and enters another room within 60 seconds. the badge will not prompt for the room entry.

Re-Entry:

- Exit patient room (reminder may begin); return to same room within 60 seconds and reminder will stop.

Cross Contamination:

- If a caregiver exits one patient's room without performing hand hygiene, then enters a different patient's room, the reminder will become more urgent, and the badge will flash

Infection Prevention: Bloodborne Pathogens

Bloodborne pathogens include Human Immunodeficiency Virus (HIV), Hepatitis B, and Hepatitis C. Bloodborne pathogens are found in body fluids such as:

- Blood
- Semen and vaginal secretions
- Amniotic fluid
- Cerebrospinal fluid (CSF)
- Synovial fluid
- Pleural fluid
- Pericardial fluid
- Peritoneal fluid
- Saliva
- Any body fluid containing blood

Healthcare workers are at risk for occupational exposure to bloodborne pathogens through:

- Needlesticks or sharp injuries contaminated with an infected patient's blood or body fluids
- Splashes/contact of your eyes, nose, mouth or non-intact skin with a patient's blood or body fluids

Bloodborne pathogens can also be transmitted by:

- Cuts
- Sexual contact
- IV drug use
- Mother to fetus
- Blood transfusion

The first step in reducing your risk of exposure is to assume that all blood and body fluids, including excretions and secretions from all patients, are potentially infectious. Always use Standard Precautions for all patients to prevent the spread of disease. Here are the other steps you must follow to reduce your risk:

- Wear appropriate personal protective equipment (PPE), such as gloves, gowns, face masks and eye protection when anticipating contact with blood or body fluids.
- Wash hands with soap and water immediately after contact with blood or body fluids.
- Carefully handle and dispose of needles, syringes, and other sharps after use.
- Blood or body fluid spills should not be left unattended – follow the cleaning procedure for your facility.
- Discard disposable materials contaminated with blood or body fluids into an appropriate biohazard container.

After a potential exposure:

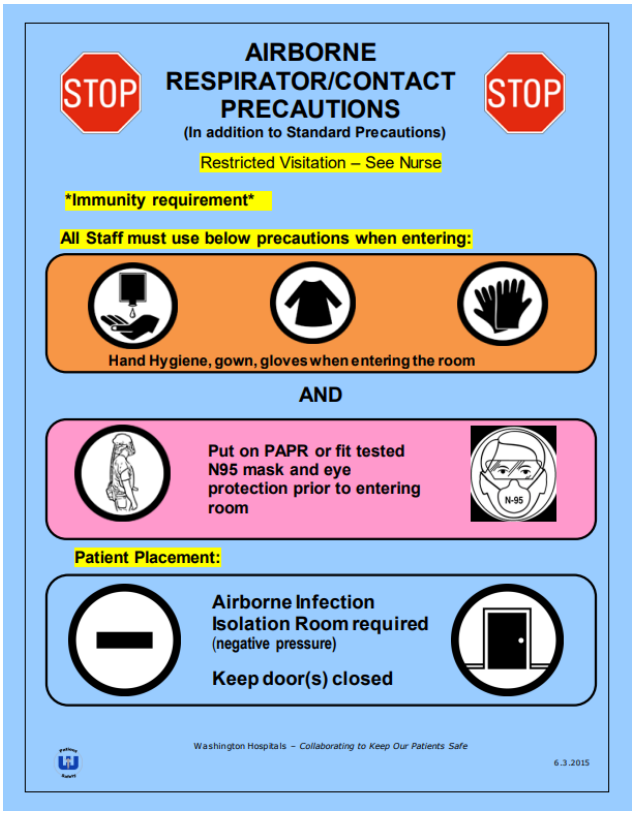
- Clean the wound with soap and water. If splashed in your eyes, irrigate with water using the eyewash station.
- Report the incident immediately to your Manager/Supervisor or, if after hours, the House Supervisor or House Coordinator.
- Complete a variance report in Safe2Share.
- Within 2 hours of exposure. Contact Employee Health. If more than 2 hours have passed, contact the House Supervisor or House Coordinator.
- Participate in follow-up care as directed by Employee Health.

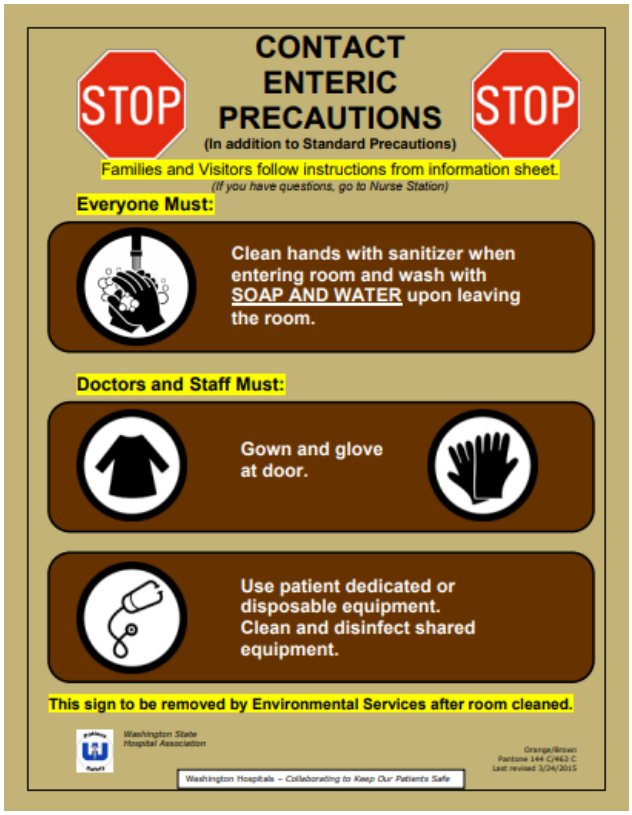
Infection Prevention: Transmission-Based Precautions

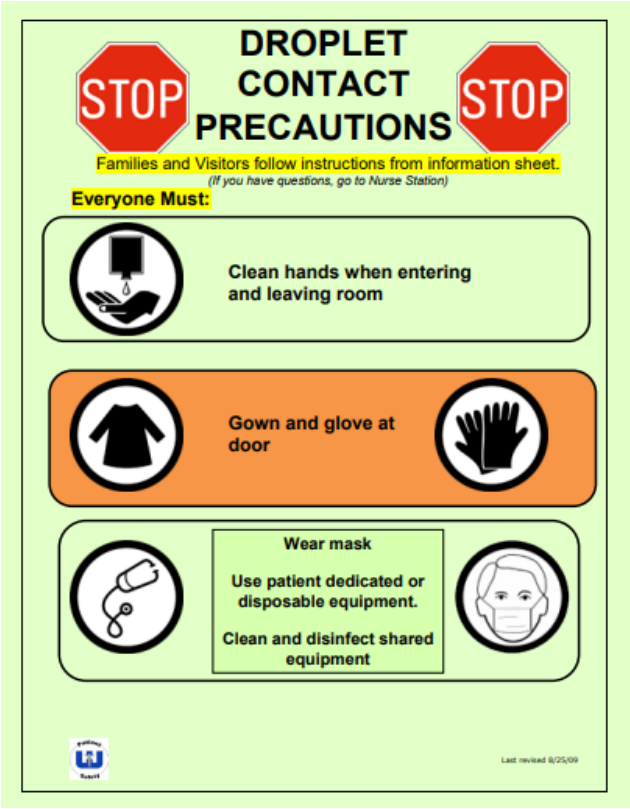
Standard Precautions are used for the care of all patients, regardless of their diagnosis or presumed infection status. Standard Precautions include:

- Hand hygiene,
- Appropriate personal protective equipment (PPE) such as gloves, gowns, masks, whenever touching or exposure to patient's body fluids is anticipated, and
- Respiratory hygiene and cough etiquette.

Transmission-based Precautions are additional precautions implemented when a patient has been identified or is suspected to have an active infection. Isolation signs posted outside the patient's door provide guidance on the isolation procedures to be followed, including the type of PPE to be worn. Be sure to follow instructions on all signs.







Infection Prevention: Personal Protective Equipment

Gloves

- Wearing gloves does not replace the need for hand hygiene. Gloves can protect both patients and caregivers from exposure to infectious agents.
- Gloves should be worn as a single use item for:
  - Each invasive procedure.
  - Contact with aseptic sites such as suture lines or percutaneous puncture sites, and non-intact skin or mucous membranes.
  - Any activity that has been assessed as carrying a risk of exposure to blood, body substances, secretions, and excretions.
- Gloves should be changed:
  - Between patients.
  - During the care of a patient, to prevent cross-contamination from dirty to clean body sites, e.g., enteral to central line site.
  - If the patient interaction includes touching equipment that is transported room to room, e.g., glucose meter.
- Hand hygiene is required with glove use at these times:
  - Before putting on gloves.
  - Immediately after removing gloves.
  - In between the "5 Moments" while caring for a patient.
- Do not apply hand hygiene products to gloves.

In addition to gloves, PeaceHealth will provide additional PPE supplies as needed (gowns, head/feet covers, etc.). It is the caregiver's responsibility to use this equipment per PeaceHealth policies and procedures.

N95 Respirators

- N95 masks must be fit tested prior to using.
- Do not wear anything under a N95 mask as it may alter the proper fit.
- Perform a "seal check" each time you put on a new N95 mask.
- Do not reuse N95 masks (once an N95 mask has been doffed, discard it).

Face Shields

- A face shield must be used for eye protection when working in a sterile field or when there may be a risk of exposure to high velocity splashes, sprays or splatters of blood or body fluids with direct patient contact.

PeaceHealth follows the sequence for donning (putting on) and doffing (removing) PPE recommended by the CDC.

Find the latest information related to COVID-19 by clicking on the KNOW Coronavirus tile on Crossroads: