Student/Instructor Orientation
Independent Study

Please review all materials in the independent study packet. Print the answer sheet, the Information Access Security and Patient Confidentiality Agreement, and the Code of Conduct & Business Acknowledgement Form and turn in all answered/signed forms to the Academic & Contract Liason Department in Human Resources, 1623 Medical Drive. If you have any questions, please do not hesitate to call Tallahassee Memorial HealthCare University at 431.5250. Thank you!

☐ Review Student/Instructor Independent Study packet
☐ Confidentiality Agreement
☐ Code of Conduct Form
☐ Post-test Answer Sheet (page 67)
Student/Instructor Responsibilities and Restrictions

**Student Responsibilities**

1. Students must notify their clinical instructor if they are unable to meet their scheduled clinical rotation.
2. Students **must sign a confidentiality statement** and **must always maintain patient confidentiality**.
3. Students must have their school identification badges and green TMH identification badge visible at all times while in the hospital premises. The green TMH identification badge is obtained from Human Resources.
4. Students must conduct themselves with self-respect and respect for others. Conversations and activities should not be distracting to others.
5. Students must **verify procedures/treatments** with nurse prior to implementing the procedure or treatment.
6. Students are to **report on and off duty to nurse/TMH preceptor** with whom they are working. Students must inform the nurse/TMH preceptor whenever they are off the unit for breaks, lunches, in-services, or other reasons. Students must inform the nurse when they leave for the day.
7. If not assigned to a nurse/TMH preceptor, the student is to report off to the RN caring for the patient(s) the student is assigned to.
8. Students must identify the patient prior to the implementation of any procedure.
   a. Positive identification of the patient is accomplished by checking the patient’s identification bracelet for name and FIN number compared in electronic medical record.
   b. Positive identification must be used to verify patient identification prior to any medication administration or blood specimen collection. Prior to medication administration, the patient’s armband must be scanned. The patient’s name and the FIN on their ID band are to be compared and verified with the name and number on the blood specimen label.

*Continued on Next Page*
### Student/Instructor Responsibilities and Restrictions; continued

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<th>Student Restrictions</th>
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<td>1. Students are not allowed to witness any legal documents.</td>
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<td>2. Students are not allowed to enter any isolation rooms requiring the N95 respirator (mask) – airborne precautions and enhanced droplet precautions.</td>
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<td>3. Students are not allowed to set up or refill PCA/PCE equipment.</td>
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<td>4. Students are not allowed to administer chemotherapy agents.</td>
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<td>5. Students are not allowed to accept verbal or phone orders.</td>
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<td>6. Students are not allowed to administer hypertonic solutions.</td>
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<td>7. Students are not allowed to administer or discontinue blood or blood products.</td>
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<td>8. Students are not allowed to perform RN Review on electronic orders or &quot;sign off&quot; orders in the computer.</td>
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<td>9. Students are to confer with the nurse responsible for the patient prior to initiating any nursing action.</td>
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<tr>
<th>Instructor Responsibilities</th>
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<tr>
<td>1. Instructors are to supply a copy of the clinical objectives to the manager/director of department.</td>
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<tr>
<td>2. Instructors are to notify Charge Nurse/supervisor if student(s) are unable to meet their scheduled clinical rotation.</td>
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<td>3. Instructors are to collaborate with Charge Nurse/supervisor, unit Clinical Specialist, and/or Nursing Administration for making assignments.</td>
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<td>4. Instructors/designated preceptors must oversee procedures for assigned students.</td>
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<td>5. Instructors/designated preceptors must accompany student for all NG, PEG, and parenteral medications (including IVs). Student may administer PO meds independently only following approval by faculty instructor.</td>
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<td>6. Instructors must complete Pyxis tutorial and will be responsible for removing medications for students.</td>
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<td>7. Instructors must sign a “Confidentiality” statement.</td>
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<td>8. Instructors must ask patient/family for permission for students to work with patient.</td>
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<td>9. Instructors must provide TMH with copies of:</td>
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<td>a. Verification of current licensure</td>
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<td>b. Proof of liability insurance</td>
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<td>c. Statement of health status</td>
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<tr>
<td>d. Phone numbers (work and home)</td>
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<td>10. TMH policies and procedures are to be adhered to at all times.</td>
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</table>

Instructors must verify that TMH has a valid Clinical Experiences Agreement with their educational institution on file prior to students beginning their clinical experience. **No clinical activities will be allowed under any circumstances without a signed, current affiliation agreement.**
About TMH

Welcome to Tallahassee Memorial HealthCare

- Founded more than 60 years ago
- A comprehensive system of healthcare services, including operation of a not-for-profit hospital, a teaching institution with clinic, and satellite facilities/family medicine centers in five surrounding counties
- More than 35,000 inpatient admissions per year and 770 patient beds
- The eighth-largest hospital in Florida
- Staff consists of over 500 doctors, representing 50 different specialties
- A Family Medicine Residency Program and five satellite Family Medicine practices in surrounding counties of the Big Bend Region

Hospital Mission
Transforming Care
Advancing Health
Improving Lives

Hospital Vision
Leading our community to be the healthiest in the nation.

I CARE Values
INTEGRITY
We believe in strict personal honesty and independence.

COMPASSION
We believe in sharing one’s suffering and showing mercy.

ACCOUNTABILITY
We believe in being responsible for our actions.

RESPECT
We believe in showing consideration to others.

EXCELLENCE
We believe in achieving the highest level of quality.
Focus Areas of the 2013 Strategic Plan

Population Health Management and Care Coordination

TMH, with leadership from its medical staff, will evolve its regional care delivery model to engage populations in preventive and health management while providing coordinated care across preventive, ambulatory, inpatient and post acute settings.

Physician Alignment

TMH will advance an alignment among the hospital and physicians to foster shared goals, collaboration, and transparent communication to achieve high quality, safety and value of care provided to the patients and communities served.

Regionalization

TMH will lead a network of partners with which it can share and obtain the knowledge, capabilities and resources to further its vision and mission toward population health.

Cultural Development

TMH’s culture will be patient-centric in its orientation as well as collaborative and quality-driven in its operations, thus yielding best practice for improving all components of the Triple Aim. Our culture will attract and retain physicians and colleagues motivated to provide the best possible care for our patients and families.

Technology Enablement

TMH will have leading clinical and information technologies that advance care and serve as a differentiator in the region.

Academic Medical Center Development

TMH will continue to evolve toward becoming an Academic Medical Center.

Operational Efficiency and Financial Performance

TMH and its affiliates will operate as an integrated system, with an emphasis on building its financial strength, capital capacity, and transformational leadership capability.
General Information

**Personal Belongings**
- Students are responsible for their valuables and are encouraged to leave them at home
- TMH does not provide lockers for students.

**Access to Food**

<table>
<thead>
<tr>
<th>Time</th>
<th>Hours of Operation</th>
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<tr>
<td>Breakfast</td>
<td>7:00am – 10:30am</td>
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<tr>
<td>Lunch</td>
<td>11:00am – 2:00pm</td>
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<tr>
<td>Dinner</td>
<td>5:00pm – 7:00pm</td>
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<tr>
<td>Midnight</td>
<td>12:00am – 2:00am</td>
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</table>

The cafeteria is open 24 hours a day except from 10:30 to 11 am.

**Tobacco Free Policy**

Recognizing the health, safety and comfort benefits of smoke-free air and as a healthcare provider, the special responsibility that Tallahassee Memorial HealthCare, Inc. has in establishing, maintaining, and promoting a healthy and safe environment for our community, all facilities, premises and all Tallahassee Memorial HealthCare, Inc. campuses are tobacco-free environments, where the use of tobacco products, including but not limited to, cigarettes, cigars, pipes, smokeless tobacco, chew, snuff, and dip, is strictly prohibited, with exceptions for patients made only by order of attending physicians.

**Parking Information**
- Nursing students are to park in the East Hill Baptist Church parking lot or Lot C.
- To request the shuttle, call from the lot phone.
- To return to the lot, the shuttle will pick up students in front of the Magnolia Lobby (south lobby).
Safety Information

**General Safety Rules**

- No storage is permitted in the exit corridors. Temporary carts (with wheels/castors), are parked only on one side of the corridor.
- Smoke and fire doors are not to be blocked or propped open.
- Fire hose cabinets, fire extinguishers, or any component of a fire alarm system are not to be blocked.
- Only approved ladders are used to work overhead.
- Storage areas are to be kept free of debris and clutter.
- All flammable liquid/materials are to be stored in approved containers and cabinets.
- Any spill is to be cleaned up promptly.
- Material Safety Data Sheets (MSDS) are available for all hazardous materials in the workplace.
- An 18 inch clearance between storage and sprinkler heads is to be maintained at all times.
- Compressed gas cylinders are to be in approved holders that are chained or safely secured. Gas cylinders must never be left free standing.
- Extension cords, provided by Plant Engineering are to be used only in temporary emergency situations.
- Worn, tattered or bubbled carpet is to be repaired or replaced in a timely manner. All staff will report these deficiencies to Plant Engineering.
- Storage in file cabinets is to be evenly distributed to maintain balance.
- Only one drawer of a file cabinet is to be opened at a time. File drawers will not be left open.
- The top of file cabinets is not used for storage which may create overturning, but may be used as a work area, if appropriate.
- All colleagues have a role in safety/hazard surveillance. Any potential hazard is to be reported to the Safety Officer.
- When driving vehicles on TMH property, all colleagues will obey Security directives. Patients, visitors and colleagues have the right-of-way as pedestrians.
- All colleagues will yield to patients being transported throughout the facility.
- Patient transport equipment such as wheelchairs and stretchers is to be left in a secure position when not in use.
- All medical equipment is inspected by Clinical Engineering prior to placing the equipment into service. All medical equipment is inspected and dated annually.
- Defective equipment is not to be used under any circumstance. Defective equipment will be removed from service and taken to or reported to Clinical Engineering.
- When lifting heavy objects, let your legs, not your back, do the lifting.
- All corridors intersections are to be approached with caution.
Emergency Codes

<table>
<thead>
<tr>
<th>Dial Phone #</th>
<th>Code</th>
<th>Condition</th>
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<tbody>
<tr>
<td>0</td>
<td>Code <strong>Red</strong></td>
<td>Fire</td>
</tr>
<tr>
<td>0</td>
<td>Code <strong>Black</strong></td>
<td>Bomb Threat</td>
</tr>
<tr>
<td>0</td>
<td>Code <strong>Pink</strong></td>
<td>Infant/Child Abduction</td>
</tr>
<tr>
<td>88</td>
<td>Code <strong>Blue</strong></td>
<td>Cardiac Arrest/Stroke Alert</td>
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<tr>
<td>0</td>
<td>Code <strong>Brown</strong></td>
<td>Severe Weather</td>
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<tr>
<td>0</td>
<td>Code <strong>Grey</strong></td>
<td>Violence/ Security Alert</td>
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<tr>
<td>0</td>
<td>Code <strong>White</strong></td>
<td>Hostage Situation</td>
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<tr>
<td>0</td>
<td>Code <strong>Orange</strong></td>
<td>Hazardous material spill</td>
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<tr>
<td>0</td>
<td>Code <strong>Yellow</strong></td>
<td>Lockdown</td>
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<tr>
<td>0</td>
<td>Code <strong>Green</strong></td>
<td>Disaster Internal/External</td>
</tr>
<tr>
<td>0</td>
<td>Code <strong>Silver</strong></td>
<td>Active Shooter</td>
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For staff response in any emergency, refer to the Environment of Care Manual (EOC Manual) located on the TMH Intranet, Safety Information section.

Fire Procedures – Code **Red**

Remember **RACE:**
- R **Rescue** the patient
- A **Alarm**, pull the alarm & call 0: Give location & type of fire
- C **Contain** the fire, close all doors
- E **Extinguish** the fire

Pull stations for fire alarms are located near every exit.

Use of Fire Extinguisher – Remember **PASS:**
- P **Pull** - safety pin at top of extinguisher
- A **Aim** - hose, nozzle, at the base of the flames
- S **Squeeze** - or press the handle
- S **Sweep** - from side to side at the base of fire until it goes out

Do not use elevators when fire/smoke alarms are activated.
Safety Information; continued

**Infant/Child Abduction – Code Pink**
When an infant/child is discovered missing, the staff member will immediately institute the following – Immediately notify the operator of a “Code Pink, age, race and sex” of abducted infant/child. Give the location of your unit.

Be on alert for the following:
- A person physically carrying an infant instead of using the bassinet to transport the child, or leaving the hospital with an infant/child on foot rather than a wheelchair & without a colleague escort.
- A person carrying a large package (gym bag, duffel bag, back pack), particularly if the person is “cradling” or “talking” to the bag.
- Be aware that a disturbance may occur in another part of the hospital, thereby creating a diversion that facilitates an infant abduction.
- Stop anyone with an infant/child until a positive identification is made or until an all clear is called.

**Bomb Threat – Code Black**
- Remain calm, keep the caller on the line as long as possible & complete the “Bomb Threat Card.”
- Immediately hang up the phone and call PBX with bomb threat.

**Material Safety Data Sheets (MSDS)**
MSDS information is available via the TMH Intranet, in the Safety Information section. These sheets & container labels provide safety & first aid information to colleagues using hazardous materials in the workplace.

**Waste Disposal – Sharps Box**
The following items are disposed of in the **sharps box**:
- needles - clean or dirty
- syringe and needle combos - clean or dirty
- pacemaker wires and pacing needles
- introducers and guide wires
- any glass contaminated with blood or body fluids
- lancets
- disposable scissors, scalpels, blades, trocars and other instruments - clean or dirty
- glass vials or containers

Continued on Next Page
Safety Information; continued

Waste Disposal – Red Bag Trash Container

The following items are disposed of in the red bag trash container:

- Swan-Ganz, CVP or dialysis catheters, PICC lines and IV catheters
- suction tubing, catheters, yankauers and canisters with blood or body fluids should have Isolyser in to solidify the liquid to decrease chance of spill (no need to empty soft-sided canisters before disposal)
- N/G or similar tubing with visible blood
- any absorbent item saturated with blood or body fluids
- blood or blood products bags and tubing
- any non-absorbent item with blood or body fluids on it
- any tubing, container, or drain contaminated with blood or body fluids like Penrose, Jackson-Pratt drain, Hemovac, etc. (no need to empty soft-sided containers before disposal)

Waste Disposal – White/Clear Bag Trash Container

The following items are disposed of in the white/clear bag trash container:

- used paper towels, food wrappers, napkins, paper cups, and disposable dinnerware
- clean syringes with no needles
- IV tubing and bags with no visible blood
- plastic vials or containers
- Styrofoam of any kind including Styrofoam cups
- all other non-paper items NOT contaminated with blood or body fluids
- plastic, glass, and metal items without blood or body fluids on or in them
- dressings with blood or body fluids that are not saturated
- Tubing/drains/dressing contaminated with urine, sputum, mucous, tears, sweat or feces
- cardboard and packing materials
- newspapers, telephone books (not recyclable due to the poor quality of the paper)
- Alkaline batteries (all other batteries must be disposed of through Plant Engineering.)

IF IN DOUBT – USE A RED BAG OR A SHARPS CONTAINER!

Continued on Next Page
Human Resource Information

Harassment and Discrimination

TMH is committed to maintaining a work environment that is free of discrimination and harassment & will not tolerate harassment and/or discrimination in any form. It is the responsibility of each member of the TMH team to maintain a workplace free of harassment.

Types of Harassment:

- Hostile work environment – when an intimidating, offensive atmosphere is created that interferes with a person’s ability to perform their job.
- Tangible Employee Action (Quid Pro Quo) – expressed or implied demands for sexual favors in exchange for some benefit (a promotion, a raise, change in shift, etc) or to avoid a detriment (corrective action, termination, demotion, a failing grade, etc) that occurs in the workplace.

TMH’s Internal Complaint Procedure:
Our goal in the investigation is to seek appropriate resolution of the matter within the applicable laws and policy guidelines. Any colleague who believes that he or she has been subjected to harassment should immediately report the incident to a supervisor, Colleague Relations, or the Chief Human Resource Officer.

Cultural Diversity

What is cultural diversity?

- Multiculturalism – variations in language, dress, beliefs, and behaviors, such as eye contact and personal space within an ethnic group.

Why is cultural diversity important to us?

- We care for people from many different cultures.
- Understanding different cultural preferences and behaviors helps us to meet the needs of patients more completely and to work with one another in a spirit of mutual respect.
- Better awareness of cultural diversity also helps us to avoid misunderstandings.

Continued on Next Page
What is a cultural assessment?

Fostering an environment that values diversity must include a cultural assessment. The core components should include:

- Cultural/racial ethnic identity
- Language/communication ability and style
- Religious beliefs and practices
- Illness and wellness behaviors
- Healing beliefs and practices

Also consider determining the patient’s:

- Typical nutritional regimen
- Family system functions (identifying the chief decision maker)
- Lifestyle and habits

What do we need to do?

- We need to develop our cultural awareness. This means we need to recognize, understand, and respect our patients’ beliefs, values, and practices.
- It also means to recognize, understand and respect the beliefs, values and practices of our co-workers.
- We all are responsible for solving issues created by diversity.
- We treat every person as an individual.
- We treat every person not as we would like to be treated, but as they would like to be treated.
Service Excellence at TMH

The expectation for all TMH colleagues, students, and instructors is that we demonstrate or “live” the I CARE values in every interaction, every day. The following I CARE Service Standards provide the framework for doing so.

Integrity
- Be honest and trustworthy in all actions and communication.

Compassion
- Demonstrate understanding of customer needs and perceptions.

Accountability
- Take ownership for resolving customer issues and concerns.
- Follow up to ensure resolution and customer satisfaction.
- Apologize for and correct service failures.

Respect
- Show consideration for colleagues, patients and visitors.
- Honor perspectives in addition to your own.

Excellence
- Achieve the highest level of quality by exceeding expectations.
- Anticipate customer needs.

In healthcare when we think of customers we often think of patients first. While patients are certainly our primary customers we also have plenty of customers who are not patients. In fact, every person that enters our doors is our customer. Visitors, family members, physicians and fellow colleagues are all customers and deserve the same level of service as our patients.
Service Recovery is the process of making things right for a customer after a service failure has occurred and is the responsibility of everyone at TMH. The LEAP process for service recovery adopted from the Ritz-Carlton Hotel Company is how we do this.

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<th>The LEAP Process for Service Recovery</th>
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Service Excellence at TMH, continued

10 Habits of a CARE-ing Organization

Johns Hopkins University and Health System has developed the 10 Habits of a CARE-ing Organization – a set of simple behaviors that help each of us deliver world-class service to our customers.

Habit #1: Mind your manners. Use courtesy words like "please", "thank you" and "may I help you".

Habit #2: Be Present. Give your customer 100% of your attention with your eyes, words and body language.

Habit #3: Be Positive. Think the best of people in all situations.

Habit #4: Teamwork Works. Respect each other's privacy and eliminate gossip.

Habit #5: Do Sweat the Small Stuff. A small gesture of kindness can make a big impact.

Habit #6: Make a Promise, Keep a Promise. Follow through with all commitments. If you say you're going to do something, do it.

Habit #7: Re-discover Silence. Practice active listening skills. Remember that listening is not just waiting for your turn to speak.

Habit #8: Be Thankful. Take time to thank someone every day.

Habit #9: Think Ahead. Anticipate your customers' needs.

Habit #10: Just Do It! Put yourself in your customers' shoes. How would you expect to be treated?
Corporate Compliance Information

Introduction

Governmental health care regulations and their enforcement are extremely complex and change frequently. They affect every area of the hospital. To assure full compliance with these laws, rules and regulations, and to maintain the professional integrity of our organization and operations, we have developed and instituted this Corporate Compliance Program.

It is our expectation that all colleagues, contractors, students, members of the Boards of Trustees and medical staff members maintain the standards established by the TMH Corporate Compliance Program in all hospital manners.

The Corporate Compliance Program is instituted to provide guidance to TMH employees to effectively detect, correct, and prevent irregularities, improper conduct and systematic problems which are or may become legal or regulatory violations or violations of the Corporate Compliance Program. The Corporate Compliance Program also assists in developing effective internal controls that promote adherence to applicable Federal and State law, and the program requirements of Federal, State and private health plans.

Code of Conduct and Business Practice Guide

Every Colleague Must Commit to the Following Standards:

1. PROVIDE QUALITY CARE AND SERVICES
We are committed to providing quality care and services to our patients, their families, visitors and the community by:

- Providing treatment and medical services without discrimination.
- Listening and doing our best to understand the needs of our patients, families and visitors by promptly addressing any issues or complaints.
- Including patients in decisions regarding their medical care, whenever possible.
- Ensuring that clinical duties are performed by properly trained, licensed or credentialed individuals. We will conduct appropriate background checks on all potential employees and also verify credentials and qualifications of licensed health care professionals providing services at our facilities.
- Acknowledging that patients and their families are to be informed about the outcomes of care and associated risks.

Continued on Next Page
2. PROMOTE FAIR EMPLOYEE TREATMENT

We are committed to providing a work environment throughout the organization that promotes fair treatment and complies with laws in all matters relating to employment at TMH by:

Demonstrating appropriate respect and consideration for one another.

- Applying all Human Resources Policies & Procedures fairly, equitably and consistently, regardless of position.
- Hiring, training, promoting and compensating on the basis of personal competence and potential for advancement without regard for race, religion, gender, national origin, age, marital status, creed, citizenship or disability, or other classification protected by law.
- Maintaining an environment free of harassment, disruption, intimidation or hostility.
- Encouraging open expression of concerns and use of the problem-solving process.
- Protecting an employee’s job status, working conditions or employment relationship if he/she, in good faith, follows the Problem Resolution Procedure or contacts the Compliance Office.

3. COMPLY WITH THE LAW IN ALL BUSINESS PRACTICES

We will provide health care services and otherwise conduct our business in compliance with laws, regulations and standards that apply to the services provided by TMH by:

- Pursuing only those business opportunities that are both legal and ethical.
- Refraining from engaging in illegal business practices including bribery, kick-backs or payoffs, intended to influence the decisions of TMH colleagues or any external representative.
- Marketing and advertising truthfully and accurately.
- Ensuring that every contract payment or other benefit paid to physicians is for specifically defined services at fair market value.
Corporate Compliance Information; continued

- Maintaining company business records accurately and truthfully and discarding them only according to retention guidelines.
- Recording financial transactions in accordance with generally accepted accounting principles, established accounting policies and internal control policies.
- Ensuring that contracts are approved by legal counsel as and when required by TMH policies and signed only by authorized agents of TMH.
- Acting in good faith in contractual relationships.
- Complying with copyright laws for materials such as software, printed and audiovisual works.
- Complying with Risk Management reporting requirements.

4. RESPECT AND PROTECT CONFIDENTIAL INFORMATION
We will ensure the responsible use of patient, visitor, employee, business or other confidential information by:

- Maintaining the confidentiality of protected health information concerning our patients and TMH by using and sharing it according to established Privacy and other guidelines.
- Limiting access to confidential information to only those who need to know.
- Refraining from discussing confidential information in public areas.
- Preventing others from examining, making copies of or sharing confidential documents or information without authorization.
- Not disclosing to any outside party any restricted nonpublic business information, plans or data acquired during employment with TMH, unless specifically authorized to do so by management.
- Complying with HIPAA’s security and privacy standards.

5. CODE, BILL AND COLLECT IN ACCORDANCE WITH APPLICABLE GUIDELINES
We are committed to integrity in our coding, billing and collection practices by:

- Maintaining honest and accurate records of all services provided to patients. We will submit charges for services and products in accordance with applicable laws and regulations.
- Ensuring bills submitted for payment are properly coded, documented and billed in accordance with applicable laws and regulations.

Continued on Next Page
Corporate Compliance Information; continued

Code of Conduct and Business Practice Guide, continued

- Ensuring that medical information is properly documented in patient records.
- Using codes that accurately describe the services that were appropriately ordered by physicians or health affiliates and actually provided to patients.
- Preventing the submission of claims for payment or reimbursement of any kind that are fraudulent, abusive, inaccurate or medically unnecessary including, but not limited to the following:
  - Billing for items or services not provided to patients;
  - Upcoding for higher reimbursement than is supported by documentation;
  - Submission of claims for outpatient services that are required to be included with an inpatient stay.
  - Submission of duplicate bills (more than one claim for the same service);
  - Unbundling claims (submission of bills in a fragmented fashion to maximize reimbursement if guidelines require the services be billed together);
  - Inclusion of costs that are not allowable to be reimbursed in a cost report; and
  - Billing for a patient discharge when it is appropriate to bill the claim as a patient transfer.
- Taking immediate steps to correct an error, and promptly refund or collect any payments due and owed in accordance with TMH Policies and Procedures should a billing error be discovered.

6. AVOID CONFLICTS OF INTEREST
We will conduct ourselves with integrity, honesty and fairness to avoid any conflict between personal interests and the interests of TMH by:

- Graciously declining any offers of money from patients, their families, visitors and others which are not intended for the benefit of TMH and refer such offers to the TMH Foundation.
- Not providing, or appearing to provide, payment or other benefits for referrals of patients.
- Not accepting gifts/gratuities offered in exchange for favorable treatment.
- Not using any proprietary or nonpublic information acquired as a result of employment with TMH for personal gain or the gain of another organization.

Continued on Next Page
Code of Conduct and Business Practice Guide, continued

- Not accepting educational activities grants that create the appearance of a conflict of interest or exchange for favorable treatment.
- Following the Conflict of Interest Policy in reporting any circumstances that could cause a conflict of interest.
- Conducting all fundraising ethically, within the guidelines and in support of TMH and the TMH Foundation.
- Not contributing or donating TMH funds, products, services or other resources to any political cause, party or candidate without the advance approval of the General Counsel.

7. SAFEGUARD ASSETS, PROPERTY AND INFORMATION

We will use our resources wisely and will be accountable for their proper use by:

- Maintaining, preserving and being personally responsible for TMH assets, property, facilities, equipment and supplies, as well as the property of others.
- Reporting time records accurately and using time at work responsibly for work-related activities.
- Ensuring that property is disposed of in accordance with TMH Policies and Procedures.
- Using E-mail, Voice-mail, Intranet, Internet and other present and future electronic communication responsibly and for approved business purposes in accordance with TMH policies and procedures.

8. MAINTAIN A SAFE ENVIRONMENT

We are committed to providing a safe environment for our patients, staff and visitors by:

- Recognizing, correcting and/or reporting unsafe practices, conditions or potential hazards that may violate any rule, regulation or TMH policy and procedure.
- Refraining from any threats or acts of violence. Immediately reporting such acts or threats to a supervisor and/or Security.
- Using TMH equipment, property and medical products appropriately.
- Using care in the handling and disposal of medical waste or other hazardous materials.
- Eliminating or minimizing hazards to the health and safety of employees, patients and visitors.

Continued on Next Page
Corporate Compliance Information; continued

**Code of Conduct and Business Practice Guide, continued**

- Refraining from using illegal drugs either on or off the job, using non-prescribed controlled substances, or reporting to work under the influence of alcohol.
- Not manufacturing, distributing or possessing a controlled substance or drug not medically authorized.

9. **WHAT TO DO WHEN YOU BELIEVE THERE MAY BE A PROBLEM**
   - Refer to TMH’s Compliance Program and/or Policies and Procedures for additional information.
   - Contact your department manager or, if necessary, up to the appropriate Vice President.
   - Contact Human Resources for employment-related matters to begin the Problem Resolution Procedure as outlined in the TMH Personnel Policy and Procedures Manual.
   - Contact the Compliance Office at 431-COMP (2667) or the Compliance Helpline at 1-877-772-6723 to seek additional information or report improper conduct. You are encouraged to resolve issues, whenever possible, by utilizing TMH’s Policies & Procedures or by contacting your department manager or, if necessary, other appropriate Vice President. If you are unsuccessful in using this approach, the Compliance Helpline is available to you at 1-877-772-6723 (24 hours per day). When calling the Compliance Helpline, you may remain anonymous. Should you choose to identify yourself, your identity will be protected to the limit of the law. Concerns brought to TMH attention through the Compliance Helpline will be promptly and thoroughly evaluated and investigated for proper resolution.

**Important Terms to Know**

- **Abusive/Abuse** – Inappropriate, consistent or incorrect practices that directly or indirectly lead to incorrect payment for services; abusive acts may be committed without certainty of knowledge, willfulness or intention.
- **Billing for Services and Items Not Rendered** – Submitting a claim which represents that the provider performed a service all or part of which was not performed.
- **Colleagues** – All TMH Employees, Medical Staff members, temporary per diem personnel, volunteers, students and others rendering paid or unpaid services to TMH, and all TMH Agents.

Continued on Next Page
Corporate Compliance Information; continued

**Important Terms to Know, continued**

- **Compliance Program** – A process designed to promote ethical and honest practices in our day to day operations, detect and prevent illegal activities by employees, physicians, vendors and all others providing services and/or doing business within TMH.

- **Conflicts of Interest** – Any situation in which the personal interest of any individual may conflict with the interest of the TMH System.

- **Copyright Laws** – Laws granting the legal right for exclusive publications, products, sale or distribution of material to the author or designated individual. Material cannot be reproduced without written permission of the copyright holder.

- **Credentialed/Credentialing** – The process of assessing qualifications and granting privileges to licensed health care professionals to treat patients.

- **Duplicate Billing** – Submission of more than one claim for the same service of the bill is submitted to more than one primary payer at the same time.

- **Fraudulent/Fraud** – False statements, representation or concealment of material facts to obtain a benefit or payment for which no entitlement exists; acts that are committed knowingly, willfully and intentionally.

- **Good Faith Reporting** – Reporting an act of known or suspected non-compliance based upon facts or observations that the individual making the report considers to be true to the best of their knowledge and belief.

- **Harassment** – An inappropriate or unwelcome act or series of acts that significantly impacts the ability of another individual to perform his/her duties.

- **Informed Consent** – Informed consent is a process which involves exchange of information between the patient and practitioner as well as permission, approval or assent. Informed consent is consent given by the patient based on knowledge of the nature of the procedure to be performed and its risks, benefits and alternatives, including neuroleptic drugs.

- **TMH Agents** – Includes all persons and entities that have contracted with TMH to provide health care related services, equipment or other goods or services.

- **Upcoding** – The practice of using billing codes that provide a higher payment rate than the billing code that actually reflects the service furnished to the patient.
Corporate Compliance Information; continued

**Reportable Acts**

The following are reportable acts:

- Waste
- Fraud
- Abuse

Contact the Compliance Office at 431-COMP (2667) or the Compliance Connection Helpline at 1-877-772-6723 to seek additional information or report improper conduct.

See Appendix A for more information regarding TMH’s Corporate Compliance Program and a list of resource staff and their contact information.

**HIPAA Privacy and Security Rules**

In today’s healthcare industry, health information is frequently created, stored or shared electronically through the use of computers, email, fax machines, and the internet. The positive and negative features of this new communication environment have been debated and now these communications are regulated by law. The Health Insurance Portability Act of 1996 (HIPAA) was created for the following purposes:

- To guarantee portability of health insurance coverage
- Reduce Fraud and Abuse
- Protect Patient Information
- Establish Standards for simplification of the administration of health insurance claims

Generally, the Act provides standards and requirements for maintaining and transmitting health information including:

1. **Transaction and Code Set Standards:** The Transaction and Code Set Standards define and standardize the form and format of health insurance claims.

2. **Privacy and Security Standards:** Developed to protect the confidentiality and security of health information (known as Protected Health Information or PHI).
   - The Privacy Standards deal with all forms of health information – oral, written, and electronic. There are policies & procedures that became effective on April 14, 2003 because of these standards.
• The Security Standards deal with information created, maintained or transmitted electronically. The Security Standards were released in final form on February 13, 2003 with a compliance date of April 21, 2005.

See Appendix B for more information regarding HIPAA and TMH Privacy Officer contact information.

Patient Information

Patient Rights and Responsibilities
Patients at Tallahassee Memorial Hospital have certain rights and responsibilities. When patients understand these rights and responsibilities, they can contribute to the effectiveness of their treatment and the quality of their care.

As a member of the healthcare team, you can play an important role in educating patients and their families. A summary of the Patient Rights and Responsibilities that reflect TMH’s concern and commitment to patients is found in Appendix C. This list refers to all patients; the parents or guardians if the patient is a newborn, child or adolescent; or person acting on their behalf if the patient is incapacitated. This summary is part of the Patient Admission Packet.

Advance Directives
“Advance Directives” means a written instruction, such as a living will, designation of healthcare surrogate, organ donation direction, or durable power of attorney for healthcare, signed by the patient, recognized under state law, and related to the provision of healthcare when the person is incapacitated. Advance Directives are important when severe illness or accident makes the patient unable to communicate. These directives allow the patient to be treated as if the patient were able to communicate healthcare decisions.

Information on the extent to which the hospital is able, unable, or unwilling to honor advance directives is given to every patient upon admission. Individuals are not required to complete advance directives. Tallahassee Hospital will not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

For more information on “Advance Directives”, refer to Administrative P&P 40-61.
Patient Information; continued

Tallahassee Memorial Hospital’s Administrative Policy and Procedure (Administrative P&P 40-59, 40-39, 40-73 Abuse Child, Abuse Adult, Abuse Domestic Violence) describes our duties and responsibility in reporting abuse, neglect, and exploitation cases. Please refer to the above policy for an extensive list of characteristics of abuse, neglect, or exploitation, as well as the reporting contact information.

- **“Domestic Violence”** is any assault, battery, sexual assault, sexual battery or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit.
- **“Abuse”** is intentional maltreatment or infliction of injury, either physical or psychological, upon an elderly or disabled adult. This includes mental, physical, or sexual abuse:
  - Mental Abuse - includes humiliation, harassment, and threats of punishment or deprivation.
  - Physical Abuse - includes hitting, slapping, pinching, or kicking. Also includes controlling behavior through corporal punishment.
  - Sexual Abuse - includes sexual harassment, sexual coercion, and sexual assault.
- **“Neglect”** is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This includes withholding food, hydration, clothing, medical care, and good hygiene.
- **“Exploitation”** of the elderly or disabled is knowingly obtaining or using or trying to obtain or use an elderly or disabled adult person’s funds, assets, or property with the intent to temporarily or permanently deprive them of the use, benefit or possession of funds, assets, or property or to benefit someone other than the elderly or disabled adult by a person or conspiring to do the same with another person.

*Continued on Next Page*
Patient Information; continued

Abuse, Neglect, and Exploitation, continued

Florida law mandates that any physician, nurse, or hospital employee that is involved in the admission, examination, care or treatment of a person with suspected abuse, neglect, exploitation MUST report this to the Department of Children and Family Services @ 1-800-962-2873.

- The patients’ primary physician and case management should be notified.
- An incident report must be made and forwarded to Risk Management.
- Document in the patient’s medical record date, time, name, and title of the person to whom you reported the suspected or actual abuse, neglect, or exploitation.

The patient/family may access protective services independently. Case Management Services can provide assistance. Please check the TMH abuse policy for the list of protective services and advocacy groups.

See Appendix D for the physical indicators of elderly abuse and neglect

See Appendix E for physical and behavioral indicators for the abuse and neglect of children

Clinical Information

Restraint and Seclusion Policy

PURPOSE:

1. To protect patient rights, ensure patient safety and eliminate the inappropriate use of restraint or seclusion.
2. To use restraint or seclusion only when necessary to ensure the immediate physical safety of the patient, staff or others.
3. To eliminate the use of restraints whenever possible and, when they are used, to discontinue their use as soon as possible based on an individualized patient assessment and re-evaluation.

DEFINITIONS:

Restraint: Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body or head freely. Some commonly used hospital devices and practices that would meet the definition of a restraint are:

A. Tucking a patient’s sheets in so tightly that the patient cannot move
B. Use of a “net bed” or “enclosed bed” that prevents the patient from freely
exiting the bed. **EXCEPTION:** placement of a toddler in an “enclosed” or “domed” crib.

C. Use of “Freedom” splints to immobilize a patient’s limb

D. Using side rails to prevent a patient from voluntarily getting out of bed

E. Geri chairs or recliners, only if the patient cannot easily remove the restraint appliance and get out of the chair on his or her own

**Seclusion:** The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff member or others.

**Timeout** is not considered seclusion.

**Chemical Restraint:** A drug or medication used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

**Nurse:** In the context of this policy, applies to either a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is competent and trained in restraint use. “RN” is used when the statement applies only to a registered nurse.

**Qualified caregiver:** Clinical caregiver who has been trained in the application and release of restraints which may include Patient Care Assistants (PCA), Certified Nursing Assistants (CNA), Respiratory Care Therapists, Physical Therapists and Security Officers.

**Policy**

1. Restraint or seclusion will only be imposed to ensure the immediate physical safety of the patient, staff members or others and when less restrictive measures have been determined to be ineffective. Restraints will be discontinued at the earliest possible time.

2. The patient will be assessed to determine whether the use of less restrictive measures pose a greater risk than the risk of using a restraint or seclusion.

3. Application includes the least restrictive restraint, as determined by the physician or RN, and as appropriate for the situation and will be applied and removed by a trained, qualified caregiver. Restraint options include (from least to most restrictive):
   - A. Side rails
   - B. Hand mitts
   - C. Roll belt
   - D. Limb restraints

4. Restraints are used only upon the order of a physician which will be obtained prior to initiation of restraint or seclusion. They may not be ordered by a PA or ARNP.

5. In an emergency situation where the safety of the patient, staff or others is jeopardized, the physician will be notified as soon as possible (within 30 minutes) of the initiation of restraints or seclusion and an order will be obtained.

6. Restraints will be secured with a “quick release” tie.

7. Use of restraints for violent, self-destructive behaviors:
   - A. Non-physical interventions violent, self-destructive behaviors are used whenever possible. Restraint or seclusion for violent, self-destructive behaviors are used only when non-physical interventions are ineffective or not viable and when the patient is at imminent risk of self harm or harm to others.
B. The hospital does not permit restraint or seclusion for violent, self-destructive behaviors to be used for the purpose of coercion, discipline, convenience or staff retaliation. Seclusion is only used at the Behavioral Health Center.
C. The type of intervention used in lieu of restraint or seclusion for violent, self-destructive behaviors takes into consideration information learned from the patient’s initial assessment.

**Non-Violent use of restraints**

- Physician’s order must be renewed every calendar day.  
The patient in restraints will be observed and monitored at least every two (2) hours or more frequently, as required by his or her needs:
  1. Physical well being including vital signs, neurological assessment, circulation and skin integrity and range of motion of affected limbs
  2. Emotional well being such as level of distress and agitation, mental
  3. Status and cognitive functioning
  4. Comfort
  5. Hydration and nutritional needs
  6. Elimination needs
  7. The patient’s rights, dignity and safety.
- The patient must be released a minimum of every 2 hours for range of motion, food, fluids, toileting and assessment.
- Restraints are discontinued if the behavior is resolved, a sitter is with patient, or clinical justification no longer exists.
- Patients are not restrained in the prone position. Patients restrained in the supine position are done so in a manner to prevent aspiration.

**Threatening Behavior**

A person’s behavior often reflects his or her mood. Emotional responses can vary from calm to anxious, angry, or aggressive. Behavior can also be influenced by injuries and illnesses. Aggressive behavior may be caused by:

- Head injury
- Seizure disorder
- Diabetes mellitus
- Respiratory distress with hypoxemia
- Medications
- Alcohol intoxication
- Substance abuse
- Dementia/cognitive decline

Situations in the hospital can also lead to aggressive behavior by patients or families – some of these are influenced by staff behavior:

- Time delays
- Not understanding staff comments or explanations
- Perceiving staff to be rude or uncaring
- Grief
- Trauma
• Being a victim of a crime

A patient’s behavior should dictate the staff member’s response. When the patient is anxious but still able to exhibit some control, the most important thing that staff can do is listen.

• When it is time to talk, use a calm, low tone of voice.
• Reassure the patient that his / her needs will be met, but don’t make unrealistic promises like “we’ll get rid of your pain”.
• Set reasonable limits and be prepared to act on them.
• Do not allow patients to make bargains with you.
• Be realistic in the management of patients with severe judgment impairment. Recognize that medications or restraints may be indicated to maintain safety of the patient and to treat their condition.

See Appendix F for more information on managing escalating behavior

Care of the Dying Patient – End of Life Issues

1. Assessment (by the RN, in collaboration with the interdisciplinary team)
   • Review chart for presence of advance directives/living will. If none available, discuss with patient/loved ones their wishes regarding end-of-life care and assist patient in formulating an advanced directive, as appropriate.
   • Assess symptoms such pain, discomfort, nausea/vomiting, abnormal patterns of elimination, inadequate nutrition, dehydration and ineffective breathing patterns
   • Monitor coping abilities of patient & loved ones.

2. Reportable Conditions – Report the following to the physician:
   • lack of pain relief or lack of relief from obvious discomfort-look for signs such as facial grimacing, tearing, restlessness, air hunger, anxiety, or tachycardia
   • lack of relief from other adverse symptoms
   • adverse reactions or side effects to medications or treatments

3. Care and Consults
   • Provide/assist with hygiene/ grooming and other ADLs
   • Position of comfort
   • Symptom control & management (a) non-pharmacologic-presence of family/friends/pastoral care, private & peaceful environment (b) pharmacologic-analgesics and sedatives
   • Discuss care goal with patient/loved ones and allow them to participate in decision making
   • Coordinate visitation, provide privacy, when preferred & encourage loved ones to participate in care, if appropriate
   • Respect patient's/loved ones' cultural, social & spiritual beliefs;
   • To provide a holistic & optimum care, collaborate and consult with the following disciplines, as needed:
     • Case management (social worker)
     • CNS
     • Respiratory therapist
     • Dietitian/Nutritional Support
     • Other – ethics committee

4. Safety
   • Appropriate safety monitoring and measures (include assessment for Fall Risk)
HAND HYGIENE

PURPOSE:  
- To decrease the risk of transmission of infection by appropriate hand hygiene.  
- To ensure compliance with the JCAHO safety goal of implementing the current CDC hand hygiene guidelines.

POLICY:  
Hand hygiene is generally considered the most important single procedure for preventing healthcare-associated infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects. Although antiseptics and other hand hygiene agents do not sterilize the skin, they can reduce microbial contamination depending on the type and the amount of contamination, the agent used, the presence of residual activity and the hand hygiene technique followed.

This facility has implemented the CDC Category I recommendations for hand hygiene.

I. INDICATIONS FOR HANDWASHING AND HAND ANTISEPSIS

A. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water.

B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands.

C. Decontaminate hands before having direct contact with patients.

D. Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter.

E. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure.

F. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient).

G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled.

H. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care.

I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.

J. Decontaminate hands after removing gloves.

K. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water.

L. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if exposure to Bacillus anthracis is suspected or proven. The physical action
of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores.

II. HANDWASHING
When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water.

A. Turn on water to a comfortable warm temperature.
B. Moisten hands with soap and water and make a heavy lather.
C. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction.
D. Rinse hands well under running water.
E. Turn off faucet with paper towel and discard.
F. Dry hands with a clean paper towel and discard.

III. HAND HYGIENE TECHNIQUE
If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations other than those listed under “handwashing” above.

A. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
B. Follow the manufacturer’s recommendations regarding the volume of product to use.
C. Waterless handwash stations should be strategically placed to be used as an adjunct to soap and water handwash. Note: Flammability of product may be an issue. Check with state and local fire guidelines before placement and bulk storage.

IV. SURGICAL HAND ANTISEPSIS
A. Remove rings, watches, and bracelets before beginning the surgical hand scrub.
B. Remove debris from underneath fingernails using a nail cleaner under running water.
C. Surgical hand antisepsis using either an antimicrobial soap or an alcohol-based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures.
D. When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2-6 minutes. Long scrub times (e.g., 10 minutes) are not necessary.
E. When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol solution,
precwash hands and forearms with a non-antimicrobial soap and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves.

V. HAND LOTIONS
The healthcare facility may choose to provide a hand lotion approved by the Infection Prevention Committee that is compatible for use with hand hygiene products and gloves already in use by facility.
A. Some products interfere with persistence of skin antiseptics or glove integrity.
B. Hand lotion stations should be installed near handwash stations.
C. Hand lotions should not be allowed to be brought from home. Contaminated hand lotions have been implicated in outbreaks of diseases (primarily gram negative rods) in healthcare facilities. Large bottles or poorly designed nozzles can become colonized allowing for spread of microorganisms on the hands of healthcare workers.

VI. OTHER ASPECTS OF HAND HYGIENE
A. Do not wear artificial fingernails or extenders when having direct contact with patients.
B. Keep natural nails tips less than 1/4-inch long.
C. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and nonintact skin could occur.
D. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients.
E. Change gloves during patient care if moving from a contaminated body site to a clean body site.

STANDARD PRECAUTIONS

PURPOSE: It is the intent of this facility that all patient blood and body fluids will be considered potentially infectious, and standard precautions will be used for all patients.

I. Gloves—gloves should be worn whenever exposure to the following is planned or anticipated:
   A. Blood/blood products/body fluids with visible blood, excretions, secretions
   B. Urine
   C. Feces
   D. Saliva
   E. Mucous membranes
   F. Wound drainage
   G. Drainage tubes
   H. Nonintact skin
   I. Amniotic, cerebral spinal, pericardial, pleural, peritoneal, synovial fluids
   J. Performing venipuncture or invasive procedures

II. Masks and eyewear (or face shields)—should be worn during procedures that are likely to generate droplets/splashing of blood/body fluids.

III. Gowns/Aprons (fluid resistant)—should be worn when there is potential for soiling clothing with blood/body fluids.

IV. Eyewear—protection over the eyes should be worn during procedures that are likely to generate droplets of blood/body fluids.

V. Private room—consider when patient hygiene is poor or in cases where blood/body fluids cannot be contained.

VI. Hand hygiene—refer to hand hygiene procedures. Waterless products are encouraged for use and should be placed in strategic locations.

VII. Resuscitation equipment—mouthpieces or other ventilation devices should be available as alternatives for mouth to mouth resuscitation.

VIII. Sharps precautions—safer sharps should be used and used sharps should be placed in an appropriately labeled puncture resistant container. Container should be placed so that healthcare workers can easily see opening and reach across horizontally to use, whenever possible.

IX. Lab specimens—should be placed in a container that prevents leakage during collection, handling, processing, storage, transport, or shipping and should be labeled with biohazard symbol. If outside contamination of the primary container occurs, it should be placed within a second container.

X. Blood spills—spills of blood or other body fluids should be removed and the area decontaminated using the facility blood spill supplies to include, gloves, gown, face mask with eyeshield, Solidifier Powder, disposable scraper, paper towels, and biohazardous red
bag. The manufacturer’s directions will be followed for use of the product in cleaning and decontaminating spills. The disinfectant should be EPA registered and have kill data against Hepatitis B and HIV or should be tuberculocidal.

XI. Linen—soiled linen should be handled as little as possible. Gloves should be worn to handle wet linen. Linen will be bagged in an impervious bag or placed in a container lined with an impervious lining.

XII. General waste—waste should be bagged in impervious bags.

XIII. Biomedical waste—refer to biomedical waste policy.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

I. PPE is provided to all associates. Each associate is responsible for knowing where the equipment is kept in the department.

II. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.

III. PPE available includes gloves, gowns or aprons, masks, eye protection, and resuscitation devices.

See “Donning and Removing PPE” following the Contact Precautions policy.

RESPIRATORY HYGIENE

Excellent respiratory hygiene practice shall be used for all patients at all times. This practice should be in use between all healthcare workers and families at all times to reduce the spread of respiratory illnesses.

References:


RESPIRATORY HYGIENE/COUGH ETIQUETTE
IN HEALTHCARE SETTINGS

PURPOSE: To prevent the transmission of all respiratory infections in healthcare settings, including influenza, the following infection control measures should be implemented at the first point of contact with a potentially infected person. They should be incorporated into infection control practices as one component of Standard Precautions.

I. VISUAL ALERTS

Post visual alerts (in appropriate languages) at the entrance to the facility and to outpatient facilities (e.g., emergency departments, physician offices, outpatient clinics) instructing patients and persons who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection when they enter the building or first register for care and to practice Respiratory Hygiene/Cough Etiquette.

A. Notice to Patients to Report Flu Symptoms
   Emphasizes covering coughs and sneezes and the cleaning of hands

B. Cover Your Cough
   Tips to prevent the spread of germs from coughing

C. Information about Personal Protective Equipment
   Demonstrates the sequences for donning and removing personal protective equipment

II. RESPIRATORY HYGIENE/COUGH ETIQUETTE

A. The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection.
   1. Cover the nose/mouth when coughing or sneezing;
   2. Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use;
   3. Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic handwash) after having contact with respiratory secretions and contaminated objects/materials.

B. Healthcare facilities should ensure the availability of materials for adhering to Respiratory Hygiene/Cough Etiquette in waiting areas for patients and visitors.
   1. Provide tissues and no-touch receptacles for used tissue disposal.
   2. Provide conveniently located dispensers of alcohol-based hand rub; where sinks are available, ensure that supplies for hand washing (i.e., soap, disposable towels) are consistently available.
III. MASKING AND SEPARATION OF PERSONS WITH RESPIRATORY SYMPTOMS

During periods of increased respiratory infection activity in the community (e.g., when there is increased absenteeism in schools and work settings and increased medical office visits by persons complaining of respiratory illness), offer masks to persons who are coughing. Either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties) may be used to contain respiratory secretions (respirators such as N-95 or above are not necessary for this purpose). When space and chair availability permit, encourage coughing persons to sit at least three feet away from others in common waiting areas. Some facilities may find it logistically easier to institute this recommendation year-round.

IV. DROPLET PRECAUTIONS

Advise healthcare personnel to observe Droplet Precautions (i.e., wearing a surgical or procedure mask for close contact), in addition to Standard Precautions, when examining a patient with symptoms of a respiratory infection, particularly if fever is present. These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions

Cover your Cough

Cover your mouth and nose with a tissue when you cough or sneeze

Cough or sneeze into your upper sleeve, not your hands.

Put your used tissue in the waste basket.

You may be asked to put on a surgical mask to protect others.

Clean your Hands

Wash with soap and water

or clean with alcohol-based hand cleaner.

after coughing or sneezing.

Isolation
CONTACT PRECAUTIONS

PURPOSE: It is the intent of this facility to use contact precautions in addition to standard precautions for patients known or suspected to have serious illnesses easily transmitted by direct patient contact or by contact with items in the patient’s environment.

BARRIERS INDICATED FOR CONTACT PRECAUTIONS

Contact Precautions shall be used in addition to standard precautions for patients with infections that can be easily transmitted by direct and indirect contact.

There are two types of contact transmission:

- **Direct Contact Transmission** – microorganisms are transmitted directly from person to person.
- **Indirect Contact Transmission** – transfer of the infectious agent through a contaminated intermediate object or person.

I. PATIENT PLACEMENT

A. Patient may be placed in a private room. If a private room is not needed/not available, the patient may be placed in a room with a patient(s) who has an active infection with the same organism but with no other infection.

B. When a private room is not available and cohorting is not an option, consider the organism and patient population when determining placement. A decision will be made on a case-by-case basis regarding the safety of placing the patient in a room with another patient. Examples of patients who may require a private room include patients with resistant organisms who have copious drainage from a wound, patients with poor hygiene and whose behavior cannot be positively influenced, etc.

II. GLOVES AND HAND HYGIENE

A. Hand hygiene should be completed prior to donning gloves.

B. Gloves should be worn when entering the room and while providing care for the patient.

C. Gloves should be changed after having contact with infective material (e.g., fecal material and wound drainage).

D. Gloves should be removed before leaving the patient’s room and hand hygiene should be performed immediately.

E. After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items.

See “Donning & Removal of PPE” following this policy.
III. GOWNS

A. A gown should be donned prior to entering the room or patient’s cubicle.

B. The gown should be removed before leaving the patient’s room.

C. After removal of the gown, clothing should not contact potentially contaminated environmental surfaces.

See “Donning & Removal of PPE” following this policy.

IV. PATIENT TRANSPORT

A. Activities of the patient may need to be limited. This will be determined on a case-by-case basis.

B. If the patient leaves the room, precautions should be maintained to minimize the risk of transmission of microorganisms to other patients and contamination of environmental surfaces or equipment.

V. PATIENT CARE EQUIPMENT

A. Dedicated patient-care equipment should be considered for the patient.

B. If use of common equipment or items is unavoidable, the items should be adequately cleaned and/or disinfected before use for another patient.

VI. CONTACT PRECAUTIONS MAY BE CONSIDERED FOR (EXAMPLES):

A. Multi-drug resistant organisms (e.g., MRSA, VRE, ESBLs, KPC)

B. Scabies

C. *Clostridium difficile*, diarrhea, incontinence

D. Uncontained draining wounds

Please refer to the table titled “Type and Duration of Precautions Recommended for Selected Infections and Conditions” for a complete listing of diseases requiring precautions.
DONNING PPE

Type of PPE used will vary based on the level of precautions required, e.g., Standard and Contact, Droplet or Airborne Isolation Precautions

GOWN
- Fully cover torso from neck to knees, arms to end of wrist, and wrap around the back
- Fasten in back at neck and waist

MASK OR RESPIRATOR
- Secure ties or elastic band at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

GOGGLES/FACE SHIELD
- Put over face and eyes and adjust to fit

GLOVES
- Extend to cover wrist of isolation gown

SAFE WORK PRACTICES
- Keep hands away from face
- Limit surfaces touched
- Change PPE torn or heavily contaminated
- Perform hand hygiene
REMOVING PPE

Remove PPE at doorway before leaving patient room or in anteroom; remove respirator outside of room

GLOVES
- Outside of gloves are contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist

GOGGLES/FACE SHIELD
- Outside of goggles or face shield are contaminated!
- To remove, handle by “clean” head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

GOWN
- Gown front and sleeves are contaminated!
- Unfasten neck, the waist ties
- Remove gown using a peeling motion; pull gown from each shoulder toward the same hand
- Gown will turn inside out
- Hold removed gown away from body, roll into a bundle and discard into waste or linen receptacle

MASK OR RESPIRATOR
- Front of mask/respirator is contaminated – DO NOT TOUCH!
- Grasp bottom then top ties/elastics and remove
- Discard in waste container

HAND HYGIENE
Perform immediately after removing all PPE
DROPLET PRECAUTIONS

PURPOSE: It is the intent of this facility to use droplet precautions to decrease the risk of droplet transmission of infectious agents.

BARRIERS INDICATED FOR DROPLET PRECAUTIONS
Droplet precautions shall be used in addition to Standard Precautions for patients with infections that can be transmitted by droplets. Droplet transmission involves contact of the conjunctiva or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets may be generated by the patient’s coughing, sneezing, talking, or during the performance of procedures, e.g., suctioning.

I. PATIENT PLACEMENT
A. Patient may be placed in a private room. If a private room is not necessary/not available, the patient may be placed in a room with a patient(s) who has an active infection with the same organism but with no other infection (cohorting).
B. When a private room is not available and cohorting is not an option, maintain spatial separation of at least 3 feet between the infected patient and other patients and visitors. Special air handling and ventilation are not necessary and the door may remain open.

II. MASKS
A. A mask should be worn to enter the room or cubicle.

III. TRANSPORT
A. Limit the movement and transport of the patient. If transport is necessary, masking the patient may minimize dispersal of droplets.

IV. DROPLET PRECAUTIONS MAY BE CONSIDERED FOR (EXAMPLES):
A. Influenza
B. Mycoplasma pneumonia
C. Strep pharyngitis or pneumonia

Please refer to “Type and Duration of Precautions Recommended for Selected Infections and Conditions” for a complete listing of diseases requiring precautions.
AIRBORNE PRECAUTIONS

PURPOSE: It is the intent of this facility to use precautions to decrease the risk of airborne transmission of infectious diseases.

POLICY: Airborne precautions will be used in addition to standard precautions for patients known or suspected to be infected with a disease spread by very small droplet nuclei (5 mm or smaller). These particles may be spread through the air and may be carried on air currents or inhaled by another person. Special air handling/ventilation is needed.

I. PATIENT PLACEMENT
   A. A private, negative-pressure Airborne Infection Isolation Room (AIIR) is necessary. The room must meet the American Institute of Architects/Facility Guidelines Institute standards including:
      1. Monitored negative pressure relative to the surrounding area.
      2. 12 air exchanges per hour for new construction and renovation and 6 air exchanges per hour for existing facilities.
      3. Air exhausted directly to the outside or recirculated through HEPA filtration before return.
   B. Door must remain closed to ensure negative pressure.
   C. A visual monitor is required to check continued negative pressure.
   D. Patients with same diseases may be placed together.

II. MASKS
   A. A mask should be worn when entering the room.
   B. Susceptible persons entering the room of a patient with measles, chickenpox, or disseminated zoster must wear a mask. Preferably, caregivers immune to these diseases should provide care and do not have to wear a mask. For ease of communication, some facilities may require all staff to wear a mask.
   C. An N-95 respirator is required to be worn for patients known or suspected of having TB, smallpox, or SARS.

III. TRANSPORT
   A. Patients must be masked when being transported to other areas of the facility. Efforts should be made to keep the patient within the room, when possible.

IV. DISEASES
   A. TB, SARS, Chickenpox, Disseminated Zoster, Measles, Hemorrhagic fevers (Ebola, Lassa, Marburg).

V. MONITORING OF CONTROLS:
   A. A program should be established to fit test employees for the N-95 mask best suited to their anatomy and needs.
   B. Equipment should be easily available.
C. Masks should be changed during the shift when becoming moist, misshapen, etc.

VI. ENGINEERING CONTROLS
A. Isolation rooms should be checked visually by caregivers during the course of the
   workday.
B. Engineering should check air control changes and negative pressure daily while in
   use for airborne precautions.
C. Visual monitors should be installed outside the rooms. (AIA Guidelines for
   Design and Construction of Healthcare Facilities, 2006.)

VII. CONTACT AND AIRBORNE ISOLATION:
A. Certain diseases may require use of mask, goggles, gowns, and gloves or other
   additional protection at all times during the care of the patient.
B. Both signs should be posted, and dedicated equipment should be used for that
   patient.
C. Depending on the disease, the facility may choose to cohort staff or limit traffic
   into room. Some examples are SARS and smallpox. Each situation shall be
   evaluated on a case-by-case basis as some diseases are emerging and information
   is rapidly changing.

Please refer to “Type and Duration of Precautions Recommended for Selected Infections
and Conditions” for a complete listing of diseases requiring precautions.

Reference: CDC, Guideline for Isolation Precautions: Preventing Transmission of Infectious

AIA, 2006 Guidelines for Design and Construction of Health Care Facilities by the
Facility Guidelines Institute and the AIA Academy of Architecture for Health, with
https://aia-
timssnet.uapps.net/timssnet/products/TNT_Products.cfm?SR=1&action=long&prim
ary_id=157165013X
DROPLET ISOLATION

• Wear surgical mask when entering the room.
• Wear eye protection, gown, and gloves if within six (6) feet of the patient.
• Limit patient transport to essential purposes only. Mask patient with surgical mask for transport and notify receiving department.
• Use Standard Precautions for all other aspects of care.
• Do not allow the patient to wait in a hallway before or after a procedure.
AIRBORNE ISOLATION

• Wear N95 mask to enter the room.
• Keep door closed – this is a negative airflow room.
• Limit patient transport to essential purposes only. Mask patient with surgical mask for transport and notify receiving department. Do not allow the patient to wait in a hallway before or after a procedure.
• Use Standard Precautions for all other aspects of care.
• Continue precautions for 30 minutes after patient has been discharged from a negative pressure room.
ENTERIC CONTACT ISOLATION

• Wash hands with SOAP and WATER ONLY
• Wash hands before donning gown/gloves and immediately after removing gown/gloves
• Wear gown and gloves to enter room
• When transporting patient, place clean gown and sheet on patient and notify receiving department
• Use dedicated patient care equipment only
• Use Standard Precautions for all other aspects of care
CONTACT ISOLATION

• Hand hygiene before donning gown/gloves and immediately after removing gown/gloves
• Wear gown and gloves to enter room
• When transporting patient, place clean gown and sheet on patient and notify receiving department
• Use dedicated patient care equipment only
• Use Standard Precautions for all other aspects of care
Fall Prevention for the Adult Patient

GOALS:
1. Falls and/or complications related to falls are prevented.
2. A safe environment is maintained for the patient.

ASSESSMENT:
1. Assess the patient for the following risk factors on admission:
   a. Cognitive or physical deficits that may increase the potential for falling
   b. Communicative barriers (i.e. non-verbal, hard of hearing, different language)
   c. History of falls
   d. Altered mobility/use of walking aid.
   e. History of orthostatic hypotension, dizziness and/or vertigo
   f. History of weakness
   g. History of incontinence and/or urinary frequency
   h. Uncompensated sensory deficits that would impede safe access to restroom facilities, chair, etc.
   i. Currently taking laxatives, diuretics, and/or sedatives, antihypertensive, psychotropic drugs
   j. 65 years or older.
   k. Two or more diagnoses/medical conditions.
   l. Altered mental status.
2. Utilizing the following Morse Risk Assessment Tool, assess as follows for an increased risk of falling:
   a. Assess the adult patient on admission and then every shift
   b. Assess the obstetrical patient on admission and then every morning
Clinical Information; continued

<table>
<thead>
<tr>
<th>Morse Risk Assessment Tool</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>History of falling</td>
<td>No = 0</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>No = 0</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking aid</td>
<td>No = 0</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>IV therapy/ pump</td>
<td>No = 0</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Gait</td>
<td>Normal/Bedfast/Wheelchair/Immobile = 0</td>
</tr>
<tr>
<td></td>
<td>Patient has normal gait, head is erect, arms swing freely or is on bed rest or immobile</td>
</tr>
<tr>
<td></td>
<td>Impaired = 20</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Oriented to own ability = 0</td>
</tr>
<tr>
<td></td>
<td>Patient’s self assessment of own ability matches nurse’s/physician’s assessment or orders</td>
</tr>
</tbody>
</table>

A score of 55 or greater means the patient is high risk for falls

Continued on Next Page
**Fall Prevention for the Adult Patient, continued**

**INTERVENTIONS for Universal Fall Precautions:**

**NOTE:** This applies to **ALL** adult patients admitted to the hospital.

1. Position the call bell and possessions within reach.
2. Proactive hourly rounds.
3. Assess ability to ambulate and how much assistance is needed.
4. Place BSC near bed, keep assistive devices nearby.
5. Non-skid footwear.
6. Assess medication effects (Ex. sedatives, laxatives, diuretics, new CV meds).
7. Prompt response to call light.

**INTERVENTIONS for High Risk Fall Precautions:**

**NOTE:** This applies to any patient with a score greater than or equal to **55** on the Morse Risk Assessment Tool. For pediatric patients, a high fall risk equals a Humpty Dumpty Score >12.

1. Maintain Standard Fall Precautions interventions as above.
2. Signage above door.
3. Scheduled toileting every 2-3 hours.
4. Keep bed in lowest position when patient in bed; adjust to appropriate height when getting up.
5. Remain within arms' length when OOB - includes toilet in bathroom & BSC. Do not leave patient unattended.
7. Encourage the family to provide supervision for the patient. Ask them to inform staff when leaving the patient unattended. Assist in obtaining a cot, recliner, etc. if a family member chooses to stay with the patient for prolonged periods.
8. Use "Family Pass" when patient being left alone.
9. Reinforce education and specific reasons patient is at risk.
10. Collaborate with the physician(s) and pharmacist regarding medications currently ordered which may contribute to a higher fall risk such as narcotics, opioid, diuretics, psychotropics, antihypertensives or sedatives.

*Continued on Next Page*
Fall Prevention for the Adult Patient, continued

TEACHING AND COMMUNICATION:

1. Instruct the patient to call for assistance when getting out of bed.
2. Instruct the patient on the importance of wearing prescription glasses and hearing aids as much as possible.
3. Give the patient/family/caregiver a copy of the “Tips to Prevent Falls” handout.
4. Educate the patient and family/care giver about risk factors that contribute to falls and how they can decrease risks. Document this education appropriately.
5. Communicate patient's fall risk with all necessary healthcare workers involved in patients care. This includes during the SBAR process.

DESIRED OUTCOMES:

1. The patient does not fall during the hospital stay.
2. The patient/family/care giver verbalizes/demonstrates an understanding of all teaching.

DOCUMENTATION:

1. Refer to Nursing Policy #40-05240: “Charting”.
2. Appropriately document all fall assessments.
3. If a fall occurs, complete the Clarity and forward to Risk Management.
Clinical Information; continued

**Patient Transportation**

Patient Transportation Services are available (7 days/week) from 7:30 am to 10:30 pm (hospital wide) and 10:30 pm to 3:30 am (ER only)

- Procedures will call unit to allow Nursing services to coordinate
- Nurse determines when the order is placed in PowerChart

When the order is received by the transportation dispatch office, the next available transporter will be dispatched.

---

**Use of Abbreviations and Symbols in Medical Record Documentation**

**PURPOSE:**

The purpose of this policy is to:

A. Establish standards for the use of abbreviations, acronyms and symbols used throughout the organization.

B. Eliminate the use of potentially dangerous abbreviations and dose expressions used in prescribing medications.

**POLICY:**

Symbols and abbreviations may be used in the medical record only when approved by the Medical Staff. Stedman’s Book of Abbreviations, Acronyms & Symbols, with the exception of the abbreviations listed on the unacceptable abbreviations list attached, shall be considered the official source of abbreviations for all TMH colleagues. This source shall be made available in all patient care areas and other departments as deemed necessary. Abbreviations and symbols with more than one definition in the approved reference should be used only when the caregiver is reasonably able to identify the purpose/intent of the prescriber through professional experience and content of orders or notes. When the intent is not clear to the caregiver, the prescriber will be contacted for clarification.

Unacceptable abbreviations and symbols related to medication orders shall be approved by the Medical Staff and published to all caregivers as on the following list. If an unacceptable or unclear abbreviation is used in a medication order, the order will be clarified with the prescriber prior to its being filled.

**RESPONSIBILITY:**

Each patient care area, clinical department managers and the Chief Medical Officer are responsible for assuring compliance with this policy and procedure.

*Continued on Next Page*
Clinical Information; continued

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”</td>
<td>Write &quot;unit&quot;</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write &quot;International Unit&quot;</td>
</tr>
</tbody>
</table>
| Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (once daily & every other day) | Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I" | Write "daily"
Write "every other day"
| Trailing zero (X.0 mg) Lack of leading zero (.X mg) | Decimal point is missed                                                            | Write X mg
Write 0.X mg                                       |
| MS MSO4 and MgSO4 | Can mean morphine sulfate or magnesium sulfate Confused for one another            | Write "morphine sulfate"
Write "magnesium sulfate"                             |
# 2016 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in healthcare safety and how to solve them.

<table>
<thead>
<tr>
<th>Identify patients correctly</th>
<th>NPSG.01.01.01</th>
<th>Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment. Make sure that the correct patient gets the correct blood when they get a blood transfusion.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NPSG.01.03.01</td>
<td></td>
</tr>
<tr>
<td>Improve staff communication</td>
<td>NPSG.02.03.01</td>
<td>Get important test results to the right staff person on time.</td>
</tr>
<tr>
<td>Use medicines safely</td>
<td>NPSG.03.04.01</td>
<td>Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.</td>
</tr>
<tr>
<td></td>
<td>NPSG.03.05.01</td>
<td>Take extra care with patients who take medicines to thin their blood.</td>
</tr>
<tr>
<td></td>
<td>NPSG.03.06.01</td>
<td>Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.</td>
</tr>
<tr>
<td>Use alarms safely</td>
<td>NPSG.06.01.01</td>
<td>Make improvements to ensure that alarms on medical equipment are heard and responded to on time.</td>
</tr>
<tr>
<td>Prevent infection</td>
<td>NPSG.07.01.01</td>
<td>Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.03.01</td>
<td>Use proven guidelines to prevent infections that are difficult to treat.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.04.01</td>
<td>Use proven guidelines to prevent infection of the blood from central lines.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.05.01</td>
<td>Use proven guidelines to prevent infection after surgery.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.06.01</td>
<td>Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.</td>
</tr>
<tr>
<td>Identify patient safety risks</td>
<td>NPSG.15.01.01</td>
<td>Find out which patients are most likely to try to commit suicide.</td>
</tr>
<tr>
<td>Prevent mistakes in surgery</td>
<td>UP.01.01.01</td>
<td>Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body.</td>
</tr>
<tr>
<td></td>
<td>UP.01.02.01</td>
<td>Mark the correct place on the patient’s body where the surgery is to be done.</td>
</tr>
<tr>
<td></td>
<td>UP.01.03.01</td>
<td>Pause before the surgery to make sure that a mistake is not being made.</td>
</tr>
</tbody>
</table>

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This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.
Risk Management Information

**Safety Event Reporting System**

An incident is "any happening not consistent with the routine operation of the hospital or the routine care of a particular patient which causes harm. It may be an accident or a situation which might result in an accident". Employees and physicians are obligated to report incidents.

Further, Florida law also places a legal obligation on all health care providers, agents, and hospital employees to report incidents to Risk Management. Incidents are to be reported immediately, particularly those involving:

- a) death of a patient
- b) brain or spinal damage to a patient
- c) performance of a surgical procedure on the wrong patient
- d) performance of a wrong site surgical procedure
- e) performance of a wrong surgical procedure.

Healthcare SafetyZone Portal located at: [http://172.16.32.50/hsz101/home.aspx](http://172.16.32.50/hsz101/home.aspx)

What is it? **An online reporting and educational forum** ... to increase our awareness of events that signal harm or potential harm to our patients, staff and visitors and support our efforts to enhance service and safety.

How to use it? **Select and click** ... to submit a report click the center button or to view policies, procedures, and educational materials without submitting a report, select and click **Library**, the other topic headings, or **Search**.

**Policy Reference**

Administrative P&P 10-8 Incident Reports

See **Appendix G** for a list of reportable incidents

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**Working in an Interdisciplinary Team Setting**

Providing **safe patient care requires team effort**. Every member of the health care team has a key role in ensuring an error-free health care environment.

**Interdisciplinary communication** has a relationship to patient safety. JCAHO’s research into sentinel events identified that a contributing factor to every event is unclear communication. Our aim is to increase your awareness about team dynamics, developing mutual understanding, and the **importance of communication and collaboration**.
As a TMH colleague or student/faculty member, you have a vital role in effective communication. Team training facilitates communication among health care providers.

What is your focus?

- Be aware that effective communication is the key to excellence in patient care.
- Recognize that everyone at TMH has the potential to play a significant role in the care and treatment of patients.
- Respect the advice and suggestions any employee, student, or volunteer has to offer.
- Do your part in making every member of the team feel comfortable in contributing.
- Seek every opportunity the hospital offers to improve how you perform as a member of an interdisciplinary team.
- Remember, it’s all about the patients.

As part of the hospital team, you are expected to:

- Serve the needs of our patients as part of an interdisciplinary team.
- Get the most out of being a team player for yourself and for the well-being of your patients.
- Use only approved, recognized, abbreviations, as trained.
- Properly report all errors or near misses.
- Follow all nationally recommended safety guidelines.
- Support a blame-free culture.
- Remember our “Golden Moment” for procedures.
Appendix A

Corporate Compliance Program

Reporting: TMH colleagues are encouraged to report actual or perceived violations of the Corporate Compliance Code of Conduct utilizing various reporting methods including:

- Contacting the colleague’s Supervisor or Department Director
- Contacting any Corporate Compliance Officer
- Contacting the Corporate Compliance Office directly at 2667 (COMP)
- Placing a call to the 24 hour Compliance Helpline at 1.877.772.6723

TMH is committed to an environment that encourages reporting of perceived or actual violations to the TMH Corporate Code of Conduct. You will not be punished for raising an issue in good faith.

The following staff members are your resources in the Corporate Compliance Program at Tallahassee Memorial HealthCare Inc.:

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Department</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corporate Compliance Department Staff</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Andrea Eklund – Corporate Compliance Officer</td>
<td>Corporate Compliance</td>
<td>850.431.5339</td>
</tr>
<tr>
<td>Andrea Eklund – Corporate Compliance/ Privacy Officer</td>
<td>HIPAA/Privacy Officer</td>
<td>850.431.5339</td>
</tr>
<tr>
<td><strong>Integrity Liaisons – Tallahassee Memorial HealthCare</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judy Davis – Director of Risk Management</td>
<td>Administration</td>
<td>850.431.5364</td>
</tr>
<tr>
<td>Bill Giudice – Chief Financial Officer/VP</td>
<td>Finance</td>
<td>850.431.5238</td>
</tr>
<tr>
<td>Barbara Alford – Chief Clinical and Nursing Officer/VP</td>
<td>Patient Care Services</td>
<td>850.431.5304</td>
</tr>
<tr>
<td>Dr. Andrea Friall – Chief Medical Officer/VP</td>
<td>Medical Staff Office</td>
<td>850.431.5121</td>
</tr>
<tr>
<td>Dr. Dean Watson, Chief of Health Operations Officer/VP</td>
<td></td>
<td>850-431-5121</td>
</tr>
<tr>
<td>Warren Jones – Chief Communications Officer/VP</td>
<td>Public Relations</td>
<td>850.431.5450</td>
</tr>
<tr>
<td>Don Lindsey – Chief Information Officer/VP</td>
<td>Information Technology</td>
<td>850.431.5662</td>
</tr>
<tr>
<td>Mark O’Bryant – Chief Executive Officer</td>
<td>Administration</td>
<td>850.431.5380</td>
</tr>
</tbody>
</table>
Appendix B

HIPAA Privacy Standards

First and foremost, the HIPAA Privacy Standards address the rights of patients concerning the use and disclosure of their protected health information. They were developed to provide federal-level protection of the privacy and confidentiality of a patient’s health information.

Patients are granted certain rights under the HIPAA Privacy Standards.

1. **Notice of Privacy Practices:** Patients have the right to receive a copy of the hospital’s Notice of Privacy Practices (NPP).
   - The NPP describes the ways in which we access, use, and release (disclose) their health information during the course of providing health care services.
   - The NPP provides our patients with a notice of their rights and our legal duties under the HIPAA Privacy regulations.
   - On the first date of service occurring on or after April 14, 2003, the hospital began providing its patients with a copy of the NPP. The Privacy Standards also permit the NPP to be mailed if the service is not face to face and to be provided as soon as is reasonably possible in an emergency situation.
   - Delivery of the notice is only required once in the patient’s association with the hospital. We are not required to issue the notice at each encounter. We must make a “good faith effort” to get a written acknowledgement that the patient received the Notice.
     
     **Note:** The acknowledgement is that the patient received the Notice. There is no requirement or expectation that there be an acknowledgement of acceptance or understanding of the Hospital’s privacy practices.

2. **Restrictions on Uses and Disclosures:** Patients have the right to request that we not use their information for certain purposes, such as the inclusion in the patient directory, marketing, etc. However, we do not have to agree to the restrictions requested.

3. **Confidential Communications:** Patients have the right to receive communications about their protected health information in a confidential manner. A patient may request to be taken to a private area to discuss his or her health situation or may request that billing information be sent to a different address.

4. **Sensitive Subjects:** The only class of information that is given special protection under the HIPAA Privacy regulations is psychotherapy notes. Specific authorization is required for release of psychotherapy notes. However, other information that is commonly considered as “Super Confidential” such as general mental health records, substance abuse and HIV information continues to be governed by applicable state law and is not separately addressed by HIPAA other than as PHI.

Continued on Next Page
Appendix B; continued

5. **Authorization for Release of PHI**: Hospitals are permitted to use and disclose PHI for the purposes of Treatment, Payment, and Health Care Operations or as required by law. Any other use or disclosure of PHI will require an explicit Authorization from the patient.

6. **Accounting for Disclosures**: Patients have the right to request a written listing of who we disclosed their PHI to (outside the hospital) for purposes other than treatment payment or health care operations.

7. **Right to Access**: Patients or their legal representatives have the right to review their PHI. They may inspect the actual record or obtain a copy. However, if the release of the information contained in the record could present a danger to the patient or others, we are permitted to suspend the patient’s access rights.

8. **Right to Request Amendment of PHI**: Patients have the right to request amendment (correction) of information in their medical record. This request must be made in writing.
   a. We may deny the patient’s request if the information to be amended:
      - Was not created by us (came from another provider)
      - Is not part of the official record
      - Is accurate and complete
   b. We will not alter or delete information in the medical record; amendments will be added to the record.

9. **Complaints**: Patients have the right to file a compliant with the hospital and / or with the Department of Health and Human Services if they feel their privacy rights under the HIPAA Privacy regulations have been violated. The patient should not be retaliated against for issuing a complaint.

**Basic Concepts of the HIPAA Privacy Standards**

1. **What is the information we are supposed to protect?**
   There is a great deal of information sharing in a hospital. The HIPAA Privacy Standards are only concerned with a specific type of information: Individually Identifiable Health Information (health-related information that can be traced back to the patient to which it relates).
   - The information can be actual medical information related to the care given (e.g., lab results, progress notes, dictated reports, physician orders, nurses notes)
   - Or it can be information related to payment for the health care given (patient bill, UB92, HCFA 1500 form, account notes in the Hospital Information System).
   - The information can be about past, present, or future activities related to the patient’s health care
   - The information can be in any form (oral, written, or electronic format).
Appendix B; continued

Any health information that meets the definition above is considered **Protected Health Information** or “PHI” according to the HIPAA Privacy Standards. From a practical perspective, this is essentially all of the patient-related information you would work with at the hospital.

2. **How is this Protected Health Information utilized?**

The HIPAA Privacy Standards and Security Standards address the concept of **Access** related to PHI. The HIPAA Privacy Standards address two different activities related to PHI: **Use** and **Disclosure**.

- **Access**: Your ability to see, hear, or read protected health information (PHI).
  - Access to the computer system
  - Access to the medical record
  - Access to the patient, physicians, or other healthcare employees

- **Use**: Taking that information you have accessed and using it or sharing it with others within the hospital.
  - Examples:
    - To provide treatment to the patient
    - To communicate with other departments about patients
    - To monitor quality of services

- **Disclosure**: Sharing (releasing or transmitting) PHI to people or organizations **outside of the hospital**. It may be oral disclosure, disclosure of written documents or electronic disclosure.
  - Examples:
    - Sending reports to a doctor or another hospital
    - Filing a claim to an insurance company
    - Reporting communicable diseases to the health department

Hospitals are familiar with the practice of “Release of Information” associated with the release of a medical record to the patient or another outside individual or entity. The vast majority of the official releases of information are handled through the Medical Record Department. It is very important for the Medical Record Department to control or coordinate the releases of medical record documents to assure that standards are met and releases are tracked.

3. **How and where is PHI used and disclosed?**

Hospitals are permitted to use and disclose PHI for some activities without seeking the patient’s consent. Hospitals may, without the patient’s consent, use and disclose protected health information for the purposes of **Treatment**, **Payment**, and **Health Care Operations** otherwise known as “TPO”.

- **Treatment**: We may use and disclose PHI to **treat** the patient. Treatment providers include individuals who are part of our work force as well as those who are independent of the hospital yet directly involved in providing treatment services for the patient.

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Continued on Next Page


**Appendix B; continued**

- **Payment:** We may use and disclose PHI to seek payment for the services we have provided or will provide to the patient. This includes activities to determine future eligibility (getting authorizations from health plans prior to providing services).

- **Health Care Operations:** We may use or disclose PHI for activities that are necessary to run the hospital and to monitor and improve the quality of the services we provide. The use or disclosure of PHI for Health Care Operations is permitted only between individuals (or organizations) that have or have had a relationship with the patient.

- **Examples:**
  - Quality assessment and improvement activities
  - Reviewing the competence or qualifications of health care professionals and evaluating practitioner and provider performance
  - Conducting training programs for students trainees or practitioners and training of non-health care professionals
  - Accreditation, licensing, certification or credentialing activities
  - Conducting or arranging for medical review, legal services, and auditing functions, and compliance programs
  - Business planning and development activities related to managing the covered entity
  - Business management and general administrative activities of the covered entity
  - Use of PHI for the purpose of customer service activities as long as PHI is not inappropriately disclosed
  - Resolution of internal grievances

We may also disclose PHI for Health Care Operations to those individuals or organizations with which we have a Business Associate Agreement.

- **Business Associates:** Business Associates are people or entities outside of our workforce that perform functions on our behalf and with whom we would normally share PHI in order for them to perform those functions for us. Under the HIPAA Privacy Regulations, we are responsible for the manner in which our Business Associates use and disclose PHI that they have received from us. Because of this, we have and will establish contractual agreements (Business Associates Agreements) that hold our Business Associates to the same requirements that we are held to under HIPAA.

*Continued on Next Page*
Appendix B; continued

4. Do the HIPAA Privacy Standards impose limitations on what or how much PHI may be released?
The Standards state that when accessing, using, or disclosing PHI (in any form), we must limit the access, use or disclosure to only the information that is necessary to fulfill the purpose. There are no hard and fast rules or lists that define what is “minimum necessary” in every setting. Professional judgment will often be employed in determining what is necessary to meet any specific situation involving the release of PHI.

In fact, there are certain circumstances in which the Minimum Necessary provisions do not apply, such as:
- The purpose of the use or disclosure is for treatment of the patient;
- Disclosing a patient’s own PHI to that patient;
- The use or disclosure is made based on a valid Authorization (from the patient);
- Providing a patient with an accounting of disclosures of his/her PHI;
- Disclosing PHI to the Department of Health and Human Services for compliance or enforcement purposes; or
- The disclosures are required by law.

Personnel Access to PHI: Because of the Minimum Necessary provisions, we have assessed job assignments within the Hospital to determine how much PHI each position needs to access. Policies and procedures have been developed to define this and help assure that personnel access only information necessary to do their jobs. Inappropriate access of PHI, including yours or that of your family, is a violation of TMH policy and will result in disciplinary action, up to and including termination of employment.

If you have any questions about the HIPAA Privacy Standards or patient confidentiality in general please contact the TMH Privacy Officer.

| TMH Privacy Officer | Andrea Eklund | 850.431.5339 |

HIPAA Security Rule

ePHI – Electronic Protected Health Information

You are aware of the HIPAA Privacy Rule – federal standards that protect our right to privacy & confidentiality. Now there is a second set of federal standards to protect health information in electronic form. This is the HIPAA Security Rule.

Continued on Next Page
Appendix B; continued

Covered entities are expected to comply with the Security Rule by April 21, 2005.

The Security Rule protects the following:

- Confidentiality of electronic protected health information, termed ePHI.
- Integrity of ePHI – this means that once ePHI is created it can’t be tampered with.
- Availability of ePHI – ensuring information can only be accessed by people with the authority to do so whenever it is needed.

The Security Rule is divided into 3 parts. They cover the policies, procedures, processes & systems you need to protect ePHI from the time it is created to its disposal and all parts in between.

Administrative Safeguards
Administrative safeguards are carried out by teams, managers & the designated HIPAA Security officer who has the ultimate responsibility for TMH’s security program.

- Security incident policies on how to handle violations & security breaches. This includes internal process for reporting security concerns and infractions.
- Contingency plans that outline how to respond in emergencies or natural disasters that damage ePHI.
- Back-up systems off-site that can be retrieved quickly in the event of an emergency or disaster.
- On-going evaluations & audits to ensure TMH is in compliance with the Security Rule.

Computer passwords

- Never share your password – they could breach security in your name.
- If someone is terminated, steps are taken to lock the person out of the system.
- Each user must use their unique user identification to log on and access ePHI to verify that the person logging on to workstation is who he/she claims to be.
- Passwords to log on to your workstation are changed regularly.

Continued on Next Page
Appendix B; continued

Physical Safeguards
Physical safeguards address the protection of physical things such as computer systems and high tech equipment as well as the facility where ePHI is stored.
- Physical access controls limit access of ePHI and ensure an authorized person can access data when they need it.
- Facility access controls to protect areas where ePHI is housed.
- Security guards and ID verifications, such as ID badges and nametags.
- Device & media control to ensure the security of ePHI when moving or disposing of hardware or software both inside & outside TMH.
- Workstation guidelines to secure areas where ePHI is accessed & guarded against unauthorized access including laptops & PDAs on & off campus.
- Workstations located away from public areas.
- Transmission safeguards to protect ePHI transmitted over open networks from intruders.
- Encryption convert ePHI into code for transmission over public networks.
- Monitoring systems to track who is logging into the system successfully, and who is trying to log in unsuccessfully.

Technical Safeguards
Technical safeguards include all the technology that makes physical safeguards possible.
- Access controls for electronic systems that hold ePHI to make sure people with access rights can access data when they need it.
- Internal system audits & controls to track & record daily activity in information systems to look for abnormal or suspicious behavior.
- Reporting to alert administration of possible intruders.

Think security
- When you enter TMH make sure you have on your ID badge.
- Never leave laptops or PDAs in your car. You or TMH will be held liable for the data on those portable devices.
- Never download or use software given to you. All software must be approved by the IT department.
- Never open an email attachment unless you know who sent it. Email attachments are the most common way for viruses to infect an entire network. I.e. Do not send chain mail electronically.
- Always, log off when you walk away from your workstation.

Violations of the Privacy and Security Rules can result in fines, prison time and dismissal from your job.
Appendix C

Patient Rights & Responsibilities

Tallahassee Memorial HealthCare recognizes the rights you have as a patient receiving medical care or undergoing treatment at our hospital. Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider’s or health care facility’s right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

You as a Patient

- have the right to be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy.
- have the right to a prompt and reasonable response to questions and requests.
- have the right to know who is providing medical services and who is responsible for your care.
- have the right to know what patient support services are available, including whether an interpreter is available if you do not speak English.
- have the right to know what rules and regulations apply to your conduct.
- have the right to refuse any treatment, except as otherwise provided by law.
- have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
- if eligible for Medicare, have the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- have the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
- have the right to impartial access to medical treatment or accommodations regardless of race, national origin, religion, physical handicap or source of payment.
- have the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- have the right to know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
- have the right to express grievances regarding any violation of your rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility that served you and to the appropriate state licensing agency.

Continued on Next Page
Appendix C; continued

- have the right to be given by your health care provider information concerning
diagnosis, planned and unplanned outcomes in the course of treatment, alternatives,
risks and prognosis.
- have the right to have your pain treated, to be taught about pain and how your pain
can be relieved, and to have your complaint of pain addressed.
- have the right to be free from restraint unless the restraint is needed to protect you or
others from harm.
- are responsible for providing to your health care provider, to the best of your
knowledge, accurate and complete information about present complaints, past
illnesses, hospitalizations, medications and other matters relating to your health.
- are responsible for reporting unexpected changes in your condition to your health care
provider.
- are responsible for reporting to your health care provider whether you comprehend a
contemplated course of action and what is expected of you.
- are responsible for following the treatment plan recommended by your health care
provider.
- are responsible for keeping appointments and, when you are unable to do so for any
reason, for notifying the health care provider or health care facility.
- are responsible for your actions if you refuse treatment or do not follow the health
care provider’s instructions.
- are responsible for assuring that the financial obligations of your health care are
fulfilled as promptly as possible.
- are responsible for following health care facility rules and regulations affecting
patient care and conduct.

Availability of a Medical Ethicist

Recognizing the stress and indecision that may accompany any illness, Tallahassee
Memorial provides medical ethics consultation that may assist patients and families to
better understand a variety of choices or decisions that may arise during the course of an
illness. You may contact the Medical Staff Office at (850) 431-5122.

Access to Patient Advocacy Groups

- Suspected abuse or neglect of a child, elderly person or a disabled person 1 (800) 962-
2873 - Abuse Registry Hotline
- Suspected sexual abuse or partner abuse (850) 681-2111 - Refuge House • Suspected
violation of Residents Rights at Long Term Care (850) 493-9000 - Long Term Care
Ombudsman

Continued on Next Page
Appendix C; continued

The Medical Ethicist will assist you if you need help in calling or contacting one of these groups. Contact the Medical Staff Office at (850) 431-5122.

Filing a Complaint
If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1 (888) 419-3456, (press 1) or write to:

Agency for Health Care Administration
Consumer Assistance Unit
2727 Mahan Drive/Bldg. 1
Tallahassee, FL 32308

If you have a complaint against a health care professional and want to receive a complaint form, call the Consumer Services Unit at 1 (888) 419-3456 (press 2) or write to:

Agency for Health Care Administration
Consumer Services Unit
P.O. Box 14000
Tallahassee, FL 32317-4000

Para obtener una copia en Español de “Sus Derechos y Responsabilidades Como Paciente,” haga el favor de preguntarle a su enfermera.
Appendix D

Abuse and Neglect of Elderly

From California Registry/Elder Abuse Website: www.calregistry.com/resources/eldapag.htm and
Los Angeles County District Attorney’s Office Website: http://da.co.la.ca.us/seniors/abuse.htm

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Financial Exploitation</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Indicators:</strong></td>
<td><strong>Physical Indicators:</strong></td>
<td><strong>Physical Indicators:</strong></td>
</tr>
<tr>
<td>• Obvious lacerations, abrasions, fractures, welts, bruises, discoloration, or swelling</td>
<td>• Cashing of pension check without proper authorization from elder</td>
<td>• Shows signs of dehydration or malnutrition</td>
</tr>
<tr>
<td>• Reluctance to seek medical treatment for injuries or denial of their existence</td>
<td>• Bills and expenses continually unpaid</td>
<td>• Sudden weight loss</td>
</tr>
<tr>
<td>• Pain or tenderness on mere touch</td>
<td>• Standard of living not appropriate for an elder’s income level</td>
<td>• Does not have necessities such as eyeglasses, dentures, prostheses, hearing aids, canes, walkers, or other critical items</td>
</tr>
<tr>
<td>• Burns caused by cigarettes, ropes or other bonds</td>
<td>• Sudden sale of property belonging to an elder</td>
<td>• Caregiver has history of violence, or alcohol or drug abuse</td>
</tr>
<tr>
<td>• Detached retina, bleeding, or scalp wound</td>
<td>• Sudden revision of will, naming of a new beneficiary</td>
<td><strong>Another form of neglect is SELF-NEGLECT. This is the inability of an elder who does not have a caregiver to provide for himself/herself (This is not a crime).</strong></td>
</tr>
<tr>
<td>• Elder becomes withdrawn or protective of the suspect</td>
<td>• Disproportionately high contribution by the elder to household expenses</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

Abuse and Neglect of Children

From Prevent Child Abuse/New York Website: http://www.pca-ny.org/childabuse.html

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Sexual Exploitation</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Indicators:</td>
<td>Physical Indicators:</td>
<td>Physical Indicators:</td>
</tr>
<tr>
<td>• Bruises, welts, or bite marks</td>
<td>• Difficulty walking or sitting</td>
<td>• Failure to thrive</td>
</tr>
<tr>
<td>• Injuries to BOTH eyes and cheeks</td>
<td>• Torn, stained, or bloody underclothing</td>
<td>• Positive indicator of toxicology (especially in newborns: drug withdrawal symptoms, tremors)</td>
</tr>
<tr>
<td>• In clustered, forming pattern</td>
<td>• Pain or itching in genital area</td>
<td>• Consistent hunger, poor hygiene</td>
</tr>
<tr>
<td>• In shape of article (belt, cord)</td>
<td>• Bruises or bleeding in external genitalia, vaginal, or anal areas</td>
<td>• Inappropriate dress for the season</td>
</tr>
<tr>
<td>• Lacerations or abrasions to ♦ Mouth, lips, gums, eyes</td>
<td>• Bruises to hard or soft palate</td>
<td>• Speech disorders</td>
</tr>
<tr>
<td>♦ External genitalia</td>
<td>♦ STDs, especially in preteens</td>
<td>• Consistent lack of supervision, especially in dangerous activities for long periods</td>
</tr>
<tr>
<td>♦ [On] back of arms, legs, or torso</td>
<td>• Repeated UTIs</td>
<td>• Unattended physical problems or medical needs</td>
</tr>
<tr>
<td>• Burns ♦ Cigar, cigarette</td>
<td>• Foreign bodies in vagina or rectum</td>
<td>• Chronic truancy</td>
</tr>
<tr>
<td>♦ Scalding water immersion</td>
<td>• Burns</td>
<td>• Abandonment</td>
</tr>
<tr>
<td>♦ Patterned, eg., electric iron</td>
<td>• Burns on arms, legs, neck, torso</td>
<td></td>
</tr>
<tr>
<td>♦ Rope burn on arms, legs, neck, torso</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Behavioral Indicators:

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Sexual Exploitation</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Indicators:</td>
<td>Behavioral Indicators:</td>
<td>Behavioral Indicators:</td>
</tr>
<tr>
<td>• Wary of contacts with parents or other adults</td>
<td>• Unwilling to change for gym or participate in physical education class</td>
<td>• Begging, stealing food</td>
</tr>
<tr>
<td>• Apprehensive when other children cry</td>
<td>• Withdrawal, fantasy, or infantile behavior</td>
<td>• Extended days at school</td>
</tr>
<tr>
<td>• Behavioral extremes</td>
<td>• Unusual sexual behavior</td>
<td>• Constant fatigue</td>
</tr>
<tr>
<td>• Afraid to go home</td>
<td>• Poor peer relationships</td>
<td>• Alcohol or drug abuse</td>
</tr>
<tr>
<td>• Reports injury to parents (sometimes blames self – “I was bad.”)</td>
<td>• Delinquent or runaway</td>
<td>• Delinquency</td>
</tr>
<tr>
<td>• Low self-esteem</td>
<td>• Reports sexual assault by caretaker</td>
<td>• States that there is no caretaker</td>
</tr>
<tr>
<td></td>
<td>• Prostitution</td>
<td>• Runaway behavior</td>
</tr>
<tr>
<td></td>
<td>• Forcing sexual acts on other children</td>
<td>• Habit disorder (sucking, biting, rocking)</td>
</tr>
<tr>
<td></td>
<td>• Extreme fear of being touched</td>
<td>• Conduct disorder</td>
</tr>
<tr>
<td></td>
<td>• Suicide attempts</td>
<td>• Neurotic traits (sleep disorders, inhibition of play)</td>
</tr>
<tr>
<td></td>
<td>• Low self-esteem</td>
<td>• Overly adaptive behavior, adult-like or infantile</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lags in mental/emotional development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Attempted suicide</td>
</tr>
</tbody>
</table>
Managing Escalating Behavior

The first step in managing a potentially violent situation is to recognize behaviors associated loss of control.

<table>
<thead>
<tr>
<th>Watch for signals that associated with impending violence:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Verbal</strong></td>
</tr>
<tr>
<td>• Repeating the same thing over and over</td>
</tr>
<tr>
<td>• Talking rapidly, verbally expressing anger and frustration</td>
</tr>
<tr>
<td>• Speaking in a loud, angry voice</td>
</tr>
</tbody>
</table>

Behavioral signs of danger escalate from small (wringing of the hands) to extreme (yelling, kicking, hitting) in a steady progression as frustration and anger build. To have the best success in diffusing the situation, intervene as early as possible, while the behavior is manageable.

### The Diffusing Approach

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Watch your attitude</td>
<td>• Present a calm, caring attitude – smile, show interest in the person</td>
</tr>
<tr>
<td>2. Watch your tone of voice</td>
<td>• Use a calm tone of voice and normal volume — respond to a loud voice when you speak</td>
</tr>
<tr>
<td>3. Don’t present behaviors that will escalate aggressive behavior in the other person</td>
<td>• Don’t match threats</td>
</tr>
<tr>
<td></td>
<td>• Don’t give orders</td>
</tr>
<tr>
<td></td>
<td>• Move slowly</td>
</tr>
<tr>
<td></td>
<td>• Respect personal space and privacy</td>
</tr>
</tbody>
</table>

Continued on Next Page
Appendix F; continued

It is also important to be alert to the environment and the situation to manage escalating behavior and avoid potential violence.

<table>
<thead>
<tr>
<th>The Environment and the Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluate the situation for potential violence</td>
</tr>
<tr>
<td>• Is there something negative attached to the situation that could cause anger and/or hostility?</td>
</tr>
<tr>
<td>• Does an individual show signs of hostility?</td>
</tr>
<tr>
<td>• Continually monitor behavior</td>
</tr>
<tr>
<td>2. Evaluate the environment and adjust</td>
</tr>
<tr>
<td>• Do not isolate yourself with a potentially violent person</td>
</tr>
<tr>
<td>• Always keep an open path for exiting — do not let a potentially violent person stand between you and the door.</td>
</tr>
</tbody>
</table>
Appendix G

Reportable Incidents

Maintaining an effective incident reporting and trending system that meets the early warning and data needs of the organization and complies with regulatory requirements is essential. This system is dependent upon communication from all employees and physicians. An adverse event is an accidental or unexpected happening or any occurrence or outcome which is not consistent with the care or condition of a patient, excluding ordinary complications arising out of illness or foreseen risks of treatment; and any happening of an untoward nature to a visitor. An incident report form is completed immediately after an incident is discovered. A sentinel event is an unexpected occurrence that results in death or serious injury. Therefore, any of these occurrences are to be reported to Risk Management immediately:

- Unexpected or unexplained death
- Brain Damage
- Spinal Damage
- Surgical procedure or medical treatment performed on the wrong patient
- Surgical procedure or medical treatment unrelated to the patient's diagnosis or medical needs
- Surgical procedure or medical treatment performed on the wrong site
- Wrong surgical procedure or medical treatment performed
- An unplanned surgical procedure to remove foreign objects remaining from surgical procedures
- Surgical repair of injuries or damage resulting from a planned surgical procedure or other medical treatment
- Unexpected or unexplained returns to surgery
- Unexpected permanent disfigurement
- Unplanned fracture or dislocation of bones/joints
- Injury or removal of a healthy tissue
- Any event requiring surgical or medical intervention to correct/control
- Any event that extends the patient's length of stay
- Any event requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's needs or patient's pre-existing condition
- Any event resulting in the transfer of the patient within or outside the facility to a unit providing a more acute level of care
- Any event that results in an unexpected limitation of neurological, physical, or sensory functions which continues after discharge from the facility due to the adverse event.

Continued on Next Page
Appendix G; continued

Other issues requested to be reported include:
- Patient/family dissatisfied with hospital care with specific complaints noted
- Serious threats/complaints of lawsuit by patient/family
- Specific concerns verbalized by patient/family

Risk Management Issues

Safety Terms:
- **Error** – an unintended act of omissions or commission that does not achieve its intended outcomes.
- **Sentinel event** – a serious, unexpected negative event or problem that could have lead to an undesirable outcome.
- **Near miss** – a variation in the process which did not affect the outcome.
- **Hazardous conditions** – a set of circumstances which significantly increase the likelihood of a serious adverse outcome.

Sentinel or adverse events are reported to the Agency of Health Care Administration and/or the Joint Commission. The hospital conducts detailed analysis & follow-up: so that we focus our attention on the underlying cause(s) of the event, to increase our knowledge of why things happen & implement plans to prevent further occurrences, & to improve patient care.

When an adverse event occurs: stop, think, remain calm, & stabilize the situation, remember that the patient is the first priority, save all physical evidence – it may help to reconstruct when happened & document accurately & notify Risk Management.

A root cause analysis is the process used to follow up on a sentinel or adverse event. This process: includes all involved parties looking at the circumstances/systems surrounding the even to figure out why this event occurred & develop action plans to prevent recurrence.

Near miss (close call) is: a term used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome, could have resulted in an accident, injury or illness, but did not do so, and is stopped either by chance or through timely intervention.

In accordance with administrative policy and procedure 40-68 “Patient Identification” every patient undergoing a procedure, test, or treatment must have an identification bracelet. When a patient is received in any department, the person receiving the patient will check the patient’s medical record or face sheet against the patient’s identification bracelet and FIN to make certain the identification matches.
Orientation Independent Study Post Test

Tallahassee Memorial Healthcare University

<table>
<thead>
<tr>
<th>Class Title</th>
<th>Content Code</th>
<th>Class Title</th>
<th>Content Code</th>
</tr>
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Please read material and complete the following test. Return or fax (850.431.6555) post-test and signed forms to Coordinator Academic & Community Outreach, 1207 TMH Court.

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Please put your answers on the answer sheet at the end of the test.

Please use the materials found in your home-study orientation packet to answer the following questions:

1. The vision of TMH is leading our community to be the healthiest in the nation.
   a. True
   b. False

2. Which of the following I CARE values have been identified as important to guiding TMH in fulfilling its purpose?
   a. Honesty, Teamwork, Creativity
   b. Innovation, Caring, Action, Responsibility, Empowerment
   c. Integrity, Compassion, Accountability, Respect, Excellence
   d. Learning, Stewardship, Sustainability

3. TMH’s customer groups are:
   a. Colleagues
   b. Patients
   c. Physicians
   d. All of the above

*Continued on Next Page*
Orientation Independent Study Post Test; continued

4. The TMH Corporate Compliance office can be reached at which number?
   a. 3405
   b. 2667
   c. 1.877.772.6723
   d. b & c

5. TMH is committed to maintaining a work environment that is free of discrimination & harassment & will not tolerate harassment and/or discrimination in any form. It is the responsibility of each member of the TMH Leadership team to maintain a workplace free of harassment.
   a. True
   b. False

6. “Committed to providing quality care” from the Corporate Compliance Program includes:
   a. Listening & doing our best to understand the needs of our patients, families & visitors by promptly addressing any issues or complaints
   b. Acknowledging that patients & their families are to be informed about the outcomes of care & associated risks
   c. Providing treatment & medical services without discrimination
   d. All of the above

7. If you discover a fire in your department, you should:
   a. Make sure all doors are open so to avoid smoke inhalation
   b. Follow the RACE and PASS protocols
   c. Put as many people as possible on the elevators to quickly evacuate the area
   d. All of the above

8. When “Code Red” is announced on the overhead paging system, it means that fire or smoke have been reported in the building.
   a. True
   b. False

9. If you answer the phone and the caller tells you there is a bomb in the area, you should:
   a. Remain calm, keep the caller on the line as long as possible, and complete the “Bomb Threat Card”
   b. Immediately hang up the phone and call PBX
   c. Put the caller on hold and notify your supervisor
   d. Hand the phone to a colleague and go in person to alert security

Continued on Next Page
10. A “Code Pink” announcement alerts staff to:
   a. An infant or child kidnapping
   b. A community disaster
   c. A bomb threat
   d. A telephone system failure

11. The goal of TMH is to ensure that dying patients and their families will receive end of life care that optimizes:
   a. Assessment and palliative treatment of primary and secondary symptoms
   b. Assessment and appropriate management of pain
   c. Consideration of patient’s and family’s cultural, social, and spiritual values and preferences
   d. All of the above

12. Material Safety Data Sheets are available for all chemical hazards found in the hospital. These sheets and container labels provide safety and first aid information to colleagues using hazardous chemicals in the workplace.
   a. True
   b. False

13. TMH facilities are tobacco free.
   a. True
   b. False

14. The single most important measure in preventing the spread of infection is:
   a. Airborne isolation precautions
   b. Hand washing
   c. Contact isolation precautions
   d. None of the above

15. A student exposed to blood, body fluid, or infectious disease should immediately notify Occupational Health. After clinic hours, the student should:
   a. Report to the Leon County Health Department
   b. Call his or her physician
   c. Call the Occupational Health on-call nurse
   d. Wait until office hours and report to the clinic

16. Which of the following items are used to prevent the risk of exposure to blood and body fluids?
   a. Gloves
   b. Red Bag trash
   c. Needle and sharps disposal boxes
   d. All of the above

17. Risk Management is every colleague’s responsibility.
   a. True
   b. False
Orientation Independent Study Post Test; continued

18. An incident is defined as any happening that is not consistent with the routine operation of the hospital or the routine care of a particular patient which causes harm.
   a. True
   b. False

19. The Joint Commission for Accreditation of Health Care Organizations has come forward with a minimum required list of acronyms, symbols, and abbreviations that should never be used in a medical record. Which of the following are on the list?
   a. MS
   b. U
   c. QD
   d. All of the above

20. TMH has a policy that gives guidelines for reporting actual or suspected cases of abuse for any patient (aged, battered women, drug-exposed newborn, and child) in the hospital.
   a. True
   b. False

   a. True
   b. False

22. The intent of the HIPAA Privacy Rule is to ensure that doctors, hospitals, and others who provide and pay for healthcare protect patients’ personal medical information.
   a. True
   b. False

23. PHI (Protected Health Information) can be disclosed in which of the following forms?
   a. Verbal
   b. Paper
   c. Electronic
   d. All of the above

24. TMH has guidelines for the security of:
   a. Computers and printers
   b. E-mail and networks
   c. Copy machines, fax machines, and telephones
   d. All of the above

25. If a person is acting violently, you should:
   a. Present a calm, caring attitude
   b. Give clear orders to the person and those that are nearby
   c. Move slowly and respect personal space and privacy
   d. A & C are correct

Continued on Next Page
26. TMH is a drug-free workplace. This means that:
   a. Colleagues or students found using, possessing, selling, or buying drugs on TMH property may be dismissed
   b. Colleagues or students may not report to work with traces of illegal drugs in their system
   c. Colleagues or students should notify their immediate supervisor if they are taking prescription or non-prescription drugs that may affect their work performance
   d. All of the above

27. Violations of the Privacy and Security Rules can result in fines, jail time, and dismissal from your job.
   a. True
   b. False

28. Which of the following privacy principles are accurate?
   a. Patient information should not be discussed outside the workplace
   b. Caregivers should speak quietly when discussing a patient’s condition with family members in waiting room
   c. Documents and other records with confidential information should not be left in public view
   d. All of the above

29. Which of the following is a way to guard against computer viruses?
   a. Not opening unknown attachments
   b. Documenting suspicious activity
   c. Neither of the above
   d. Both A & B

30. The goals for fall prevention include:
   a. Improve or maintain the patient’s condition during the hospital stay
   b. Prevent falls or complications related to falls
   c. Maintain a safe environment for the patient
   d. All of the above

31. Smoke and fire doors should not to be blocked or propped open.
   a. True
   b. False

32. You spend extra time with an elderly patient. The family is appreciative and gives you $50.00 for being nice to their mother. You should:
   a. Accept if it makes the family happy
   b. Accept the money, but make sure to tell your supervisor immediately
   c. Tell the family that you cannot accept the money, but you would appreciate a gift
   d. Graciously decline the money and refer such offers to the TMH foundation.
33. Behaviors such as absenteeism, frequent breaks, lapses in memory, and decreased care in physical appearance are common in:
   a. People who are abusing substances
   b. People who are not qualified for their positions
   c. People who suffering from tuberculosis
   d. People who are being harassed
34. Tuberculosis is transmitted by:
   a. Needle sticks
   b. Airborne particles
   c. Touching respiratory secretions
   d. None of the above
35. Symptoms of active tuberculosis include which of the following:
   a. Fever
   b. Night sweats
   c. Weight loss
   d. All of the above
36. Which of the following is not a service standard related to Accountability?
   a. Take ownership for resolving customer issues and concerns.
   b. Anticipate customer needs.
   c. Follow up to ensure resolution and customer satisfaction.
   d. Apologize for service failures.
37. In the LEAP process for service recovery, A stands for:
   a. Act quickly
   b. Ask for help
   c. Ask for clarification
   d. Announce that you are willing to help
38. The Morse Risk Assessment tool is related to patient:
   a. Eating habits
   b. Spiritual needs
   c. Medications
   d. Falls
39. Patients are not restrained in the prone position.
   a. True
   b. False
40. TMH provides medical ethics consultation that may assist patients/families to better understand a variety of choices or decisions that may arise during the course of an illness.
   a. True
   b. False

Continued on Next Page
Orientation Independent Study Post Test; continued

41. Which of the following are expectations of hospital team members?
   a. Properly report all errors or near misses.
   b. Support a blame-free culture.
   c. Remember the “Golden Moment” for procedures.
   d. All of the above

42. Which of the following is a National Safety Goal?
   a. Improve the accuracy of patient identification
   b. Improve the safety of using medications
   c. Improve the effectiveness of communication among caregivers
   d. All of the above

43. Fostering an environment that values diversity must include a:
   a. Personal assessment
   b. Health assessment
   c. Cultural assessment
   d. Risk assessment

44. Hands should be washed for a minimum of:
   a. 8 seconds
   b. 10 seconds
   c. 15 seconds
   d. 20 seconds

45. Which of the following should go in the sharps box?
   a. All syringes with or without needles – clean or dirty
   b. Glass vials or containers
   c. Pacemaker wires and pacing needles
   d. All of the above

46. HIPP Privacy Standards have no hard and fast rules or lists that define what “minimum necessary” in every setting is.
   a. True
   b. False

47. “Domestic Violence” is any assault, battery, sexual assault, sexual battery or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit.
   a. True
   b. False

48. Airborne isolation is utilized to prevent transmission of tuberculosis due to *M. tuberculosis*, *M. bovis* or *M. africanum*, *Varicella, Measles, Variola.*
   a. True
   b. False

49. PRN orders are acceptable for the use of restraints.
   a. True
   b. False
Orientation Independent Study Answer Sheet

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FOR INTERNAL USE ONLY

Scorer ___________ Date ___________ Score/Percentage

PASS ☐ FAIL ☐
INFORMATION ACCESS SECURITY AND PATIENT CONFIDENTIALITY AGREEMENT

The undersigned agrees and commits to the following statement:

Tallahassee Memorial HealthCare, Inc. (“TMH”) respects the confidentiality of our patients’ medical information. We believe that patients have the right to have their medical information used appropriately for their care and to expect that caregivers will carefully protect the privacy of that information. The HIPAA Privacy and Security Standards, HITECH Act of 2009, Florida Statutes, and the related TMH Privacy and Security policies and procedures (“P&P’s”) (on the TMH Intranet) place certain restrictions on the processing, use, and disclosure of individuals’ and patients’ Protected Health Information (“PHI”) and other Confidential Information. During the performance of duties, colleagues (employees), students, volunteers, and certain contract staff may have access to and/or be involved in the processing of Confidential Information, including but not limited to: patient PHI and electronic PHI (“ePHI”) to include medical records; indexes of medical information; patient demographics, billing, and appointment history; confidential communications for diagnosis and treatment purposes; Human Resources (“HR”) records; and other business, financial, corporate and proprietary information. TMH expects that all individuals who have been granted authorized access to Confidential Information will do so in a manner consistent with regulatory requirements, laws, and established TMH P&P’s related to the transmission, use, and disclosure of Confidential Information and the security of TMH information systems and data.

I understand and agree to adhere to the following:

1. All information related to a patient’s healthcare and treatment in any facility, department, or unit of TMH is considered “protected health information.” This information can only be accessed and shared with those who have a “need to know” while performing duties related to treatment, payment, and healthcare operations (“TPO”). While performing my duties, I may have access to information concerning all TMH patients; however, only the minimal amount of information necessary to adequately perform my specific job responsibilities will be accessed.

2. No information concerning TMH patients will be used, disclosed, or discussed outside of TMH unless specifically authorized by the patient, permitted by the HIPAA Privacy Rule, or required by law. If I have any questions about the appropriateness of disclosure, prior to disclosure, I will make inquiry to the appropriate supervisor or Privacy Officer as indicated.

3. Patient information will not be discussed openly in a public environment, such as elevators, corridors, hallways, cafeterias, or at any other location where others may overhear comments. Discussions necessary for the care of the patient will be conducted as discreetly as possible.

4. Only authorized personnel may release copies of the patient’s medical record and only in accordance with TMH policy and consistent with state and federal regulations. Patient information, such as name, date of birth, address, and/or social security number, will not be recorded on any documents which are removed from my work area or from the facility. Patient information may not be photocopied for personal or school-related use.

5. Telephone inquiries concerning a patient’s condition must be referred to individuals who are authorized to respond to such inquiries. Disclosure of PHI over the telephone will be done in a manner that reasonably ensures protection of the information, to the greatest extent practicable, without interfering with the intended purpose of the communication.

6. Computer passwords will be kept confidential. Inappropriate use of or failure to maintain the confidentiality of any computer password will be cause for disciplinary action.

7. I shall not provide any opinion or testimony, in any form, concerning care provided at TMH or otherwise assist in any way, any attorney, plaintiff or prospective plaintiff or defendant in any cause of action against or contemplated against TMH unless subpoenaed or Court ordered to do so.

8. I will use my user identification code (user ID) and password solely in connection with my authorized access to information. I will take all necessary steps to prevent anyone from gaining knowledge or use of my user ID and password. I understand that my password is recognized as my personal signature on each computer function. For security purposes, I understand that if my account is inactive for 90 days or more, it will be disabled until notice is given by the authorized user or supervisor to reactivate.

9. I am responsible and accountable for all entries made and all records retrieved under my username and password.

10. I will use TMH information resources for business reasons only and will not use information resources for personal use. Under no circumstances will I utilize TMH information resources (specifically e-mail) for purposes prohibited by TMH’s P&P’s, or for personal benefit or gain, solicitation, or distribution of information that is not related to TMH business, with the exception of short informational messages approved by my supervisor.

11. I acknowledge that e-mail communications, computer systems, and any other information resources are not private and may be monitored by TMH to ensure that there is no unauthorized use of the company’s systems. I also acknowledge that use of TMH communications facilities to convey offensive, harassing, vulgar, obscene or threatening information, including disparagement of others based on race, national
origin, marital status, sex, sexual orientation, age, disability, pregnancy, religious or political beliefs, or any other characteristic protected under federal, state or local law, is strictly prohibited and can result in termination.

12. I will respect laws regarding copyrighted software and not make unauthorized copies of software, even when the software is not physically protected against copying.

13. I acknowledge that my obligations and responsibilities continue after termination of employment, contract or affiliation with TMH.

14. I will ensure that Anti-virus software is run by authorized information technology department staff on all new software loaded on TMH computers. I understand that I am not authorized to bypass this step.

15. I will sign off and/or physically secure a terminal or PC when leaving it unattended in an area open to unauthorized individuals.

16. I will not load copyrighted software, shareware and/or freeware, etc. (software programs that are not protected by copyright) on any TMH computer without prior approval by the Information Technology Department.

17. I will protect terminals, network devices and personal computers from theft and physical damage.

18. If applicable to my job description, it is my responsibility to correct colleagues’ time; I must follow hospital policies set forth in the TMH HR P&P’s (on TMH Intranet). I understand that failure to pay colleagues in accordance with hospital policy can and will result in disciplinary action up to and including termination.

19. I will follow the process established for patients to access patient records and accounts, and I will not access patient records or accounts for myself or family.

20. I will not remove PHI from TMH property either in hard copy of electronic form or on any mobile device, i.e., laptop, PDA, or storage medium, (i.e., CD, thumb drive, USB stick) without the written authorization as required by TMH P&P’s.

21. I will report any violation of the information security and patient confidentiality policy to Supervisors, the TMH Security Officer or the TMH Privacy Officer.

22. I understand that violations of security and/or privacy rules and P&P’s, whether due to carelessness or malicious intent, are causes for appropriate corrective action in accordance with HR P&P’s, up to and including discharge, based on the seriousness of the breach.

23. I understand this agreement will not expire, however, will be reviewed annually.

• All TMH colleagues’ access is subject to be renewed at their annual review to re-enforce TMH’s confidentiality and security policy, as set forth in the TMH HIPAA Security Program P&P’s (on TMH Intranet).

• All Non-TMH employees must review this Confidentiality agreement annually thereafter or at the beginning of a new engagement and/or contract when a break in continuous service is greater than two months, or as determined by the appropriate manager.

24. I acknowledge my access privileges are subject to periodic review, revision, renewal, or revocation and that I am obligated to maintain the confidentiality of any new information or systems I am granted access to in order to perform my specific job responsibilities.

______________________________  ______________________________
Colleague Name                                Department

______________________________  ______________________________
Signature                                      I.D. #

______________________________  ______________________________
School Affiliation (if applicable)            Date

69 Revised 09-2013
I hereby acknowledge that I have received and reviewed the Code of Conduct and Business Practice Guide. I fully understand that, as an employee, colleague or TMH agent that I have an obligation to fully adhere to the policies and principles of the Compliance Program.

In particular, I hereby acknowledge and affirm that:

1. I agree to comply with TMH policies and The Compliance Program.

2. When I have a concern about a possible violation of TMH policy, I will promptly report the concern to the appropriate manager, Corporate Compliance officer, Richard Zyski at 431.2667 or Compliance Connection Helpline at 877.772.6723 in accordance the Compliance Program.

_________________________________________     _______________________________
Signature       Date

_________________________________________     _______________________________
Print Name      TMH Employee # if applicable