What's New and Important Reminders in 2016

What's New and Important Reminders in 2016 emphasizes new information and important changes that everyone should know and understand. It also provides an opportunity to emphasize already existing policies and practices to serve as important reminders. This document is not intended to replace the UC Davis Medical Center Mandatory Annual Training (MAT) text. A complete copy of the 2016 MAT text is available at:  http://www.ucdmc.ucdavis.edu/cppn/documents/mat/MAT2016.pdf

Commitment to Quality and Safety

UC Davis Medical Center is accredited by The Joint Commission, a not-for-profit organization dedicated to raising the level of safety and quality of care in all health-care settings. Its accreditation is recognized within the health-care industry as a symbol of quality. UC Davis Medical Center demonstrates an extraordinary commitment to provide safe, high-quality care and a willingness to be measured against the highest standards of performance. If patients have any concerns about their care or safety at UC Davis Medical Center that have not been addressed to their satisfaction, they are encouraged to contact management through the Patient Relations department. Likewise, physicians and staff have various ways to bring forward quality and safety concerns - through your unit performance improvement (PI) process, reporting to your supervisor/manager, reporting concerns using the online Incident Reporting system, RL Solutions, use the Compliance Hotline, or contact The Joint Commission. The Medical Center does not take disciplinary action or retaliate against an employee for bringing forward quality and safety concerns.

Joint Commission (JC) Survey Readiness

Participation in the JC survey is one of the ways the Medical Center demonstrates its commitment to patient safety and quality and it is an important tool in helping the Medical Center identify areas to target for improvement. While the Medical Center’s results from the most recent survey in 2013 were excellent, our survey did indicate a few areas that warrant continued attention:

- Pain orders
- Labeling of syringes
- Maintenance of eye wash stations
- Fire rated doors, penetration
- Restraint orders
- Assessment and Reassessment of pain
- Written and documented plan of care
- Oxygen tanks not labeled appropriately
- H and P updates
- Completion of post-anesthesia assessment within 48 hours
- Be vigilant about cleanliness and infection control
- Keep hallways clear and free of obstructions
- Store supplies appropriately

**The Top Ten Most Frequently Scored Standards - January to June 2015**

1. **EC.02.06.01** (56%) – Establishes and maintains a safe, functional environment
2. **EC.02.05.01** (53%) – Manages risks associated with its utility system
3. **IC.02.02.01** (52%) – Reduce risk of infection associated with medical equipment, devices, and supplies
4. **LS.02.01.20** (50%) – Maintains integrity of the means of egress
5. **RC.01.01.01** (49%) – Complete and accurate Medical Records
6. **EC.02.03.05** (48%) – Maintains fire safety equipment and building features
7. **LS.02.01.10** (46%) – Building and fire, smoke, and heat protection features
8. **LS.02.01.30** (43%) – Provides and maintains building features to protect from fire and smoke
9. **LS.02.01.35** (43%) – Provides and maintains systems for extinguishing fires
10. **EC.02.02.01** (36%) – Manages risks related to hazardous materials and waste

**Challenges: How to Change the Scope of The Top Ten Findings?**

1. Don’t just fix it and forget about it! Short-term and Long-term resolutions?
2. Re-education – how reliable is that in fixing a problem?
3. How can you rethink, re-engineer and hard-wire compliance for some of these top issues?
4. The fix must be hard-wired or integrated into daily activities and processes in order to be effective.
5. Have you addressed the issue like you would want it addressed if you were the patient?

**Of Further Interest:**

- The Joint Commission has redefined the definition of quarterly to “every three months +/- 10 days.”
- Surveyors will focus on the fire drills in the OR – expect them to suit up!
- If using a compounding pharmacy expect surveyors to ask about contract and how quality is assessed.
- Expect a FAQ soon on the Pharmacy practice of relabeling critical medications that are in short supply.
• New is the use of data to make changes to improve Patient Flow (LD.04.03.11). Also don’t forget the behavioral health change for 2014. You must communicate with behavioral health providers and authorities to Enhance Flow.
• Supplemental findings are back!! Opportunities for Improvement (OFI) - survey reports will include single observations of issues identified during survey – will not be scored, will not require action or survey response.
• Diagnostic Imaging Standards - On hold until July 2015
• The Joint Commission is soliciting feedback on clinical alarm management NPSG to determine whether it is necessary to enhance the NPSG before the January 1, 2016 implementation date for the phase II requirements.
• NEW Sentinel Event Alert #54 – Safe Use of Health Information Technology
• NEW Sentinel Event Alert #55 – Preventing Falls and Fall-Related Injuries in Health Care Facilities

California Department of Public Health (CDPH) Hot Issues
• Ebola
• Dietary - food and nutrition safe practices
• Universal protocol
• HIPAA
• Monitoring of History and Physicals (H&P’s)
• Pharmacy compounding

California Department of Public Health (CDPH) Patient Safety Licensing Survey (PSLS)

The purpose of the Patient Safety Licensing Survey (PSLS) is to ensure patient safety in the general acute care hospital setting and compliance with statutory mandates for licensing. Generally, the Patient Safety Licensing Survey looks at compliance in the areas of:
• End of Life Care
• Brain Death
• Hospital Services
• Patient Safety and Infection Control
• Discharge Planning
• Dietary
• Immunizations
• Fair Pricing/Debt Collection
**EMERGENCY MANAGEMENT**

The Emergency Operations Plan is implemented in response to a disaster or other incident that impacts normal operations at the Health System. Code Green, Internal, is for those incidents taking place within the hospital. Code Green, External is for those incidents taking place in the community or widespread disasters, or in Sacramento campus facilities that do not provide inpatient care.

The red Disaster Manual contains the Health System’s Emergency Management Plan, an overview of the Emergency Operations Plan, Facility Evacuation policy, the Fire and Evacuation or Relocation Plan for your building or area, and your department specific emergency plan. Refer to your unit’s red Disaster Manual for specific information on your role and responsibilities in a disaster.

Fire and Evacuation/Relocation Plan templates are available on the UC Davis Health System Fire Prevention website [http://www.ucdmc.ucdavis.edu/fire/plans/](http://www.ucdmc.ucdavis.edu/fire/plans/). The templates are to be filled in by the department / unit / building in coordination with UC Davis Health System Fire Prevention. The final plan should be placed in the red Disaster Manual.

**RESPONSE TO ACTIVE SHOOTER**

An Active Shooter is a person or persons who appear to be actively engaged in killing or attempting to kill people. In most cases, active shooters use a firearm(s) and display no pattern or method for selection of their victims.

If there is an Active Shooter in your area, the phrase to remember is **RUN, HIDE, FIGHT**. Plan ahead now and look around your work area to identify an escape route if you can **RUN** and also identify one or more places where you can lock or block the entry if you need to **HIDE**. As a last resort and only when your life is in danger, **FIGHT** in an attempt to incapacitate the active shooter.

If you work with patients and are not in the area affected by the Active Shooter, identify how to lock or barricade all perimeter doors into your area to **HIDE**; guide others to safety with you. Hide out of view, set all noise-making communication devices to silent with no vibration, and turn off the lights.

The presence of an Active Shooter will be announced in plain English. The notification will state “**Active Shooter. Shooting in Progress. << announce location>>. Lockdown. This is not a drill.”**. Depending on your location, the notification will go out via the overhead paging system in the hospital, via text pager in the clinics, or via WarnMe in the other buildings.
If you encounter the shooter, call 911 when it is safe to do so. If you cannot speak, dial the number and set the phone down. If you are not in immediate danger, answer the questions to provide the following information: location, number of shooters, physical description, number and type of weapons, and number of victims.

When the UC Davis Police or other law enforcement officers arrive, follow the officers’ instructions. Keep your hands visible at all times, Avoid making quick movements toward officers such as attempting to hold on to them for safety. Avoid pointing, screaming and/or yelling.

The UC Davis Health System “Active Shooter Response” (P&P 1632) describes the expected response in more detail. In addition, a 5-minute video, called “Run. Hide. Fight. Surviving an Active Shooter Event”, was developed by the Department of Homeland Security. It is available on You Tube. The training video is intense and depicts a simulated active shooter event. Please take 5 minutes and view the video - it could save your life. [http://www.youtube.com/watch?v=5VcSwejU2D0](http://www.youtube.com/watch?v=5VcSwejU2D0)

A new video, called “Surviving an Active Shooter in a Healthcare Environment” addresses active shooter response in a patient care environment. Employees in inpatient and outpatient areas should view this 10-minutes video: [https://vimeo.com/112455575](https://vimeo.com/112455575)

**WORKPLACE VIOLENCE AND HATE INCIDENTS**

UC Davis Health System is committed to preventing and responding to violence and hate incidents in the workplace through education, adherence to policy and swift action to threats and acts of violence. UC Davis Health System’s Violence and Hate Incidents in the Workplace Policy (P&P 1616) states that the UC Davis Health System will not ignore, condone or tolerate disruptive, threatening, intimidating, violent, or hate incidents by or against any member of the University community or by any patient or visitor. Members of the University community engaging in such behavior will be subject to appropriate personnel action, up to and including termination or dismissal, as authorized by the applicable policy or collective bargaining agreement. The president of the University of California and the UC Davis chancellor have made it unequivocally clear that there is **zero tolerance** for any behavior that threatens personal safety, property and/or interferes with the mission of the University.

“Workplace violence”, as defined by UC Davis Health System Policy 1616 “Violence and Hate Incidents in the Workplace Policy” includes both violence and disruptive or threatening acts that can lead to violence. The terms in P&P 1616 include:

- **Disruptive Behavior**--Aggressive behavior or conduct that may adversely affect the campus or workplace, may generate reasonable concern for
personal safety, or may result in physical injury, including but not limited to the following:

B. **Bullying**--offensive or malicious behavior through persistent actions typically meant to undermine, intimidate or demean the recipient.

C. **Domestic violence**--abusive or violent behavior between individuals who have an ongoing prior intimate relationship that is disruptive in the workplace.

D. **Intimidation**--behavior that is intended to frighten, coerce, or induce duress.

E. **Property damage**--intentional damage to property owned by the University, its employees, students, visitors or vendors.

F. **Threat**--expression of intent to cause physical or mental harm, which may be direct, indirect, conditional or veiled.

G. **Violent behavior**--unwanted physical contact such as hitting, kicking, pushing, shoving, throwing of objects, or the use of a weapon.

H. **Hate Incident**--Any behavior or conduct that is disruptive, intimidating, threatening or violent, as defined above, and is committed against a person or his/her property because the person is, or is perceived to be, a member of a protected class (see UC Davis Personnel Policies for Staff Members [PPSM] 12 - Non Discrimination in Employment). Hate incidents may include, but are not limited to, expressions of bias, graffiti/vandalism because a person is, or perceived to be, a member of a protected class).

For training resources and information, refer to the [UCDHS Violence in the Workplace website](https://ucdhs.ucdavis.edu/violence-in-the-workplace).

**REPORTING CRIMINAL, SECURITY, WORKPLACE VIOLENCE and HATE INCIDENTS**

In the event of an emergency or imminent danger, dial 911 via landline or (916) 734-2555 via cell phone.

**Criminal events** are reported to UCDPD by dialing 911 via landline or (916) 734-2555 via cell phone to report crimes and in-progress activities that require police response; you should be prepared to provide all available information to the dispatcher. The police department conducts criminal investigations and advises UCDHS personnel on crime prevention strategies. Incidents concerning suspicious people or circumstances are also reported to the police for investigation.

**Mandatory Reporting of Workplace Violence:** California regulations require mandatory reporting for certain workplace violence incidents. Any act of assault or battery against any on-duty hospital personnel that results in injury or involves the use
of a firearm or other dangerous weapon shall be reported to UCDPD immediately by dialing 911 via landline or (916) 734-2555 via cell phone. Any act of violence (physical assault or threat of physical assault) against “community health care worker” (home health worker) shall be reported to UCDPD immediately.

**Workplace violence** incidents must also be reported as described in the Health System’s [Workplace Violence Reporting System](#). A report made via the Workplace Violence Reporting System is not a police report. Employees must contact the UCDPD to report an emergency and/or to file a police report by dialing 911 via landline or (916) 734-2555 via cell phone. The Workplace Violence Reporting System, may be accessed via the UC Davis Health System’s Intranet by typing the word violence in the address bar.

**Hate Incident Reporting:** The UC Systemwide Campus Climate Reporting System allows anonymous and identified reports of intolerance such as: Expressions of Bias Incidents, Hate Speech, Hate Crimes, Graffiti/Vandalism, Intimidation, Bullying or Physical Violence, Bias Incidents, Hostile Climate and other climate issues. The UC Systemwide reporting is available at the following website: [https://secure.ethicspoint.com/domain/media/en/gui/23531/index.html](https://secure.ethicspoint.com/domain/media/en/gui/23531/index.html)

**Security incidents** are reported via the Incident Reporting System ([http://incident.ucdmc.ucdavis.edu](http://incident.ucdmc.ucdavis.edu)), as described in Hospital P&P 1466, “Confidential Incident Report”. Security-related Incident Reports are reviewed by the UC Davis Police Department to determine if an investigation is necessary. If a determination is made that an investigation is needed, the UC Davis Police Department is responsible for conducting the investigation and disposition.

**To report threatening or violent behavior:**

1. Immediately call the UC Davis Police Department.
   - Dial 911 from a landline
   - Dial (916) 734-2555 from your cell phone.

2. Immediately notify your supervisor or manager about the situation.

3. Notify Human Resources Labor Relations as soon as possible: 734-3362

4. On the same day of the incident, document the incident by reporting it online using Incident Reporting system, RL Solutions (Safety/Security/Workplace Violence).
**FIRE PREVENTION**

The UC Davis Health System Fire Prevention Department is responsible for providing fire and life safety services to the campus facilities as well as off-site clinics and office buildings associated with the health system.

Services include: Incident response, fire and life safety plan review, construction inspections, assisting in maintaining hospital accreditation, development of Fire and Evacuation/Relocation plans, fire and life safety inspections of existing facilities, fire drills, fire protection systems inspection and auditing, fire extinguisher inspections, new and refresher fire and life safety training, chair the Life Safety Subcommittee, fire investigation/emergency incident follow up, and liaison with the Sacramento Fire Department and other regulatory agencies.

**CODE RED**

Code Red indicates a fire situation. When a Code Red is announced, ALL hospital staff members are expected to respond regardless of the location of the Code Red. Staff in affected areas must initiate their appropriate emergency response procedures. Staff in the unaffected areas should discuss internal procedures, review fire plans and prepare to receive relocated patients, staff or visitors who may have to leave an endangered area.

The Fire Prevention Department provides non-emergency incident response to a Code Red (24 hours-a-day, 365 days-a-year) to assist Sac Fire with building and room entry. The Fire Prevention Department can also provide information about a particular area due to their familiarity with the fire alarm system and practice of inspecting buildings. They help locate the alarm area for Sac Fire by checking and operating the fire alarm control panel. While trained in fire-fighting techniques, Fire Prevention Department personnel do not fight fires above incipient stages unless the Fire Department asks for their assistance. Response times may vary depending on time and day of the week. See Policy and Procedure 1606, Code Red Response.

**BUILDING EVACUATION**

In the event of an alarm, some buildings and floors require evacuation instead of relocation. If this is the case for your building or floor; proceed to lowest level of the building via the exit stairs. Do not attempt to use the elevators. Use handrails while descending. All emergency exits are clearly marked to properly guide you to the exterior of the building. From there, please proceed to your designated assembly area. Disabled individuals may be staged at the stair landing and need assistance with evacuation/descent. Assist, if able, or report the location of the individual to emergency personnel.
SMOKE BARRIERS
Smoke barrier walls separate each floor of the hospital into two or more smoke compartments. Smoke barriers are intended to create adjacent smoke compartments to which building occupants can be safely and promptly relocated during a fire, thus preventing the need to have complete and immediate building evacuation. Smoke compartments create spaces that protect occupants from the products of combustion produced by a fire in an adjacent smoke compartment and to restrict smoke movement from the compartment of fire origin. Doors in smoke barrier walls are identified with a small black and white sign located on the door that reads SMOKE BARRIER. Additionally, each departmental fire plan includes a floor plan showing each smoke barrier on the floor for which the fire plan is written. Each department should know the location of smoke barriers and plan relocating patients to them in the event of an emergency.

FIRE PREVENTION GUIDELINES AND SAFETY RULES
A list of Fire Prevention Tip Sheets and Guidelines and Safety Rules are available on the UC Davis Health System Fire Prevention website which addresses the issues of Corridor Clutter - including Portable Oxygen Storage/Oxygen Cylinder Storage, Wall mounted alcohol-based dispensers, and frequently asked questions: http://www.ucdmc.ucdavis.edu/fire/firenet.html

OXYGEN AND OTHER COMPRESSED GAS CYLINDERS
Compressed gas cylinders are used in healthcare and many research and support activities. Cylinders present significant hazards due to high pressure gases contained within the cylinders and cylinders that contain oxygen and other oxidizers may contribute to fire hazards. See P&P 1685 for specific rules on labeling and management of oxygen cylinders. Persons using or handling cylinders should have basic training including a review of operating and safety protocols for tasks to be performed, review of appropriate Safety Data Sheets (SDS) for toxic gases, and hands-on training by an experienced gas cylinder user. Transport cylinders larger than lecture bottle size with a hand truck or cylinder cart. Rolling or "walking" cylinders is extremely hazardous.

Never transport a cylinder with a regulator attached! Always protect the valve during transport by replacing the valve cover. Cylinders must never be left without
some type of physical support or restraint such as a stand, a cart, or a cylinder storage rack. Store cylinders in a well-ventilated area away from ignition sources. Additional information on the management and storage of Compressed Gas Cylinders is available in Safety Net #60 and UCDHS Fire Net on Storage & Handling of Medical Gas Cylinders at http://www.ucdmc.ucdavis.edu/fire/pdfs/Storage_and_Handling_of_Medical_Gas_Cylinders.pdf and Safety Net #60, Compressed Gas Safety.

IDENTIFICATION AND ACCESS CONTROL

All staff, faculty, and students must wear an identification badge at all times in Health System facilities and the badge must be clearly visible at all times. Visitors to the Emergency Department (ED) are required to wear visitor badges at all times. Visitors to the rest of the hospital must obtain and wear a visitor badge after 9 pm.

The photo identification badge is attached to a cardkey. The majority of buildings require use of a cardkey to enter the building during non-business hours.
CYBER SECURITY AWARENESS

Cyber security focuses on protecting computers, networks, programs and data from unintended or unauthorized access, change or destruction. Each member of the university has a responsibility to safeguard the information assets entrusted to him or her.

Studies have shown that a substantial number of cyber-attacks involve the unintended actions of users of information systems, and this risk can be significantly lowered by following safe computing practices.

How can you protect yourself?
Cybercrime—whether from malware on a single computer or the recent high-profile hacks against Anthem, Sony, Target, Home Depot and others—impacts everyone. Below are some key practices you can use to help minimize your risk of being a victim:

- **Use strong passwords:** Never use simple or easy-to-guess passwords like “123456” or “p@$$word” or “football.” Cybercriminals use automated programs that will try every word in the dictionary in a few minutes. When creating a password, refer to the UCDHS Password/Passphrase Standard for assistance in the creation and maintenance of strong passwords/passphrases.

- **Be cautious about links and attachments:** Be cautious about all communications you receive including those purported to be from friends and family, and be careful when clicking on links in those messages. When in doubt, delete it.

- **Protect your personal information:** Be aware of financial and sensitive information you give out. Cybercriminals will look at your social networking webpage to find information about you--remember, many of the answers to website and bank security questions can be found online, like the color of your car (posting that picture of you standing in front of your car?) and your mother’s maiden name. Use privacy settings to limit who can see the details of your social network pages, and be smart about what you decide to share online.

- **E-mail threats:** Scammers rely on their deception to entice users to willingly do what the scammer wants. Their deception is based upon resembling legitimate sites or trusted sources. These email scams can be very realistic and difficult to identify. However, there are some telltale signs that may indicate an email scam. By being observant of these, you can help minimize your risk of becoming a victim. Be wary of the following types of emails that:
  - Set ultimatums such as “your account will be closed,” or “the deal will expire” to create a sense of urgency, and trick the victim into providing personal information.
  - Threatens a consequence for not responding to the email
  - Has incorrect spelling;
• Use incorrect grammar or odd phrasing;
• Include a downloadable document, usually in PDF format; these downloads may be populated with malware that can infect your computer
• Appear to be from friends or family members, but the message is written in a style not usually used by that person, has numerous misspellings, or otherwise seems unusual. This is an indication your friend or family member’s account may have been hacked.
• Appear to be from official government agencies, such as Social Security Administration, or banks, requesting personal information.
• The URL does not match that of the legitimate site. Scammers cannot use the same URL associated with the legitimate websites, so they will tweak the address of their spoofed website so that at a quick glance it looks legitimate.
• The URL may use a different domain (ex: .com versus .net)
• The URL may use variations of the actual address, just spelled differently

If you receive an email that looks like it might be “phishing” for your information, please forward that e-mail to abuse@ucdavis.edu for verification before clicking!

If you have submitted your account credentials (username and password) on a phishing site, immediately contact the IT Operations Center at (916) 734-4357 to reset your passwords.

Web/Internet threats
To protect against these online threats, there are several basic precautions all Internet users should take, regardless of age or experience online.

• **Do not use public computers and public wireless access for sensitive transactions.** Wi-Fi spots in airports, hotels, train stations, coffee shops, and other public places can be convenient, but they're often not secure, and can leave you at risk. If you're online through an unsecured network, you should be aware that individuals with malicious intent may have established a Wi-Fi network with the intent to eavesdrop on your connection. This could allow them to steal your credentials, financial information, or other sensitive and personal information. It's also possible that they could infect your system with malware. Any free Wi-Fi should be considered to be “unsecure.” Therefore, be cautious about the sites you visit and the information you release.

• **Secure your computer and mobile devices.** Be sure your computer and mobile devices are current with all operating system and application software updates. Anti-virus and anti-spyware software should be installed, running, and receiving automatic updates. Ensure you use a strong password and unique password, which is not used for any other accounts. Set a timeout that requires authentication after a period of inactivity.
• **Use strong passwords.** Cyber criminals have developed programs that automate the ability to guess your passwords. To protect yourself, passwords must be difficult for others to guess, but at the same time, easy for you to remember. Passwords should have a minimum of eight characters and include upper case (capital letters), lowercase letters, numbers, and symbols. You should have a different password for each online account. Make sure your work passwords are different from your personal passwords.

• **Do not respond to pop-ups.** When a window pops up promising you cash, bargains, or gift cards in exchange for your response to a survey or other questions, close it by pressing Control + F4 on Windows devices, or Command + W for Macs.

**Everyday security**

• **Think before you act:** Most organizations – banks, charities, universities, companies, etc., – will not ask for personal information via email. Be wary of requests to update or “confirm” your information.

• **When in doubt, throw it out:** Links in e-mails, social media posts, and online ads are often how scammers access your computer. If you are instructed to click a link in a message you don’t trust, even if you know the sender, delete the message or mark it as junk mail.

• **Carefully select the sites you visit.** Safely searching for topics online requires caution. Know the site. Know the company. Do not visit a site by clicking on a link sent in an email, found on someone’s blog, or on an advertisement. The website you land on may look just like the real site, but it may be a well-crafted fake.

• **Be cautious about all communications you receive** including those purported to be from “trusted entities” and be careful when clicking links contained within those messages. If in doubt, do not click.

• **Don’t respond to any spam-type e-mails.**

• **Don’t send your personal information via email.** Legitimate businesses will not ask users to send their sensitive personal information through this means.

For more information visit:  
http://intranet.ucdmc.ucdavis.edu/it/units/security/security_tips.shtml
**BLOOD ON UNIFORMS**

Please be reminded that, in accordance with **P&P 2001: Bloodborne Pathogen Exposure Control Plan**, the use of Personal Protective Equipment (PPE) are required to protect against direct exposure to blood/body fluids. Note that uniforms/scrubs and lab coats are not PPE. If blood or body fluids accidentally contaminate personal clothing items (which include street clothing or uniforms/scrubs), **P&P 2167: Blood/Body Fluid Exposure (Needlesticks)** requires that employees follow the new procedure described in Section VII, Item C., which recommends the following:

C. Laundering of Contaminated Work Clothes
   1. If a garment(s) is contaminated by blood or OPIM, the garment(s) shall be removed immediately or as soon as feasible.
   2. Supervisor will establish that personal work clothes are contaminated and will contact Distribution for replacement green scrubs.
   3. Distribution will bring replacement green scrubs, plus a bag and tag for the contaminated personal clothing.
   4. Remove contaminated work clothes and place in a bag, complete tag.
   5. Distribution will take the personal work clothes for laundering.
   6. Laundered personal work clothes will be returned as soon as practical. Green scrubs shall be exchanged for the laundered work clothes.
   7. Contaminated work clothes will not be sent home with the employee.

**INFLUENZA VACCINATION MANDATED FOR ALL EMPLOYEES BY UC DAVIS HEALTH SYSTEM**

At the beginning of each flu season (as determined by the UC Davis Medical Center Infection Prevention Officer and the Sacramento County Public Health Officer), all UC Davis Health System employees, students and vendors and contractors are required to be vaccinated against influenza or sign a declination form. A single flu vaccination will protect against three or four strains of the flu. Declinations allow Employee Health Services to track employee concerns so educational content can be updated to dispel myths and employee concerns about the value of vaccination. Our priority is to prevent the spread of the influenza virus to patients, coworkers, and family members.

Employees who have not been vaccinated by the start of the designated flu season will be required to wear a procedure mask (type with elastic ear loops) while at work to reduce the risk of spreading influenza among non-vaccinated employees, patients and visitors. This policy (**UCDHS P&P 2011 - Influenza Vaccination Requirements**) includes employees who work in the hospital and in remote buildings during the flu season. Individuals are reminded to be respectful and supportive of colleagues who will be wearing masks during the flu season. Remember to “Cover your Cough” during cold and flu season. If you feel you have flu symptoms, stay home. Wash your hands, exercise and eat healthy to stay well.
METHICILLIN RESISTANT **STAPHYLOCOCCUS AUREUS (MRSA)**

MRSA information is available on the Infection Prevention web page: http://intranet.ucdmc.ucdavis.edu/infectioncontrol/bsi/index.shtml

As of September 2015, UCDMC has made a significant change to the MRSA Policy. Refer to Patient Care Standard XI-12: Methicillin/Oxacillin-Resistant *Staphylococcus aureus* (MRSA) Patient.

*Staphylococcus aureus* (SA) is a pathogen that commonly causes infections in humans. MRSA is a variety of SA that has developed resistance to the common antibiotics used to treat SA infections. Because MRSA infections are more difficult to treat, UCDMC has always had a policy to control its spread. We do this by controlling the use of antibiotics through the Antimicrobial Stewardship Program. In addition to this, important elements of the MRSA Control Program are as follows:

1. To prevent cross-transmission between patients is strict hand hygiene by staff and visitors. Refer to PCS XI-23: Handwashing (Hand Hygiene) Policy.
2. The use of Standard Precautions for all patients. In addition to appropriate and consistent hand hygiene, this requires the use of personal protective equipment (PPE) when caring for all patients. Refer to PCS XI-25: Isolation – All Categories: Availability of Infection Control Devices, Waste and Waste Containers.
3. Daily bath treatments with CHG (chlorhexidine gluconate) for all patients is required to reduce the numbers of organisms (including MRSA) on patients’ skin.
4. Careful and frequent cleaning of the patient’s environment, which includes the patient’s room and all equipment used by the patient.

Please note: MRSA patients are no longer routinely placed in Resistant Organism Precautions/Contact Precautions unless the patient has an infection where there is drainage (respiratory secretions or purulent wound drainage) that cannot be contained in a dressing.

As mandated by Senate Bill 1058 (Nile’s Law), an anterior nares swab will continue to be obtained on each patient admitted looking for the presence of MRSA. Nurses are required to educate patients about MRSA and document this education on the MPER.

There is a brochure available to educate patients about MRSA; this brochure is available in multiple languages. Physicians are required to notify their patients of positive MRSA results. Refer to PCS XI-15: MRSA Active Surveillance.

**PERSONAL PROTECTIVE EQUIPMENT (PPE)**

The proper use of personal protective equipment (PPE), such as respirators, protective gloves and impermeable gowns, is vital to assure your safety and protection against
work place hazards. You should receive training so that you know: when to wear PPE; what PPE is required; how to properly put it on, adjust it, wear it and take it off; the limitations of the PPE; required maintenance; its useful life; and proper disposal. Notify your supervisor if you have questions or if you have any problems with defective or damaged PPE. Some workplaces, such as research laboratories, may have minimum PPE requirements that are posted at entryways. Read and follow posted requirements. Note that normal hospital scrubs do not function as personal protective equipment.

Information regarding the Management of Patient with Ebola Virus Disease (EVD) can be located in Hospital P&P 2040. Ebola resource and information is also available on the Insider webpage.

NIOSH APPROVED RESPIRATORS and RESPIRATORY PROTECTION

Always wear a NIOSH approved respirator for protection against AirIDs. This protection is an N95 mask or elastomeric mask for which you have been fit tested or a powered air purifying respirator (PAPR). As of January 2015, required fit tests must be no older than 12 months. Therefore, any unit that requires fit tests should ensure that all fit tests are now renewed on an annual basis.

SMOKE AND TOBACCO-FREE CAMPUS

Improving health and maintaining a healing environment has always been the top priority for UC Davis Health System. It’s the key reason why the health system is a smoke-free environment.

Smoking and tobacco use (including cigarettes, smokeless tobacco, and E-cigarettes) is prohibited in all buildings and outdoor areas on both the Davis and Sacramento campuses. Smoking and tobacco use also is prohibited inside any vehicle owned, leased or occupied, by UC Davis Health System or its employees (regardless of where the vehicle is situated), and in any vehicle parked at a location where smoking and tobacco use is completely prohibited. Complete details on the no-smoking and tobacco-free policy, including new enforcement procedures, is available in the No Smoking and Tobacco-Free Policy, UC Davis Health System P&P 1628.

USE OF CELL PHONES

In areas where there are signs indicating “Cell Phones Must Be Turned OFF”, cell phones must be POWERED OFF, not simply in vibrate or silence mode. “Airplane” mode with WiFi ON is acceptable in “OFF” areas.
Three Foot Rule: Cell phone users, when conversing on their cell phones, shall stay a minimum of three feet away from all medical devices and instrumented patients (patients connected to medical devices). Three feet is approximately the length of the adult arm. Cell phone use, in accordance with the three foot rule, is allowed in all areas of UC Davis Medical Center, except where signs indicate that cell phones must be turned OFF or UCDMC staff indicate that cell phones must be turned off.

Furthermore, cellular devices should never be placed on medical devices. If interference between a cellular device and a medical device is noted, the cellular device should be turned off or moved to a location greater than three meters (10 feet) from the medical equipment, and Clinical Engineering should be notified (916-734-2846). For additional information on cell phone use, refer to UC Davis Health System P&P 1331 for details of the cell phone policy.

**MEDICAL EQUIPMENT MANAGEMENT - ELECTRICAL SAFETY**

Avoid using extension cords. If it is absolutely necessary to use an extension cord, use only the yellow “hospital grade,” three-wire, heavy-duty type of extension cord. Extension cords for non-patient care equipment may only be used as temporary wiring for portable hand tools, or while a permanent electrical service is being installed. In non-patient care areas, extension cords may be used to serve a short-term research experiment not exceeding six months. Surge protectors for computer equipment shall not be used as extension cords. Extension cords shall not be used as a substitute for fixed wiring. Do not use extension cords where subject to physical damage or hazardous locations, attached to buildings, walls, doors, windows, or under carpets.

Relocatable power taps (RPTs), also known as power strips, or plug strips, for use in patient care areas shall meet the following requirements: labeled by their manufacturer as hospital grade, mounted (e.g. on a rack, table, pedestal, or cart), have a total electrical current (amps) draw of less than 75% of the RPT’s listed capacity, and shall be plugged directly into a wall outlet (i.e., not “daisy-chained”).

**SAFE PATIENT HANDLING**

**Knowledge of Resources**

Only staff that have been trained on approved techniques and equipment are allowed to move patients. If you have not been trained on how to move patients and come across a situation where a patient needs to be moved, notify the responsible nurse (in the main hospital you may also call the lift team). However, in the event of an emergency, you may assist in the movement of a patient.

UC Davis Medical Center has a Safe Patient Handling Policy (PCS IV-04), and supports it by providing equipment and training for the repositioning, transferring and lifting of our patients. Ongoing, unit-specific training is available to any department responsible for
transferring patients, and focuses on active posture, body mechanics, and equipment. Contact the Lift Team for this training.

Patient handling tasks that result in body exposure are:

- **Vertical**: Movement from a lower position to a higher position or vice versa (i.e. supine-to-sit transfer, sit-to-stand transfer).
- **Lateral**: Movement across a horizontal plane (e.g. bed to gurney).
- **Repositioning**: Any task which involves moving a patient to shift positions within the bed (e.g. turning a patient on their side, shifting a patient toward head of bed.)
- **Ambulation/Mobilizing**: Patient movement in standing with advancing feet.

Many types of equipment are available to assist with the different ways our patients need to move. Patient lifts help our most immobile patients, with slings sized small to XXL (90-1,000 lbs.). UC Davis Medical Center has portable lifts, with varying weight capacities (350-1,000 lbs.). These portable lifts come with special features, like being able to assist someone out of a car, or help with standing or walking. Other devices available at UC Davis Medical Center include the Hover Matt system, Prevalon Turn & Position, and Sally Tube reduced-friction transfer sheet. All have standard and bariatric versions and are designed for single patient use (allowing repeated use for the same patient during their hospital stay). Innovative technology is driving this emerging group of products, and UC Davis Medical Center is committed to evaluating new products as they are introduced for integration into our safe patient handling practices.

Safe Patient Handling information, including the Banner Mobility Assessment Tool (BMAT), and additional resources available are located on the Lift Team webpage located at: [http://intranet.ucdmc.ucdavis.edu/pcs/liftteam/index.shtml](http://intranet.ucdmc.ucdavis.edu/pcs/liftteam/index.shtml).

Selection of the appropriate method of Safe Patient Handling shall be determined by the RN in conjunction with the Lift Team and/or licensed personnel prior to the patient movement. The registered nurse (RN) shall be responsible for the observation and direction of patient lifts and direction of patient lifts and mobilization and shall participate as needed in patient handling in accordance with the RN/s description, use of the BMAT and professional judgment.

**MAINTAINING YOUR PHYSICAL FITNESS AND WELLNESS**

Did you know that being physically fit and having a healthy lifestyle prevents injuries? If your job requires physical tasks, take responsibility for maintaining the strength, flexibility, and endurance required to complete those tasks. If your job entails being more sedentary, take responsibility for maintaining a healthy diet and active lifestyle to provide balance.
Physical fitness and wellness can start at work, too. Consider how you take your breaks.

- Taking a physical and mental break means thinking and doing something different.
- If you have been on your feet and active, then your break may consist of putting your feet up or closing your eyes for a few minutes.
- If you have been getting drowsy in front of a monitor, then your break may be better spent walking briskly outdoors or getting some cold water with lemon.
- Periodic micro-breaks (1 minute per hour) may also help you through your shift.
  - Physically break from what you have been doing for one minute. If you have been standing in one place for a long time, prop one foot up or lean back on a standing stool.
  - If you have been sitting for an hour, stand up and stretch or do some active exercise to invigorate.
  - If you have been staring into a computer monitor, focus on something about 20 feet away for about 20 seconds.

For additional guidance, contact the UC Davis Health System Wellness programs through Physical Medicine and Rehabilitation (Living Fit Forever) or Human Resources (WorkLife Balance).

**ERGONOMICS/BODY MECHANICS**

The practice of maintaining proper body mechanics and using correct lifting techniques is important to prevent injuries, as is the importance of supporting neutral postures while operating a computer (sitting or standing).

- Learn how to adjust the relationship between your monitor, keyboard/mouse, and your chair with the Ergonomic Self-Evaluation tool on our website: [http://www.ucdmc.ucdavis.edu/hr/hrdepts/work_comp/ergonomics.html](http://www.ucdmc.ucdavis.edu/hr/hrdepts/work_comp/ergonomics.html)

- The self-evaluation should be completed and shared with your supervisor to assure appropriate adjustments to your workstation.
- In cases where additional assistance is needed or where an ergonomic evaluation is medically required, please contact the UC Davis Health System’s Ergonomics Unit at 734-6180.
- If assistance is needed for staff in-services relating to body mechanics, safe patient handling equipment instruction, back safety, or office ergonomic awareness, please contact the UC Davis Health System’s Ergonomics Unit at 734-6180.
If you work with Hazardous Materials, your department will train you on the use of those materials, required protective equipment, proper disposal and spill response. Notify your supervisor if you feel you need additional information before working with a hazardous material.

I. Safety Data Sheets (SDSs)

HOW TO READ A SAFETY DATA SHEET (SDS)

A safety data sheet (SDS) includes the following information, in sections labeled 1-11 and 16. If no relevant information is found for any given subheading within a section, the SDS shall clearly indicate that no applicable information is available. Sections 12-15 may be included in the SDS, but are not mandatory.

1. Identification
   (a) Product identifier used on the label;
   (b) Other means of identification;
   (c) Recommended use of the chemical and restrictions on use;
   (d) Name, address, and telephone number of the chemical manufacturer, importer, or other responsible party;
   (e) Emergency phone number.

2. Hazard(s) identification
   (a) Classification of the chemical in accordance with paragraph (d) of §1910.1200;
   (b) Signal word, hazard statement(s), symbol(s) and precautionary statement(s) in accordance with paragraph (f) of §1910.1200. (Hazard symbols may be provided as graphical reproductions in black and white or the name of the symbol, e.g., flame, skull and crossbones);
   (c) Describe any hazards not otherwise classified that have been identified during the classification process;
   (d) Where an ingredient with unknown acute toxicity is used in a mixture at a concentration = 1% and the mixture is not classified based on testing of the mixture as a whole, a statement that X% of the mixture consists of ingredient(s) of unknown acute toxicity is required.

3. Composition/ information on ingredients

   FOR SUBSTANCES
   (a) Chemical name;
   (b) Common name and synonyms;
   (c) CAS number and other unique identifiers;
(d) Impurities and stabilizing additives which are themselves classified and which contribute to the classification of the substance.

FOR MIXTURES
In addition to the information required for substances:

(a) The chemical name and concentration (exact percentage) or concentration ranges of all ingredients which are classified as health hazards in accordance with paragraph (d) of §1910.1200 and
   (1) are present above their cut-off/concentration limits; or
   (2) present a health risk below the cut-off/concentration limits.
(b) The concentration (exact percentage) shall be specified unless a trade secret claim is made in accordance with paragraph (i) of §1910.1200, when there is batch-to-batch variability in the production of a mixture, or for a group of substantially similar mixtures (See A.0.5.1.2) with similar chemical composition. In these cases, concentration ranges may be used.

FOR ALL CHEMICALS WHERE A TRADE SECRET IS CLAIMED
Where a trade secret is claimed in accordance with paragraph (i) of §1910.1200, a statement that the specific chemical identity and/or exact percentage (concentration) of composition has been withheld as a trade secret is required.

4. First-aid measures
   (a) Description of necessary measures, subdivided according to the different routes of exposure, i.e., inhalation, skin and eye contact, and ingestion;
   (b) Most important symptoms/effects, acute and delayed.
   (c) Indication of immediate medical attention and special treatment needed, if necessary.

5. Fire-fighting measures
   (a) Suitable (and unsuitable) extinguishing media.
   (b) Specific hazards arising from the chemical (e.g., nature of any hazardous combustion products).
   (c) Special protective equipment and precautions for fire-fighters.

6. Accidental release measures
   (a) Personal precautions, protective equipment, and emergency procedures.
   (b) Methods and materials for containment and cleaning up.

7. Handling and storage
   (a) Precautions for safe handling.
   (b) Conditions for safe storage, including any incompatibilities.

8. Exposure controls/personal protection
(a) OSHA permissible exposure limit (PEL), American Conference of Governmental Industrial Hygienists (ACGIH) Threshold Limit Value (TLV), and any other exposure limit used or recommended by the chemical manufacturer, importer, or employer preparing the safety data sheet, where available. 
(b) Appropriate engineering controls. 
(c) Individual protection measures, such as personal protective equipment. 

9. Physical and chemical properties 
(a) Appearance (physical state, color, etc.); 
(b) Odor; 
(c) Odor threshold; 
(d) pH; 
(e) Melting point/freezing point; 
(f) Initial boiling point and boiling range; 
(g) Flash point; 
(h) Evaporation rate; 
(i) Flammability (solid, gas); 
(j) Upper/lower flammability or explosive limits; 
(k) Vapor pressure; 
(l) Vapor density; 
(m) Relative density; 
(n) Solubility(ies); 
(o) Partition coefficient: n-octanol/water; 
(p) Auto-ignition temperature; 
(q) Decomposition temperature; 
(r) Viscosity. 

10. Stability and reactivity 
(a) Reactivity; 
(b) Chemical stability; 
(c) Possibility of hazardous reactions; 
(d) Conditions to avoid (e.g., static discharge, shock, or vibration); 
(e) Incompatible materials; 
(f) Hazardous decomposition products. 

11. Toxicological information 
Description of the various toxicological (health) effects and the available data used to identify those effects, including: 
(a) Information on the likely routes of exposure (inhalation, ingestion, skin and eye contact); 
(b) Symptoms related to the physical, chemical and toxicological characteristics; 
(c) Delayed and immediate effects and also chronic effects from short- and long-term exposure; 
(d) Numerical measures of toxicity (such as acute toxicity estimates).
(e) Whether the hazardous chemical is listed in the National Toxicology Program (NTP) Report on Carcinogens (latest edition) or has been found to be a potential carcinogen in the International Agency for Research on Cancer (IARC) Monographs (latest edition), or by OSHA.

12. Ecological information (Non-mandatory)
(a) Ecotoxicity (aquatic and terrestrial, where available);
(b) Persistence and degradability;
(c) Bioaccumulative potential;
(d) Mobility in soil;
(e) Other adverse effects (such as hazardous to the ozone layer).

13. Disposal considerations (Non-mandatory)
Description of waste residues and information on their safe handling and methods of disposal, including the disposal of any contaminated packaging.

14. Transport information (Non-mandatory)
(a) UN number;
(b) UN proper shipping name;
(c) Transport hazard class(es);
(d) Packing group, if applicable;
(e) Environmental hazards (e.g., Marine pollutant (Yes/No));
(f) Transport in bulk (according to Annex II of MARPOL 73/78 and the IBC Code);
(g) Special precautions which a user needs to be aware of, or needs to comply with, in connection with transport or conveyance either within or outside their premises.

15. Regulatory information (Non-mandatory)
Safety, health and environmental regulations specific for the product in question.

16. Other information, including date of preparation or last revision
The date of preparation of the SDS or the last change to it.

II. Hazardous Material Labeling Elements

The following information must be included on hazardous materials labels:

**Product Identifier:** a chemical name, code number, or batch number which identifies the hazardous chemical. The manufacturer, importer or distributor can decide the appropriate product identifier. The same product identifier must be both on the label and in Section 1 of the SDS (Identification).
**Signal word:** a single word used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. The signal words used are "danger" and "warning." "Danger" is used for the more severe hazards, while "warning" is used for less severe hazards.

**Pictogram:** a symbol plus other graphic elements, such as a border, background pattern, or color that is intended to convey specific information about the hazards of a chemical. Each pictogram consists of a different symbol on a white background within a red square frame set on a point (i.e. a red diamond). There are nine pictograms under the GHS. However, only eight pictograms are required under the HCS.

**Hazard Statement:** a statement assigned to a hazard class and category that describes the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard.

**Precautionary Statement:** a phrase that describes recommended measures to be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical, or improper storage or handling of a hazardous chemical. When there are similar precautionary statements for chemicals with multiple hazards, the most protective information will be included on the label.

**Name, address and phone number of the chemical manufacturer, distributor, or importer.**

Information on the labels can be used to ensure proper storage of hazardous chemicals and may also be used to quickly locate information on first aid when needed by employees or emergency personnel. Where a chemical has multiple hazards, different pictograms are used to identify the various hazards.

Information on the labels is related to the information on the SDS; for example, the precautionary statements on the label would be the same as on the SDS.
**Pictograms and Hazard Classes**

OSHA’s required pictograms on hazardous material containers are being standardized and are presented below. The pictograms must be in the shape of a square set at a point and include a black hazard symbol on a white background with a red frame sufficiently wide enough to be clearly visible. OSHA has designated eight pictograms under this standard for application to a hazard category.

<table>
<thead>
<tr>
<th>Oxidizers</th>
<th>Flammables</th>
<th>Explosives</th>
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<tr>
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<td>Self Reactives</td>
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<td>Pyrophorics</td>
<td>Organic Peroxides</td>
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<td>Self-Heating</td>
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<td>Emits Flammable Gas</td>
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<tr>
<td></td>
<td>Organic Peroxides</td>
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| Acute toxicity (severe)                       | Corrosives                                                       | Gases Under Pressure                                           |
|                                               |                                                                  |                                                                |

| Carcinogen                                    | Environmental Toxicity                                            | Irritant                                                       |
|                                               |                                                                  |                                                                |
| Respiratory Sensitizer                        |                                                                  | Dysentery                                                      |
| Reproductive Toxicity                         |                                                                  |                                                                |
| Target Organ Toxicity                         |                                                                  |                                                                |
| Mutagenicity                                   |                                                                  |                                                                |
| Aspiration Toxicity                           |                                                                  |                                                                |
|                                               |                                                                  |                                                                |

25
HAZARDOUS WASTE MANAGEMENT AND RECYCLING

EH&S provides hazardous waste pick-up and disposal services:

- **Chemical waste pick up** (this includes black and white pharmaceutical containers) - to request additional empty containers, or with questions, call EH&S - 4-2740.
- **Label your chemical waste** - download the Hazardous Waste Container Label from the EH&S website (type safety in your web browser address bar to get to the EH&S website) to print your own labels. You are encouraged to use Word to prepare labels for recurring wastestreams, but do not modify the categories or other text, as the labels are designed to meet regulatory requirements. Be sure to fill in the date, location, chemical contents, and concentration on the label and secure it to the waste container before you begin filling it with waste. It is against the law to have waste in an unlabeled container!
- **Radioactive waste pick up** - call EH&S 4-3355.
- **Medical waste pick up** (this includes blue and white pharmaceutical containers and yellow trace chemotherapy containers) call Environmental Services - 4-3777 and make the request

**UCDHS Battery Recycling Program**

EH&S also provides information and services related to battery recycling. Recycling and pick up request instructions are available on the EH&S website.

Batteries are hazardous waste, and cannot be thrown into trash, red bags, or sharps containers. Our recycling program lets us handle batteries under criteria less stringent than that for hazardous wastes, as long as we follow the rules. EH&S can accept all types of batteries except wet/lead/acid (automotive batteries), which can generally be handled by Fleet Services. Clinical Engineering manages sealed lead-acid batteries.

To recycle batteries:
- Establish a collection station. Containers are available through Eclipsys: Calcode 50024339 in Stores Inventory 136. EH&S does not provide containers.
- The container must be labeled using labels and instructions available on the EH&S website.
- Dissimilar battery chemistries should be prevented from contacting each other using individual plastic bags or by placing electrical tape over the terminals.
• Fill out a battery waste pick up request form online: visit the Environmental Health and Safety website (type safety in your web browser address bar) and click on Battery Pick Up Request under Quick Links.
• From the Medical Center campus, request a pickup within six months of the accumulation start date. EH&S will take the entire container and will not leave a replacement.

MRI SAFETY

Magnetic Resonance Imaging (MRI) uses magnetic fields, radio frequencies and a computer to produce images of the inside of the body. The magnetic fields are not known to be harmful and are painless. MRI is effective in visualizing soft tissue, the brain, the joints, and the musculoskeletal and vascular systems.

The MRI poses specific safety hazards in that any magnetic object (e.g., metal object) within the high magnetic field of the magnet will be pulled into the scanner itself. This could cause severe injuries to or even death of a patient or staff member as well as considerable damage to MRI equipment. To avoid a safety emergency, access to zones III and IV of the MRI is severely restricted. Screening of patients and staff is mandatory.

Hospital staff must be aware that the magnet is always on, and that the magnetic field cannot be seen or heard. The closer an object gets to the MRI the stronger the magnetic force. This force can pull metal objects into the machine at an incredible speed. Metal objects such as gurneys, oxygen tanks, infusion pumps, tools, and other patient-use items containing metal cannot enter the MRI environment. All personnel approaching the area must be aware of safety issues at all times.

Hospital staff will need to consult with MRI Staff if a patient has a pacemaker to determine if the device is MR conditional. Patients with pacemakers and defibrillators that are not MR conditional cannot be imaged or even come into the MRI prep area as the magnetic field may disrupt the function of these devices, which could result in death. Ventilator patients require special ventilators and monitoring devices. The MRI technologist or physician can supply the floor with the necessary instructions for these high-risk patients. Other devices, such as prosthesis, pumps, surgical clips or metal fragments, will be screened to determine if they are MRI compatible. Jewelry, hairpins, glasses, wigs, hearing aids, non-permanent dentures, etc..., must be removed.

Some of the safety precautions are:
1) Warning signs posted on doors.
2) The use of hand-held magnet scanners to help detect metal objects.
3) Being cleared by the MRI technologist
Refer to the UC Davis Health System Magnetic Resonance Imaging Policy (P&P 1727) for additional information. Any staff that enters controlled MRI spaces must complete periodic training in accordance with this policy.

QUESTIONS ABOUT RADIATION

The Health Physics Office answers questions about radiation safety at (916) 734-3355. After hours, the Health System Safety Officer can be reached by paging (916) 816-1994. Information is available on the intranet at:


Health Physics is responsible for overseeing the safe and effective use of ionizing radiation within the Health System. Radiation producing machines and radioactive materials are used throughout the hospital and research areas. Signs, such as the trefoil or the words “Caution X-Ray” or “Caution Radioactive Materials”, located at the entrance to the work area will identify the presence of hazardous materials in the work place. The trefoil alerts you so that you can minimize your potential exposure to radiation by following the established protocols. This includes limiting your time of exposure, increasing the distance between you and the radiation source, using radiation shielding, and wearing personal protective equipment as necessary. Basic rules to follow include:

1. Follow all room postings or instructions carefully.
2. Ask the laboratory personnel to identify areas that should be avoided.
3. Do not handle anything labeled with the radiation symbol (unless it is part of your job).
4. Call the Health Physics Office if you have any questions or concerns.
5. Leave the room locked when unoccupied.
COMPLIANCE QUESTION, CONCERN OR SOMETHING TO REPORT

The opportunity for you to ask questions and raise concerns is a cornerstone of a successful corporate compliance program. If you have a question or concern regarding the appropriateness of a decision or action, you can take any of the following steps:

1. **Communicate with an immediate supervisor or manager**
2. **Talk with higher level management**
3. **Contact the Chief Compliance Officer and the Compliance Office** at (916) 734-8808.
4. **Obtain help from other university resources** (i.e. Office of the President, corporate compliance office, human resources, internal audit, and campus counsel).
5. **Call the Compliance Hotline** at (877) Ethics-2 or (877) 384-4272

What Happens if I Report Something?

As a university employee or student, you have a personal responsibility to report any activity that appears to violate the Code of Conduct or any applicable laws or regulations. In general, if you are aware of a compliance violation and fail to report it, you may be subject to corrective or disciplinary action.

In addition, UC policy and state law is committed to protecting any whistleblower employee or applicant for employment from retaliation having made a protected disclosure or whistleblower report. The UC Whistleblower Protection policy can be found at: [http://policy.ucop.edu/doc/1100563/WhistleblowerProtection](http://policy.ucop.edu/doc/1100563/WhistleblowerProtection).

PRIVACY IN HEALTHCARE

Within the last year, there have been an increasing number of “phishing” scams or other tactics aimed at compromising UCDHS email accounts. Phishing scams are usually fraudulent emails that appear legitimate, but try to trick the recipient into providing his or her user name and password to gain access to that person’s account. It can be difficult to distinguish between a valid email and a malicious one. If you think you have received a phishing email, do not open or click any links. Contact the IT Operations Center right away at (916) 734-4357. You can also forward the email to abuse@ucdavis.edu for review. Never provide your login name or credentials in response to a request received by email.

Another critical technological issue affecting UCDHS is the use of unencrypted flash drives by employees. Personal and unencrypted flash drives should never be used to store patient information. Any loss or theft of these drives can result in serious reportable privacy incidents, especially since these drives may be used to store information about a large number of patients. Employees may submit requests for
encrypted flash drives via the online Employee Self Service catalog at

All UCDHS employees are required to immediately report any known or suspected
privacy incidents to the Compliance Department. Reports may be made by telephone at
(916) 734-8808, by email at privacyprogram@ucdmc.ucdavis.edu, or online at
https://disclose.ucdmc.ucdavis.edu/disclose/. Employees may also submit an Incident
Report via RL Solutions and selecting the “Confidentiality/Healthcare Information”
category on the home screen.
PROMOTING HEALTHCARE EQUALITY

Traditionally sexual orientation and gender identity have not been talked about in the course of health care. The silence on that issue appears to have been important in masking serious health disparities experienced by those with minority sexual orientation (Lesbian, Gay and Bisexual people), those with minority gender identity (Transsexual and other identified people) as well as those with medical conditions making genitals ambiguous at birth or influencing sexual development at puberty (Intersex). Jointly these people constitute LGBTI populations. By including LGBTI information in the Electronic Health Record (self-disclose sexual orientation), our goal is to enhance the quality of care provided and to improve the atmosphere for LGBTI patients, learners, staff and faculty. These efforts stem from our commitment to fully implement and live by our Principles of Community.

UC Davis Principles of Community
UCDHS LGBT EMR Task Force: LGBTI Health Care Resources
https://myhs.ucdmc.ucdavis.edu/web/lgbti

LEADER IN LGBT HEALTHCARE EQUALITY

HEALTHCARE EQUALITY INDEX™
HAND HYGIENE

Impact of Hand Hygiene on Healthcare-Associated Infections (HAI)
- 2 million patients acquire an HAI while hospitalized every year
- Estimated 98,000 will die from HAI
- HAI the 4th leading cause of death in US
- Antimicrobial resistance spreads via colonized hands
- Validated and standardized prevention strategies have been shown to reduce HAI
- At least 50% of HAI could be prevented

Handrubbing is the solution to obstacles to improve hand hygiene compliance
- Handwashing with soap and water when hands are visibly dirty or following visible exposure to body fluids or after caring for a C. diff patient.
- Adoption of alcohol-based handrub is the gold standard in all other clinical situations.

Application time of hand hygiene and reduction of bacterial contamination
**Handrubbing is:**
- More effective
- Faster
- Better tolerated
- After 15-30 seconds only, handrubbing is significantly more efficient than handwashing with plain soap and water, to reduce hand bacterial contamination

**The golden rules for hand hygiene**
- Hand hygiene must be performed exactly where you are delivering health care to patients (at the point-of-care)
- During health care delivery, there are 5 moments (indications) when it is essential that you perform hand hygiene ("My 5 Moments for Hand Hygiene" approach)
- To clean your hands, you should prefer handrubbing with an alcohol-based formulation, if available. Why? Because it makes hand hygiene possible right at the point-of-care, it is faster, more effective, and better tolerated.
- You should wash your hands with soap and water when visibly soiled
- You must perform hand hygiene using the appropriate technique and time duration

**Hand hygiene and glove use**
- Glove use does not replace any hand hygiene action.
- Gloves plus Hand Hygiene = Clean Hands
- Gloves without Hand Hygiene = Germ Transmission
- If you should clean your hands without the gloves, you should clean your hands with them!

**Optimal Outcomes**

**IMPORTANT:** Hand hygiene is everyone’s responsibility. If you witness someone not performing hand hygiene, it is your responsibility to **speak-up** and remind them. This reinforces the “just culture” that we strive for. Infection affects us all. -Making hand hygiene a priority is “best practice.”
- The goals of this project are to increase awareness of hand hygiene and to eliminate the barriers to compliance. **No one is excused from hand hygiene. It protects YOU and YOUR patient!**
**Blood Product Administration and Transfusion Reaction Annual Inservice Training**

**References**  
*Patient Care Standards XIII-12 Administration of Blood & Blood Products*

**Preparing for Blood Product Transfusion**  
− Verify MD order for transfusion and ascertain current availability of pool products.  
− Ensure that there is a signed consent for blood.

**Consent**  
− Administration of blood and components requires informed consent  
− Inpatient areas, it is the physician’s responsibility to obtain the informed consent in non-emergent situations.  
  − Informed consent for blood administration will be documented on a Consent to Operation, Procedures, Blood Transfusion and Anesthesia Administration form (#71431-854).  
  − If this form is not used, informed consent must be documented in a Physician’s Progress Note.  
  − Informed consent for blood administration covers all blood administration for a hospital admission.  
− Outpatient infusion areas for adults and children, informed consent for blood administration is valid for one year with chronic conditions, and throughout the patient’s course of treatment for transient conditions lasting less than one year.

**Patient Education**  
− Provide patient/family education related to transfusion of blood products.  
  ▪ A physician, RN, CRNA or perfusionist must explain the procedure to the patient, patient’s family or to the patient’s lawfully authorized representative.  
  − Explanation should include how the transfusion will be given, how long it will take, the expected outcome, the risks, benefits, alternatives, patient’s response and what symptoms to report.

**Obtaining Specimen for Type & Cross/Type & Screen**  
1. Two patient identification must be performed prior to any specimen collection, or transfusion  
2. Ensure that the physician’s order is complete (should be on Physician Blood Order Form)  
3. Assemble equipment needed to obtain and label the specimen:
- 4 ml purple top tube*
- EMR Lab label. Must have time, date, first initial and last name or of person drawing blood or block letter initials if two step collection is performed in order entry system.
- All specimens must be labeled at the bedside in the presence of the patient for Blood Bank testing.

4. PROCEED TO PATIENT’S BEDSIDE – all specimen labeling MUST be done at the patient’s bedside
5. Identify the patient by checking the hospital ID band for name and medical record number, and confirming the name and birth date with the patient (if the patient is alert)
6. Draw specimen
7. Place the completed EMR Lab label on the blood tube
8. Send the specimen to Transfusion Services each specimen should be in its own bag

**Specimen for ABO verification**
- If requested by the lab, draw a specimen for ABO verification. This specimen must be obtained by someone other than the person who drew the original blood specimen.

**Administering Blood Products**
- When blood product is “Ready” status in EMR, RN or designee will bring a demographic label or outpatient card to pick up blood product for the patient. The demographic label must have:
  - Patient’s complete name, medical record number, and date of birth (Optional)
  - Type of product and how many written on label.
  - Full name of RN if a designee is sent to pick up blood product.
- Check blood product with another RN/LVN/MD, verifying identification data per policy
- Assemble necessary equipment and ensure patient has adequate IV access*
- Obtain baseline vital signs prior to infusion and initiate transfusion slowly (<30 ml in the first 15 minutes). Remain with the patient for the first 5 minutes* after blood enters the vein.
- Monitor and document vital signs appropriately during the transfusion
- Continue to observe patient periodically and for up to 1 hour after transfusion
- Adjust rate of transfusion as prescribed, but not to exceed 4 hours
- At completion of transfusion, flush tubing with 0.9% NS.
RECOGNIZING TRANSFUSION REACTIONS

- Any change in a patient’s condition while blood is being administered should be considered a possible reaction to the transfusion.
- Acute reactions occur immediately, subacute reactions occur within 6 hours and delayed reactions occur up to several months after the completion of the transfusion.
  - Used blood bags should be kept for 6 hours post transfusion in case a transfusion reaction is suspected, in which case the blood bags are then returned to Transfusion Services.

Signs and symptoms of ACUTE reactions include:
- Fevers (increased temperature of >1 degree C during or immediately following transfusion)
- Chills
- Mild itching or urticaria
- Pain
- Sudden onset of dyspnea or sensation /complaint of difficulty breathing
- Hypotension (sudden drop of blood pressure > 40 mm Hg)
- Hemoglobinuria
- Complaint of a sense of impending doom
- Sudden decrease in urine output
- Unexplained bleeding or oozing from puncture or incision sites
- Chest pain
- Pulmonary edema
- Shock

Signs and symptoms of DELAYED reactions include:
- Unexplained onset of jaundice
- Unexpected decrease or failed increase in hemoglobin occurring 5-13 days after transfusion
- Unexpected elevation in liver function tests
- Sudden and unexplained rash or diarrhea 6-10 days after transfusion

At first sign of an adverse reaction:
- Stop the transfusion immediately.
- Keep IV open with normal saline infusion. Use a new administration set.
- Check patient identification and donor unit match to confirm patient is receiving correct unit.
- Notify physician immediately.
- Notify Transfusion Service STAT and describe symptoms.
- At Transfusion Service’s request, send properly labeled samples ASAP.
- Send the remaining unit or empty blood bags, the Y-filter administration set and clamped IV fluids to Transfusion Service for follow-up as described in the policy for Administration of Blood and Blood components, PCS XIII-12.
- Physician or nurse to complete the Transfusion Reaction Investigation form and return to Transfusion Service ASAP. Do this STAT if patient requires additional transfusions.

*See policy for specific pediatric and neonatal requirements
RESTRAINTS UPDATE

Purpose
Provide nursing care and documentation for patients requiring restraints according to the restraint policy and procedure.

Learning Objectives

1. Locate hospital policy on restraint.
2. Identify 3 specific risks associated with use of restraints.
3. List 4 alternatives to use of restraints.
4. Identify 2 nursing interventions to ensure patient safety in restraints.
5. Describe documentation standards for patient in restraints.
6. Identify frequency of required MD/DO/NP/PA order for continued use of restraints.

Staff are required to be familiar with current policy and to follow policy in providing patient care. Take this time to follow the links below and read through the current policy related to restraints.

1. UCDHS PCS IV-69 - Restraints
2. PCS IV-70 - Use of Restraints Protocol for Specific Patient Conditions

What is a restraint?
A physical restraint is any manual method or physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment dosage for the patient’s condition.

Four (4) Side Rails is considered a restraint when the intent of use is to restrict patient movement or immobilize or reduce the patient’s ability to move freely (e.g., If a patient is physically able to ambulate, even if it has been determined that they cannot safely ambulate and the 4 side rails prevent this, then the 4 side rails must be defined as a restraint). Conversely, if a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient’s freedom of movement. In this example, the use of all four side rails would not be considered restraint. (Other examples:
1. When a patient is on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and are not viewed as restraint.

2. When a patient is placed on seizure precautions and all side rails are raised, the use of side rails would not be considered restraint. The use of padded side rails in this situation should protect the patient from harm, including falling out of bed should the patient have a seizure.

Exclusions:

1. Standard practices that include limitation of mobility or temporary immobilization for medical, dental, diagnostic, or surgical procedures, including post-procedure care. For example, the standards do not apply to surgical positioning, intravenous arm boards, radiotherapy procedures, or protection of surgical and treatment sites in pediatric patients.

2. Adaptive support used in response to a patient's assessed need. For example, the standards do not apply to postural support, orthopedic appliances, or tabletop chairs.

3. Protective equipment, such as helmets.

4. Forensic restrictions and restrictions imposed by corrections and law enforcement authorities for security purposes.

5. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child would not be considered restraint or seclusion.

**Clinical justification for the use of restraints**

1. Violent and self-destructive behavior, harmful to self, others, and the environment such as hitting, hair pulling, throwing objects, striking at or biting staff or others, and self-mutilation.

2. Behavior interfering with life-saving and/or necessary medical treatment such as pulling, tugging, grabbing at lines or tubes, picking at open wound, dressings, drains, and traction.

3. Behavior indicating patient is unable to follow directions to avoid self-injury, such as sitting at the edge of the bed, transferring in/out of bed, standing or ambulating, without the strength or cognition function of doing so safely.

4. The use of restraint is not based on a patient's history of restraint or dangerous behavior.

5. A request from a family member for restraint, which they consider as beneficial, is not a sufficient basis for the use of restraints.

6. Use of alternative measures has proven ineffective.
Levels of restraints.

1. Treatment restraint is the use of soft restraints, Posey belts, bed enclosures, and other forms of restraints to protect a child or adult who is confused, disoriented, unable to call for assistance, or unable to follow instruction for his/her personal safety; or from dislodging a medical device; or from interfering with the integrity of a dressing or wound.

2. Behavioral Restraint is the use of a physical or mechanical device to involuntarily restrain the movement of all or a portion of a patient’s body as a means of controlling violent or assaultive behavior with the intent to prevent patient from harming self or others.

Restraint Orders/ Nursing Care

The healthcare team shall assess the need for use of restraints.

This assessment should include:

(1) a physical assessment to identify medical problems that may be causing behavior changes, e.g., hypoxia, hypoglycemia, electrolyte imbalances, etc., and

(2) alternative interventions that might prevent the need for restraints.

The RN may initiate the use of restraints upon receipt of a verbal, telephone or electronic restraint order from a MD/DO/NP/PA. If a MD/DO/NP/PA is not available to issue such an order, the RN initiates restraint use based on an appropriate assessment of the patient, notifies the MD/DO/NP/PA within 12 hours of the initiation of restraint and obtains an order.

The MD/DO/NP/PA must be notified immediately upon initiation of restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. PRN (as needed) orders are prohibited. MD/DO/NP/PA must provide an order for restraint within 12 hours of application of treatment restraints. This must be renewed every 24 hours after a face-to-face reassessment of the patient with determination of continued need. An exception to this is patients who meet criteria for protocols for specific conditions or certain specific clinical procedures.
<table>
<thead>
<tr>
<th>Type of Restraint Order</th>
<th>Order Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>May not exceed 24 hours.</td>
</tr>
<tr>
<td>Protocol for Use of Treatment Restraints for Specific Patient Conditions</td>
<td>Order expires when restraint removal criteria outlined in this protocol have been achieved.</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Behavioral restraint orders may not exceed:</td>
</tr>
<tr>
<td></td>
<td>4 hours for adults 18 years of age or older;</td>
</tr>
<tr>
<td></td>
<td>2 hours for children 9-17 years;</td>
</tr>
<tr>
<td></td>
<td>1 hour for children less than 9 years.</td>
</tr>
<tr>
<td></td>
<td>Orders may be renewed according to the time limits for a maximum of 24 hours. After 24 hours, a new behavioral restraint order may be used after seeing and assessing the adult or pediatric patient.</td>
</tr>
</tbody>
</table>

**Protocol for Use of Treatment Restraints for Specific Patient Conditions**

A MD/DO/NP/PA must issue a patient specific order authorizing the use of restraints. RN's may apply restraints under a protocol with an MD/DO/NP/PA order for specific conditions or certain specific clinical procedures (e.g., post-traumatic brain injury, insertion of intra-aortic balloon pump) to prevent significant harm to the patient (see PCS IV-70, Protocol for Use of Treatment Restraints for Specific Patient Conditions) In this situation, RN's maintain and terminate restraint in accordance with established criteria defined in the protocol.

**Patient Safety in Restraints**

The RN is responsible for using appropriate restraints, based on the MD/DO/NP/PA order, and for assessing, monitoring and re-evaluating the patient and restraints.

**The Care Plan Problem:**

In EMR, add Restraint (Adult, Ped) for Adult and Pediatric patients. For NICU patients add Restraints (NICU).
MONITORING AND ASSESSING PATIENTS IN RESTRAINTS

The RN/MD/DO/NP/PA can monitor patients in restraint. PT, OT, Speech Therapist, Psycho-Social Vocational Services, and Radiology Technologists operate under the direction of the current order and continue to monitor and document when the patient is under their sole supervision.

Assessment may include but is not limited to the following:

a. Type of restraint
b. Restraints appropriately applied, removed, or reapplied
c. Whether less restrictive methods are possible
d. Vital signs
e. Respiratory status
f. Circulation, movement, and sensation
g. Skin integrity
h. Mentation/Behavior/Cognitive Function/Level of distress and agitation
i. Bathroom needs
j. Fluids/Nourishment needs
k. Releasing the restraints to check for injury
l. Range of motion performed
m. Patient’s readiness for release from restraints
n. Call light within reach
o. Patient dignity and rights maintained

<table>
<thead>
<tr>
<th>Frequency assessment</th>
<th>Frequency documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least every 2 hours; observed as often as possible.</td>
<td>A minimum of every 2 hours</td>
<td>The selection of an intervention and determination of the necessary frequency of assessment and monitoring should be individualized according to patient needs and situational factors.</td>
</tr>
</tbody>
</table>
Discontinuing Restraint Use

1. The MD/DO/NP/PA/RN has the authority to discontinue the use of restraint.
2. Restraints will be discontinued as soon as is safely possible even if there is still time left on the order when:
   a. Improved mental status
   b. Patient’s agreement and compliance with instructions for safety
   c. Improved ability to sit at edge of bed, transfer or ambulate without risk or injury
   d. Less restrictive measures are effective
   e. Patient’s lines are discontinued or no longer required for medical treatment
   f. The need for restraints does not exist, such as discontinuation of medical treatments
   g. The order has expired
3. When restraints are terminated early and the patient subsequently exhibits the same behavior that initially required the restraints, a new order is required [CMS 482.13(e)(1)(i)(C) A-0161].

   Note: A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient’s need is not considered a discontinuation of the restraint. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.

Risks of Restraint Use

Risks associated with restraint use should be taken into consideration when assessing the need for restraint and determining the monitoring and care needed while restraints are in place. These risks include:

- Patients with cognitive impairment may attempt self-removal, increasing risk of injury.
- Patients may not be able to communicate needs while in restraints.
- Patients in vest/belt restraints may be injured by falling through split side rails.
- Patients in vest/belt restraints may experience respiratory compromise.
- Patients in restraints may exhibit increased agitation.
- Patients may experience psychological distress due to restraints.
- Patients may experience circulatory compromise of restrained extremity.
2016 National Patient Safety Goals

The Joint Commission introduced the National Patient Safety Goal program in 2002 to reinforce the need for organizations to promote specific improvements in patient safety planning. The emphasis is on assessing, managing, monitoring, improving and reporting patient safety related information and data.

UC Davis Medical Center has a strong, fundamental commitment to providing the highest level of safe, quality patient care. Why patient safety? It's important, it’s our business and it’s because we care. Staff can also access the Clinical Affairs’ intranet site, as well as through the National Patient Safety Goals link on The Insider. The Clinical Affairs’ intranet site covers current hot issues from Universal Protocol to Medication Management and Continuous Survey Readiness.

[Note: Joint Commission has established the numbering system. Some goals and/or requirements have been retired, converted to standards, or are not applicable to the hospital setting.]

The goals are:

**Goal #1: Improve the Accuracy of Patient Identification**

NPSG.01.01.01 Two Patient Identifiers: Use at least two patient identifiers when providing care, treatment, and services (neither to be the patient’s room number or physical location). (UC Davis Health System P & P 2702 – Patient Identification for the Hospitalized Patient)

NPSG.01.03.01 Eliminate Transfusion Errors Related to Patient Misidentification: Match the blood/blood component to the order; match to the patient; use a two-person verification process ensuring one person is a qualified transfusionist and the second person is qualified to participate per Health System policy. (Patient Care Standards XIII-12 – Administration of Blood and Blood Components)

**Goal #2: Improve the Effectiveness of Communication Among Caregivers**

NPSG.02.03.01 Critical Results Reporting: Report critical results of tests and diagnostic procedures on a timely basis. (UC Davis Health System P & P 2720 – Communicating Critical Lab Values; Radiology P & P 410 – Radiology Exam Priorities)
Goal #3: Improve the Safety of Using Medications

NPSG.03.04.01 Medication Labeling: Label all medications, medication containers (e.g., syringes, medicine cups, basins, etc...), and other solutions on and off the sterile field in perioperative and other procedural settings.

(UC Davis Health System P & P 3091 – Labeling of Medications in Perioperative & Procedural Areas)

NPSG.03.05.01 Anticoagulation Therapy: Reduce the likelihood of patient harm with the use of anticoagulation therapy.

(PCS IV-64 – Anticoagulation Management Program; PCS XIII-11 – Heparin Infusion, Low Molecular Weight Heparin, Fondaparinux, Direct Thrombin Inhibitors or Oral Direct Factor Xa Antagonists for Prevention or Treatment of Thromboembolism)

NPSG.03.06.01 Improve the Safety of Medications: Maintain & communicate accurate patient medication information. Obtain medication information; document, compare to resolve discrepancies. Provide written information and education to the patient at discharge or end of encounter.

(UC Davis Health System P & P 2711 – Medication Reconciliation; PCS IV-80 – Prescription Medications Following Discharge; PCS IV-85 – Management of a Patient’s Own Medications Brought into UCDMC)

Goal #6: Reduce the Harm Associated With Clinical Alarm Systems

NPSG.06.01.01 Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

(UC Davis Health System P&P 1467 – Safe Medical Device Act (SMDA); P&P 1639- Patient Care Equipment Training; P&P 2242 – Equipment in Patient Care Areas)

Goal #7: Reduce the Risk of Health Care Associated Infections

NPSG.07.01.01 Hand Hygiene Guidelines: Comply with current World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

(PCS XI 23 – Handwashing) (Hand Hygiene)

NPSG.07.03.01 Prevent Health Care Associated Infections Due to Multiple Drug-Resistant Organisms: Implement evidence-based practices to prevent health care associated infections due to multiple drug-resistant organisms in acute care hospitals.

(PCS XI-15 – MRSA Active Surveillance)

NPSG.07.04.01 Prevent Central Line-Associated Bloodstream Infections: Implement evidence-based practices to prevent central line-associated bloodstream infections. (PCS XIII-01 – Venous Access Catheter Master Policy with Links to Procedures)

NPSG.07.05.01 Prevent Surgical Site Infections: Implement evidence-based practices for preventing surgical site infections.

(PCS I-20 – Standards for Creating a Sterile Field)

(PCS XI-02 – Surgical Site Surveillance)

NPSG.07.06.01 Prevent Catheter-Associated Urinary Tract Infections (CAUTI): Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

(UC Davis Health System P & P 2000 – Process for Infection Prevention and Control and Patient Safety Plan; PCS XI-06 – Preventing Healthcare Associated Infections; PCS IX-10 – Urethral Urinary Catheter (Foley and Straight) Overview)

Goal #15: Patient Safety Risk

NPSG.15.01.01 Suicide Risk Assessment: Risk assessment is conducted on patients to determine if they are at risk for suicide. Community resources and a crisis hotline should be provided to the patient and their family members.

(PCS IV-72 – Observation of the Suicidal, Agitated, Behaviorally Difficult, and High Safety Risk Hospitalized Patient)

UNIVERSAL PROTOCOL

UP.01.01.01 Comply With the Universal Protocol: Pre-Procedure Verification Process is to be conducted. Verify correct patient, correct site, and correct procedure.

(PCS IV-19 – Universal Protocol)

UP.01.02.01 Mark the Procedure Site: The procedure site is to be marked with as much involvement by an awake/aware patient as possible.

(PCS IV-19 – Universal Protocol)
UP.01.03.01 Time-Out (Surgical Pause): Immediately PRIOR to skin incision, the entire team will actively participate in a time-out during which key information regarding the surgery/procedure and patient will be verified.

(PCS IV-19 – Universal Protocol)

For more detailed information regarding the Joint Commission National Patient Safety Goals contact: Quality and Safety at 916-734-8186 or Clinical Affairs/Licensure and Accreditation at 916-734-1166

Laminated posters of the UC Davis Medical Center/Joint Commission National Patient Safety Goals and “Badge buddies” referencing the goals for all staff members use can be obtained via interoffice mail by contacting Clinical Affairs.