# Guam Memorial Hospital Authority

*Center for Improvement in Healthcare Quality*

***Continuous Survey Readiness***

**Pocket Guide**


EST 1946

# Table of Contents

# GMHA's Mission, Vision, and Values

## Mission

"Guam Memorial Hospital Authority is a public organization entrusted to improve the health and wellness of the people of Guam. We do this by providing an exceptional patient experience centered on quality-driven, safe, cost-effective healthcare services."

## Vision

"At Guam Memorial Hospital Authority, we will strive to improve the health and well-being of the people of Guam by providing advanced outpatient, inpatient, and post-acute healthcare services. To accomplish this, we will:

- Partner with other healthcare entities to improve the level of medical care on the Island of Guam.
- Achieve and maintain financial viability, thus ensuring sufficient resources to fulfill our mission.
- Support our colleagues by creating an environment where they experience pride and joy in their work and where they are empowered to pursue excellence."

## Values

Our Values are:

**Community:** As a public hospital, GMHA accepts the responsibility entrusted to it to serve as a community asset that strives to improve the quality of life for people of Guam.

**Compassion:** GMHA believes that all persons are worthy of respect, empathy, kindness and understanding. Patients and families undergoing intense medical challenges are especially deserving of holistic and equitable care.

**Innovation:** Innovation takes many forms at GMHA – clinical innovation that leads to better health outcomes, operational innovation that breeds efficiency, workforce innovation that allows GMHA to attract top talent, and cultural innovation that acknowledges Guam's unique cultural heritage.

**Resiliency:** GMHA acknowledges and respects the nuances and challenges inherent in being a community safety net and in providing advanced healthcare on an isolated island locale. It strives to

provide reliable and safe services despite these challenges.

**Trust:** GMHA establishes a bond with its patients, families, colleagues, and the Guam community based on mutual respect, confidence, and dignity.

# CIHQ Survey Overview

## Introduction

This pocket guide is designed to assist you in preparing for our upcoming CIHQ survey.

This guide provides an overview of the survey process, and information on policies and processes. Please review this guide and think about your role in providing quality and safe patient care.

## What is CIHQ?

Established in 1999, the Center for Improvement in Healthcare Quality (CIHQ) is a membership-based organization comprised primarily of acute care and critical access hospitals. It is one of four agencies authorized by The Center for Medicare and Medicaid Services (CMS) to accredit hospitals for federal "deemed" status. Only hospitals that achieve "deemed" status may participate in and receive payment from Medicare and Medicaid.

## What Happens During the Survey?

The CIHQ survey, typically 5 days in length, is designed to confirm that a hospital follows its own guidelines and policies as well as national standards.

The survey team will include: Nurses, Physicians and/or Ambulatory Care specialists as well as an Engineer.

## Tracer Methodology

Tracer methodology is an evaluation method in which surveyors select patients and use their medical records as roadmaps to move through the organization and follow the experience of the patient through the entire health care process.

| TYPICAL PATIENTS SELECTED FOR TRACERS |
| --- |
| • They have received multiple complex services and usually are close to discharge ( e.g. Surgery, Dialysis, Interventional Radiology)<br>• They crossed different departments/services/programs (ER→OR→ICU→Med/Surg)<br>• They are related to Infection Prevention and Control and/or extensive Medication Management issues<br>• ER and In-patients who are prescribed antibiotics<br>• Patients who are scheduled for a diagnostic imaging examination such as Computerized Tomography (CT) |

| HOW THE SURVEYORS WILL CONDUCT TRACERS |
| --- |
| • Review patient's medical records with staff<br>• Observe direct patient care<br>• Observe the medication process<br>• Observe equipment use<br>• Interview patients/family<br>• Observe care planning<br>• Observe infection control and prevention processes<br>• Observe the physical environment and safety<br>• Review competencies, evaluations, and Continued Education (CE's).<br>• Closed records review of patients for restraints<br>• Discuss Quality Assurance and Performance Improvement (QAPI) & Process Improvement projects, related patient care, and services. |

## What Happens When Surveyors Visit My Department?

When surveyors arrive at your area/unit, they may:

- Tour the unit
- Observe care & listen for alarms
- Review a patient record with caregivers
- Interview caregivers
- Interview patients

## What Surveyors may be looking at:

- Identification badges worn above the waist and visible
- Use of 2 patient identifiers when administering medications, drawing blood or providing a treatment
- Perform hand hygiene before entering and after exiting patient room or patient contact, contact with the patient's environment or donning and doffing PPE
- Medication storage and security
- Cleanliness and safety of environment
- Clear corridors- stretchers and equipment on one side if they are in use. Any items in corridors for more than 30 minutes are considered "storage" rather than "in use" and therefore are considered clutter.
- Clear access to fire extinguishers and pull stations, medical gas shut-off valves and exits
- Security of HIPAA protected information
- Compliance with the Universal Protocol
- Limited access to secure areas (know who has access, how access is determined and if training is required)
- Adherence to precaution standards including how to correctly put on, or don, and remove, or doff, personal protective equipment (PPE)
- Labeling specimens in the presence of the patient

## What Surveyors may be listening for:

- Alarm audibility and response to alarms and call lights

- Evidence of write-down, read-back and confirmation of correct information for any verbal/ telephone orders/critical results
- Effective hand-off communication techniques
- Respectful treatment of patients and their families
- Compliance with privacy and confidentiality rules

### What Surveyors may interview staff about:

- Unit and hospital quality initiatives (QAPI Plans)
- Ensuring safety for your patients
- Your training and competence
- How you assess and treat pain

### What if the Surveyor Asks ME a Question?

**DO's**

- Greet the surveyor.
- Honestly answer the question(s) you are asked.
- USE phrases like, "Our policy/procedure/ process is..." If you don't know the answer to a question, it's OK. Be honest and state, "I am not sure, let me find my supervisor for clarification."

*This shows how staff are aware and know how to go about finding information. This may include referencing a policy manual, contacting a supervisor, or calling another department.*

- Emphasize that we are always looking for ways to improve our programs. We work as a team!

- Know where to find all required manuals and documents for your department/unit. If online, know how to navigate and access them.

## DON'TS

- **DO NOT attempt to hide, ignore, avoid, or run from the surveyors**, unless you are involved in a patient's care that would prohibit you from responding!
- **DO NOT Panic! RELAX and TAKE A DEEP BREATH!**
- **DO NOT** volunteer unrelated information.
- **DO NOT USE** phrases that will demonstrate inconsistencies such as, "It should be..," "Usually we…," or "Most of the time…".

*These phrases will lead the surveyors to ask more questions*

- **DO NOT** let the surveyor make you feel defensive.
- **NEVER** attempt to answer a question by assuming what the documentation was intended to mean; let the record speak for itself
- **NEVER argue with the surveyors!**

## What Surveyors may interview patients about:

- Patient and family education
- Advance Directives (Health Care Proxy)
- Pain management

- Staff responsiveness (help when needed and response to questions)
- Continuity of care
- Understanding of medications
- Preparation for discharge
- Environment of care (cleanliness)

## What You Should Know About Communicating with Patients

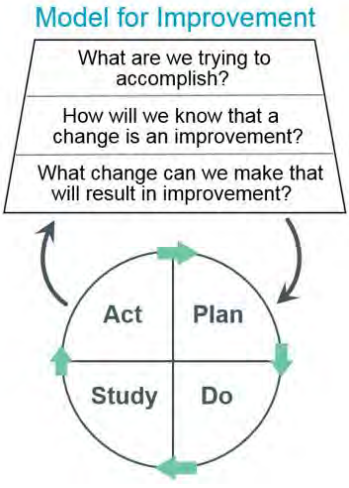
Communicate with the patient in a way that meets their needs.

- This may include personal devices such as glasses or hearing aids, language interpreters, communication boards and translated or plain language materials.
- The hospital is required to identify patient's oral and written communication needs, including the patient's preferred language for discussing health care.
- Preferred and primary language may be different.
- The medical record includes documentation of the preferred language—know where to find it.

**Remember:**
Qualified interpreters are available 24/7. Know how to access a qualified interpreter (call the Communications Center at 647-2330). Interpreter options include: scheduled live American Sign Language (ASL) interpreters, scheduled live foreign language interpreters. Family members are not "qualified" interpreters.

# Quality Assessment & Performance Improvement

Our organization has an organization-wide established program to assess the quality of care, treatment, and service we provide, and take actions to improve when needed. Our way of improving performance is known as the **Model for Improvement.**



The Model for Improvement contains 2 parts:

- Three questions which must be answered –
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What change can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) Cycle (for testing the change) –
  - **Plan** –
    - state the objective of the test
    - state your predictions of what will happen when the change is implemented/tested
    - develop the plan for implementing or testing the change
  - **Do** –
    - Perform the test/implement the change
    - Document what you observed
  - **Study** –
    - Gather all the data and analyze it
    - Compare the actual results of the test/change with your original predictions
    - Describe what was learned
  - **Act** –
    - Decide how to proceed –
    - If successful, will the change be adopted into existing or new processes?

- If not successful, what modifications to the plan or change will be done before starting the next PDSA cycle?

## Patient Safety Program

The Patient Safety Program ensures that GMHA implements and maintains a patient safety program in accordance with Centers for Medicare and Medicaid Services (CMS), accrediting body and standards of practice by different licensing authorities from state and federal regulatory agencies.

The Patient Safety Program supports and promotes the mission, vision, and values of GMHA through the practice of developing and implementing a culture of safety among its consumers. This implies, but is not limited to, its patients, staff, contractors, physicians, volunteers, and visitors.

In a just culture of safety and quality, all individuals are focused on maintaining excellence in providing care. Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and safety, and set expectations for those who work in the organization.

## Patient Safety Reporting via the Safety Learning System (SLS)

The Safety Learning System (SLS) is GMHA platform to report any unexpected patient, visitor, employee, volunteer, student, medical staff, or vendor event, regardless of whether there is an injury that occurs or not.

In order to access and use the SLS you must have a GMHA.org email address. If you do not have one, you will need to work with your department head or with the hospital's Management of Information Services department to obtain one.

Once you have obtained your email address, you will then need to contact the Patient Safety Officer to set up an SLS account for you. The Patient Safety Officer's email is:

**slsadmin@gmha.org**

| HOW TO REPORT AN EVENT? |
| --- |
|  Use the Safety Learning System (SLS) tool, which can be accessed by clicking on the SLS icon on the desktop on one of the hospitals workstations. |

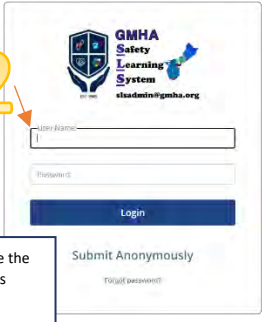
# HOW TO REPORT AN EVENT

SLS

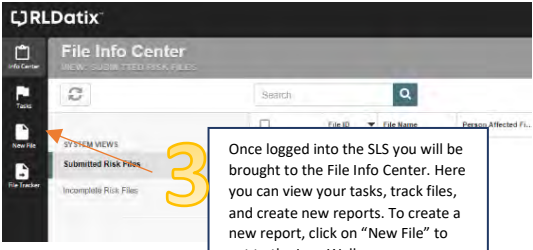
1 Click the SLS icon on the desktop (icons may vary)

Your USERNAME will be the beginning section of your GMHA email address (i.e.,firstname.lastname").

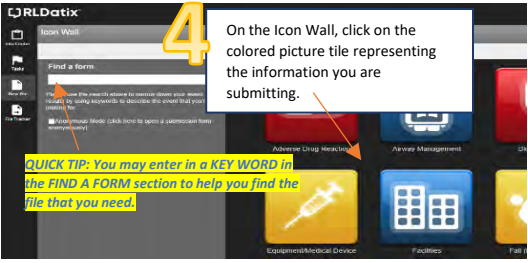
*Note: If you forget your password, send an email to the Patient Safety Officer to have it reset.*

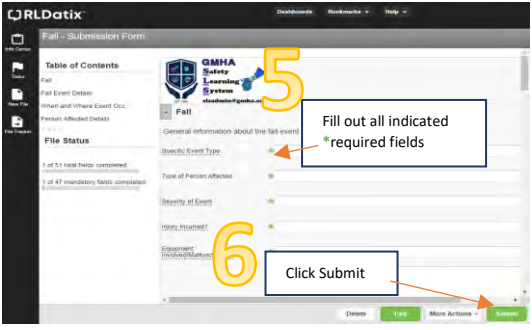


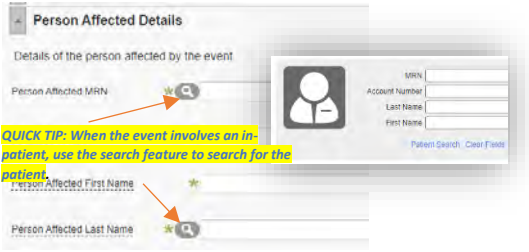

To submit anonymously, leave the Username and Password fields empty and click on the words "Submit Anonymously"




3 Once logged into the SLS you will be brought to the File Info Center. Here you can view your tasks, track files, and create new reports. To create a new report, click on "New File" to get to the Icon Wall.


RLDatix
Icon Wall
Find a form
4
On the Icon Wall, click on the colored picture tile representing the information you are submitting.
QUICK TIP: You may enter in a KEY WORD in the FIND A FORM section to help you find the file that you need.
Adverse Drug Reaction
Airway Management
Equipment/Medical Device
Facilities


RLDatix
Fall - Submission Form
Table of Contents
File Status
GMHA Safety Learning System
5
Fall
Fill out all indicated *required fields
Specify Event Type
Type of Person Affected
Severity of Event
Injury Incurred?
Equipment Involved/Malfunction
6
Click Submit
Delete
Edit
More Actions
Submit


Person Affected Details
Details of the person affected by the event
Person Affected MRN
MRN
Account Number
Last Name
First Name
Patient Search
Clear Fields
QUICK TIP: When the event involves an in-patient, use the search feature to search for the patient.
Person Affected First Name
Person Affected Last Name

## What Types of Incidents to Report

| Errors | Near Misses |
|---|---|
| An unintended act, by either omission or commission, or an act that does not achieve its intended outcomes. | A process variation that did not reach the patient but for which a recurrence carries a significant chance of a serious adverse outcome. |
| **Hazardous Conditions** | **Sentinel Events** |
| Any set of circumstances (unrelated to the patient's condition) which significantly increases the likelihood of a serious adverse outcome. | An unexpected occurrence that results in death or serious injury, or outcome unrelated to the patient's course of illness. |

| Event Categories | |
|---|---|
| Adverse Drug Reaction | Airway Management |
| Diagnosis/Treatment | Diagnostic Imaging |
| Employee/Affiliate Event | Equipment/Medical Device |
| Facilities | Healthcare Information Technology |
| Infection Prevention and Control | IV/Vascular Access Device Event |
| Lab/Specimen Event | Maternal/Childbirth Event |
| Medication/Fluid Event | Patient ID/ Documentation/Consent |
| Patient/Visitor Fall Event | Professional Conduct |
| Provision of Care | Restraints |
| Safety/Security Event | Skin/Tissue |
| Surgery/Procedure Event | Tube/Drain Event |

# Good Catch Award

A **GOOD CATCH** is a problem or error that almost got to the patient, but did not because you caught it first and corrected it. Think of it as, *"Wow, that was a close one…."*

The Good Catch Award was developed based on best practices from national patient safety standards and ECRI, our Patient Safety Organization. The overall goal of giving recipients the bi-weekly Good Catch Award, is to improve GMHA's heightened awareness of best practices in patient safety and to support a positive climate where patient safety is top priority. It also helps produce an organizational culture of safety, free from punitive blame.

In order for staff to receive the award, there must have been an event, which did not reach the patient (Near Miss) and did not do harm, due in part, to the staff member catching the event prior to it reaching the patient.

Entering the near miss event into SLS is no different than entering any other event, except the SLS user will choose from the drop down box for Severity of Harm and either choose; A. Unsafe Condition (Non-event) or B. Almost Happened/Near Miss/No Harm(Error did not reach patient/resident).

# Patient Safety Standards

## Improve Accuracy of Patient Identification

**Staff Responsibilities**

- ALWAYS use **2** identifiers when identifying patients.
  - **In-patients**
    - **Patient Full Name**
    - **Medical Record Number**
      (in the event the Patient Medical Record Number is not available, then the second identifier becomes the Patient Account Number)
  - **Out-patients**
    - **Patient Full Name**
    - **Date of Birth**
- Two staff members must verify (2 patient IDs) when drawing blood for blood products AND before giving blood products. Use the "PRE-TRANSFUCION CHECKLIST"
- LABEL BLOOD AND OTHER SPECIMENS IN THE PRESENCE OF THE PATIENT. Have patient verify labels when able to do so.
- Use distinct naming for newborn patients. FOLLOW nursing policy **6310-II-C-39**.

## Improve the Effectiveness of Communication among Caregivers

**Staff Responsibilities**

- EFFECTIVE communication skills go hand in hand with patient safety
- When sharing information, communication should be complete, clear, brief, and timely.
- Get critical results to provider **within 30 minutes** (internal policy). Evaluate effectiveness of reporting critical results.


## Improve the Safety of Using Medications

**Staff Responsibilities**

- ALWAYS reconcile, record, and pass along correct information about a patient's medicines.
- Make sure the patient knows which medicines to take when they are at home.

- Before every procedure, ALWAYS label medicines that are out of the original container. This includes syringes, basins, or other containers.


- Use protocols when administering anticoagulant therapy
- International Normalized Ratio (INR) baseline is required prior to beginning Coumadin therapy. Subsequent INRs are obtained for use in monitoring the patient's therapy.
- Use unit dose, prefilled syringes or premixed infusion bags when giving heparin

## Reduce Patient Harm Associated with Clinical Alarm Systems

**Staff Responsibilities**

- Clinical alarms alert staff of urgent or potentially adverse patient conditions
- Alarms MUST be audible and offer alerts that are understood and promptly acted by staff.
- Make sure alarms are audible with respect to competing noises in the unit.

- Always physically enter the room during an alarm and assess the patient
- DO NOT turn off or deactivate alarm capabilities.
- Ensure regular preventive maintenance and testing is done.

## Reduce the Risk of Health Care-Associated Infections

**Staff Responsibilities**

- Each year millions of people acquire an infection while receiving care in a health care organization.
- Compliance with hand hygiene guidelines reduce health care acquired infections.
- Implement evidence-based practices to prevent infections.
- Perform hand hygiene on entry to the patient room/cubicle and on exit.
- Perform hand hygiene BEFORE gloving & after removing gloves.

## Reduce the Risk of Suicide

**Staff Responsibilities**

- LISTEN, ASK, and ACT
- Staff should be AWARE of the signs of and the risk factors associated with suicide

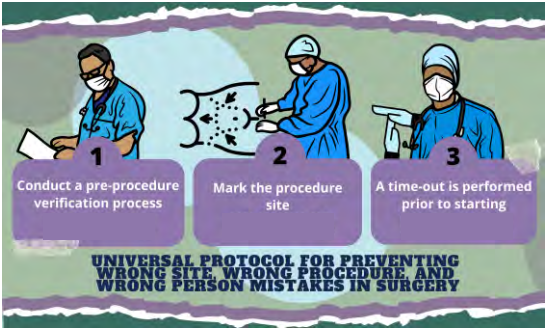
- Complete a suicide risk assessment on the physical environment

## Prevent Wrong Patient/Wrong Site Procedures

**Staff Responsibilities**

Follow the Universal Protocol Safety Check – **EVERY TIME.**

The 3 phases of UP applies to all inpatient and outpatient procedures that expose patients to more than minimal risk.



# Fall Prevention & Post-Fall Management

## For All Patient Settings


- Upon admission, every shift, and/or with any Acute Change of Condition (ACOC), every patient will be assessed for the potential for fall, using the Fall Risk Assessment Tool for adult or pediatric populations.
  - The **Morse Fall Scale** shall be used to assess all adult patients (18 years or older)
  - The **Humpty Dumpty Falls Scale** shall be used to assess infants and pediatric patients (3 months to 17 years)
  - Neonates and infants are by definition considered at risk of fall due to their developmental age. No assessment / reassessment of fall risk is required for these patients in any care setting.
- A plan of care will be implemented based on the Risk Assessment score.
- An **Environmental checklist** shall be performed on patients identified as HIGH RISK at every shift to ensure the safety of the patient.
- A yellow alert clasp for falls must be placed on the wristbands on all adult patients identified as **Moderate** or **High Risk** for fall. FALL RISK

# Infection Prevention & Control


## Hand Hygiene

| WHEN DO YOU WASH YOUR HANDS WITH SOAP AND WATER? |
|---|
| • When hands are visibly dirty or contaminated with blood or other body fluids<br>• When working with patients with known or suspected infections from spore-forming bacteria (e.g., Clostridium difficile) hands should be washed to physically remove spores from the surface of contaminated hands |

| WHEN DO YOU SANITIZE YOUR HANDS? |
| --- |
| • When hands are not visibly soiled and to reduce bacterial counts on hands |


## Important HAND HYGIENE Points

- Jewelry should be removed prior to hand cleaning.
- Employees who provide direct patient care or who handle or prepare food or medications may not wear artificial nails.
- Natural nails should not exceed 1/4 inch from the fingertip. Clear polish may be worn when well-manicured and not chipped.

**When Gloving:**

- Perform hand hygiene prior to putting on gloves
- Wear gloves when in contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur.
- Change gloves during patient care if moving from a contaminated body site to a clean body site.
- Do not use the same gloves for the care of more than one patient.

## Standard Precautions


An approach to infection control which treats all body fluids and substances as if they were infectious for Bloodborne Pathogens. Use of standard precautions is determined by nature of the patient interaction and extent of anticipated blood, body fluid, or pathogen exposure. In other words…**"treat all blood and body fluids as potentially infectious materials with appropriate precautions".**

**Core Elements of Standard Precautions**

- Use of protective personal equipment (PPE): gloves, gowns, mask, eye protection, and face shields.
- Aseptic technique, including appropriate use of skin disinfectants.
- Personal hygiene practices, particularly hand-washing and hand hygiene, and cough etiquette.
- Appropriate handling and disposal of sharps and clinical waste.
- Appropriate reprocessing of reusable equipment and instruments, including appropriate use of disinfectants.
- Environmental controls, including design and maintenance of premises, cleaning and spills management.

## Important Symbols

### Expiration date

- Do not use products or medications past their expiration date.
- Develop a process for recognizing when products and medications will expire and what to do if they are close to expiration.

- What to do if there is only a month and year for expiration? It is good until the END of the month

### Manufacturer Date

- Indicates when the device/product or medication was manufactured

### Single Use

- Only use item/product once, then dispose of it

| | | |
|---|---|---|
| STERILE | R | Sterilization by irradiation |
| STERILE | EO | Sterilization by ethylene oxide |
| STERILE |  | Sterilization by steam or dry heat |
| NON-STERILE | | Item has not been sterilized |


Do NOT Re-sterilize

Avoid Sunlight

Avoid Moisture

Temperature Limitation

## Disinfectant Contact Time

**IMPORTANT:** Contact time – or "wet time" – is how long a disinfectant needs to stay wet on a surface in order to be effective

- Two of our hospital's standardized disinfectants for use on noncritical devices include:

PDI Sani-Cloth Plus wipes
Contact time of **3 minutes**


HB Quat Disinfectant Spray
Contact time of **10 minutes**


- If you are using a disinfectant wipe, close the container after removing the wipe to retain moisture and maintain patient safety.
- Allow the equipment to air-dry before use to prevent patient exposure to the disinfectant.
- If you used a reusable cloth to clean and disinfect the noncritical patient care equipment, place the cloth in a laundry bag for laundering. If you used a disposable cloth or wipe, dispose of it in an appropriate receptacle.
- Remove and discard your gloves and other personal protective equipment, if worn.
- Perform hand hygiene.

# Pain Management

## PATIENTS HAVE THE RIGHT TO APPROPRIATE PAIN ASSESSMENT AND MANAGEMENT

- **Pain assessment is completed on ALL patients during the general admission process**

**Pain Assessment Must be Conducted...**

- Upon admission to the hospital or each outpatient visit
- After all operative or invasive procedures
- Periodically and/or routinely after procedures associated with pain ( e.g. every 5 minutes or 4 hours, if indicated)
- After any significant change in the patient's condition
- Patient's response to therapy (i.e. within 1 hour following any pain intervention)
- Prior to discharge

**Pain Assessment, Reassessment, and Documentation**

- Identification of pain—how does the patient describe the pain and where does the patient localize the pain
- Assessment & measure of pain—use of pain rating scales for the appropriate age and population (examples: children, elderly, cognitively impaired)
- Intensity and quality (character, frequency, location, duration, aggravating and alleviating factors, and symptoms)
- Note vital signs
- Responses to treatment — both pharmacological and non-pharmacological treatments
- Reassessment after treatment and at regular intervals
- Reassessment should focus on the effectiveness of therapy, any side effects caused by therapy, identifying the cause of pain, and developing or modifying the pain therapy plan as appropriate
- Consider consultation with a specialist if treatment fails.
- Written and verbal pain management information will be provided at the time of discharge

# Do Not Use Abbreviations

| DO NOT USE | Potential Problem | USE INSTEAD |
|---|---|---|
| U<br>**(for unit)** | Mistaken as "0" (zero), the number "4" (four), of "cc" | **Write "**unit**"** |
| IU<br>**(for International Unit)** | Mistaken as "IV" (intravenous) or the number "10" (ten) | **Write "**International Unit**"** |
| Q.D., QD, q.d., qd<br>**(Daily)**<br><br>Q.O.D., QOD, q.o.d., qod<br>**(every other day)** | Mistaken for each other.<br><br>The period after the "Q" can be mistaken for an "I" and the "O" can be mistaken for "I" | **Write "**daily**" or**<br><br>**"**every other day**"** |
| Trailing zero (X.O mg)*****<br><br>Lack of leading zero (.X mg) | Decimal point is missed. | **Write "**X mg**" (Never write a zero by itself after a decimal point)**<br><br>**Write "**0.X mg**" (Always use a zero before a decimal point)** |
| MS<br><br>$MSO_4$<br><br>$MgSO_4$ | Can mean "morphine sulfate" or "magnesium sulfate"<br><br>Confused for one another. | **Write "**morphine sulfate**" or "**magnesium sulfate**"** |

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.
***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be in medication orders or other medication-related documentation

# Medication Management

**Potential High Risk Findings on Survey**

1. Not following policy regarding medication orders (**Titration and Range Orders**)
2. Emergency medication accessibility
3. Storage of medications
4. Clean separate area for medication preparation (**Medication Compounding**)
5. Medication Security

**TITRATION ORDERS**

Order that provides guidance for administration and dose adjustments

REQUIRED ORDER COMPONENTS

- Medication name/route of administration
- Starting dose
- Frequency of titration
- Assessment Parameters and final endpoint
- Incremental dose change; either increase/decrease the infusion rate
- Max dose and/or when to call LIP

(e.g., Start nitroglycerin infusion at 5 mcg/min IV. Titrate by 5 mcg/min every 5 minutes to keep SBP less than 160mmHg and greater than 110mmHg. Max dose 200mcg/min. Contact LIP if unable to titrate, SBP 90mmHg, or continued chest pain or EKG changes.)

## RANGE ORDERS

Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status

REQUIRED ORDER COMPONENTS

The required order component and implementation is determined by the organization's policy requirements. Please refer to GMHA's policies and Medication Management Manual for compliance.

**Common Survey Findings**: Inconsistent interpretation of how to carry out the range order.

## SAFELY MANAGE EMERGENCY MEDICATIONS

**Readily accessible**

- Ensure Crash cart meds and supplies are not expired

**Unit dose, age specific, ready to administer**

- Crash carts are stocked with amps/vials when available from the manufacturer as prefilled syringes or premixed bags

**Resupply after use as soon as possible**

- Used or opened crash carts that were removed from patient care areas need to have fully stocked replacements

**Common Survey Findings**: Pediatric carts have missing or outdated Broselow Tapes

## SAFELY STORE and SECURE MEDICATIONS

- Medications are maintained at temperatures according to manufacturer's recommendations.
- Complete documentation of temperatures on paper logs.
- Medication refrigerators are clearly labeled as "DRUGS ONLY: NO FOOD".
- Ensure monitoring of temperatures of medication refrigerators in areas not staffed 7 days a week.
- Check expiration dates on all medications to ensure not out of date.

**Common Survey Findings:** Observed an open multi-dose vial without a revised expiration date.

**Can an anesthesia cart containing medication be left unlocked in an operating room (OR) suite between cases?** **If the cart can be monitored and assure constant surveillance to prohibit access by unauthorized individuals, then locking of the cart between cases would not be required.** **Source: TJC Standards FAQs**

## SAFELY MANAGE HIGH-ALERT (RISK) & HAZARDOUS MEDICATIONS


## SAFE USE OF LOOK-ALIKE/SOUND ALIKE (LASA) MEDICATIONS

- Annually reviewed lists available on Pharmacy and Therapeutics (P&T) Committee SharePoint site
- Safety Management Strategies for GMHA

- Tallman lettering is used for LASA medications
- Physically separating LASA medications in storage
- High alert and "Look Alike/Sound Alike" medications are clearly marked with stickers and alerts on the Pyxis system

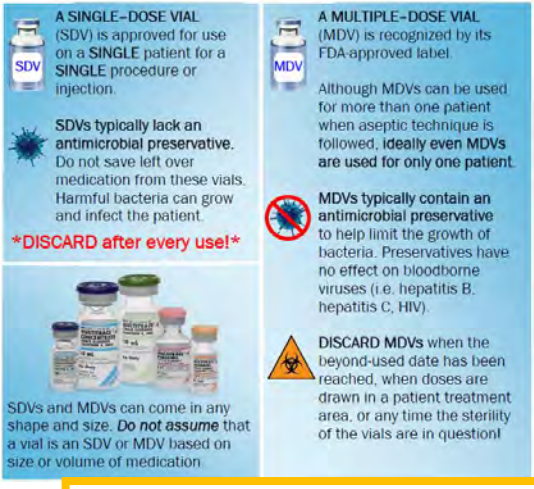
**LOOK ALIKE SOUND ALIKE**

| | |
|---|---|
| Plantinol (Cisplatin) | Paraplatin (Carboplatin) |
| Ephedrine | Adrenaline (Epinephrine) |
| Sublimaze (Fentanyl) | Sufenta (Sufentanil) |
| Dilaudid (hydromorphone injection | Infumorph (Morphine Injection) |
| Humulin (Human Insulin Prodcuts) | Humalog (Insulin Lispro) |
| Novolin (Human Insulin Products) | Novolog (Human Insulin Aspart) |
| Novolin 70/30 {70% isophane insulin (NPH) and 30% insulin injection (regular)} | Novolog Mix 70/30 (70% insulin aspart protamine suspension and 30% insulin aspart) |
| Hydralazine (Apresoline) | Hydroxyzine (Vistral Atarax) |

## INJECTION SAFETY

What is injection safety? Injection safety or safe injection practices, is a set of measures taken to perform injections in an optimally safe manner for patients, healthcare personnel, and others.

Source:https://www.cdc.gov/injectionsafety/providers/provider_faqs.html




Medication vials should always be discarded whenever sterility is compromised or questionable

## Multiple-Dose Vials (MDV)

Apply Aseptic Technique within 28 days of Opening the MDVs

1. Scrub the rubber septum with an approved antiseptic swab.
2. Allow to dry.
3. Insert a new needle attached to a new syringe for each entry.

| | |
|---|---|
| **MDVs that do not require reconstitution may be used for multiple patients if:** Doses are not drawn in "immediate patient treatment areas" including the O.R., procedure rooms, anesthesia/procedure carts, patient rooms, or bays. | **Exceptions to the 28-day expiration of MDVs:**<br>• The manufacturer identifies & extends the expiration date in the product packaging, indicating the manufacturer has conducted testing beyond the minimum required 28 days.<br>• The manufacturer identifies an expiration date earlier than the 28-day expiration date, in which case the earlier date must be used. |
| **Medications reconstituted in an injectable MDV:**<br>• Expires one (1) hour from reconstitution unless prepared and labeled by pharmacy.<br>• Must be labeled with diluent, concentration, expiration date, and time. | |

# Patient Rights/Informed Consent

### How are Patients Informed of their Rights?

- Patient Registration staff shall provide the patient, or legal representative, the "Patient's Rights and Responsibilities" document upon admission to the hospital.
- The "Patient's Rights and Responsibilities" document applies to all patients of all ages. Patients need to know that we **respect and protect these rights** and that they are entitled to make decisions regarding their care including the decision **to accept, refuse, or discontinue treatment**.

### The Rights of the Caregiver

Explains the rights and responsibilities of staff members whose cultural, ethical, or religious beliefs and/or practices conflict with specific aspects of patient care (e.g. sterilization, blood transfusions).

### Informed Consent

Prior to submitting to medical treatment, patients have the right to be informed of the nature of the treatment and procedures, the risks, anticipated benefits, available alternative treatments including probable or expected consequences of a failure to accept treatment. It is the provider's responsibility to discuss this information with the patient in language the patient can understand.

## A Living Will or Advance Directive/DNR


An **Advance Directive** allows patients to decide how to handle health decisions in the event of a life-threatening condition or terminal illness. Examples of Advance Directives include: A Living Will or Durable Power of Attorney for Health Care. Witnesses for these documents cannot be hospital employees.

### HOW ARE PATIENTS INFORMED OF THEIR RIGHTS REGARDING ADVANCE DIRECTIVES?

Upon admission, same day surgery pre-admission, or at the patient's request, patients who are 18-years of age or older, are given information which includes their rights under the Natural Death Act of Guam to accept or refuse medical or surgical treatment and to formulate an advance directive.

- If the patient has already executed an advance directive, the patient should provide a copy at the time of admission.
- Inpatient personnel should document follow-up reminders to family of patients who do not bring a copy of the advance directive upon admission.

### DO NOT ATTEMPT RESUSCITATION

In a life-threatening emergency, all inpatients will receive full life-sustaining therapy unless otherwise ordered by a nurse practitioner, physician assistant, or staff physician after discussion with patient/family.

**Patient resuscitation options include:**

- Full Code—Code Blue, Rapid Response Team (RRT)
- DNR (Do Not Resuscitate)—No Code Blue, No RRT

## Patient & Family Education

**Patient Education** is the process of influencing behavior, and producing changes in knowledge, attitudes, and skills needed to maintain and improve health. Patients are encouraged to ask questions about their care and medications, to participate in their treatment decisions, and become educated about their diagnosis and treatment plan.

**Goals for patient and family teaching include, but not limited to:**

- Basic health practices
- Plan for care and treatment
- Safe and effective use of medication and medical equipment
- Potential food-drug interactions and nutrition diets
- Habilitation/rehabilitation techniques
- Pain assessment and management
- Patient/family responsibilities throughout the treatment process
- Personal hygiene and grooming
- Availability of community resources
- When and how to obtain further treatment
- Discharge instructions
- When to seek emergency care
- Brief tobacco intervention counseling

## Disclosure of Unanticipated Outcomes

**Disclosure** is the process of informing the patient and when appropriate, the patient's family, of unanticipated outcomes of care. The unanticipated outcome may be positive or negative, and whether from an error or not, that significantly differs from what was the desired outcome of care. The primary provider or his/her supervisor should expeditiously notify the appropriate hospital representatives of negative unanticipated outcomes.

**INFORMATION FOR DISCLOSURE**

Each situation is unique and shall be handled on a case-by-case basis. At a minimum, the following information shall be disclosed:

- A truthful, factual, and compassionate account of the unanticipated outcome;
- Any short or long-term effects expected as a result of the unanticipated outcome;
- Any medical care or treatment available to the patient required as a result of the unanticipated outcome, including but not limited to, the risks, benefits and alternatives of such care and treatment;
- An expression of regret that the unanticipated outcome occurred;
- Assurance that the unanticipated outcome will be evaluated so steps may be taken to reduce the likelihood of similar risk to other patients;
- Time for the patient and/or family to ask questions or raise concerns; and
- Name of the individual(s) responsible for managing ongoing communications with the patient and the patient's family members regarding additional questions, complaints and follow-up

# Medical Record Requirements

**Important Points for MEDICAL RECORDS**

**What are the most important aspects of a survey from the medical records perspective?**

- **Timeliness** – **GMHA requires that Providers complete inpatient medical records within 30 days of discharge.**
- **Completeness** and **accuracy**
  - **General Rule:** The medical record reflects the care provided in a chronological manner.
- History and Physical (H&P) documented prior to procedure, not older than 30 days; Must document review of H&P within 24 hours prior to the procedure.

- **Confidentiality**

Other **Medical Record items** of interest include:

- Pain assessment, Control, & Reassessment
- Multidisciplinary Documentation (e.g., Nutrition, Pharmacy, Social Work)
- Advance Directives
- Complete Discharge Instructions
- Handwritten records are legible, dated, timed and provider's name is printed or stamped in addition to signature

# Physical Environment

Our organization maintains an active program to provide a safe and secure environment on a routine basis. The Environment of Care Committee (EOCC) is a multidisciplinary body that monitors the vital functions of the physical environment.

## Equipment Safety Check

### Is Your Equipment Safe for Patient Care Use?


- ❑ **Does your medical equipment have an GMHA Fixed Asset Number?** If missing, contact the Property Manager 647-2267
- ❑ **Is your medical equipment's Preventative Maintenance (PM) sticker current?**
  - o Verify Completed By, Date, and Inspection Due on PM sticker


  - o If expired or missing, contact the **Biomedical Engineering (BIOMED) Department 647-2122**
- ❑ **Do you have equipment with overdue Preventative Maintenance? How do you take it out of circulation?** Contact **BIOMED 647-2122** immediately to have Preventative Maintenance conducted on the equipment. Equipment should not used on patients until PM is completed.

❑ **Who do you contact in case of malfunctioning medical equipment?**

BIOMED Department 647-2122
Communications Center after hours to notify the on-call Medical Electronic Superintendent

- **How do you take it out of circulation?**
- **How is it marked?**

Contact BIOMED immediately to have the equipment inspected. If the equipment cannot be taken out of the work space, coordinate with BIOMED for removal and fill out and place an "Equipment/Utility Failure Report" to the equipment.

❑ **Who do you contact if medical equipment failure injures a patient of staff member?**

**What to do in case of medical equipment failure injury:**

1. Report the equipment to BIOMED and fill out the "Equipment/Utility Failure Report"
2. Fill out an incident report in the Safety Learning System (SLS)
3. Sequester the equipment and keep it removed from service.
4. Do not change any of the configuration settings.
5. Do not allow the vendor access to the equipment.

❑ **Who do you contact for user training on a piece of new medical equipment?**

BIOMED or Manufacturer/Vendor representative via **BIOMED 647-2122**

## Medical Waste

### MEDICAL WASTE
**(Biohazardous)**

**USE FOR:**
Items that are saturated with blood or bodily fluids BUT does not contain sharps:

- Blood bags and tubing
- Hemodialysis tubing
- Suction Canisters
- Pleurovac or hemovac containers
- Vials or containers contaminated with blood or body fluids

### MEDICAL WASTE
**(Sharps)**

**USE FOR:**
Sharp objects with blood or body fluids:

- Needles/syringes contaminated with blood
- Suture needles, butterfly needles
- Scissors, stylets
- IV catheters

# MEDICAL WASTE

**(Linen)**

**USE FOR:**

Dirty linen that has been used in any means whether or not it has been contaminated with blood or body fluids. This includes any clean linen that has been taken into a patient isolation room and not used.

# SOLID WASTE

**Clear (Trash) Bags**

**USE FOR:**

- Regular household type trash
- Used & empty bedpans, urinals, & emesis basins
- IV bags & tubing without medication or visible blood

# Emergency Management & CODES

The GMHA Emergency Management Plan contains action information for command emergency codes. Some of the information is listed on the following pages.

## EMERGENCY CODES

All staff, students, and volunteers at GMHA are responsible for maintaining a safe work environment. It is important to keep yourself informed and aware of the Hospital emergency codes and their appropriate responses. Phone numbers for Emergency Codes are listed on GMHA Emergency Code Badges.

**DR BURNSITE**

Fire
647-2222

**DR REDWOOD**

Mass Casualty
647-2222

**CODE 60**

Security Disturbance
647-2222

**RRT**

Rapid Response Team
647-2222

**CODE BLACK**

Active Shooter
647-2222

**CODE 99**

Bomb Threat
647-2222

**CODE YELLOW**

Hazardous Spill/Leak
647-2222

**CODE PINK**

Infant/Child Abduction
647-2222

**CODE BLUE**

Cardiac/ Respiratory Arrest
647-7200

**CODE RED**

Activates SNF Emergency
647-2222

**DR CLEARWATER**
Operations back to normal

## CODE PINK – Infant/Child Abduction

**All Departments** are required to have an SOP directing actions in the event of a missing or stolen newborn, infant, or child (up to age 18).
What actions do you take in the event of a missing newborn, infant, or child?

**In the event a newborn/infant/child cannot be accounted for:**

1. Notify the Unit Supervisor/Charge Nurse and activate **Code Pink** by calling: GMHA Communications Center 647-2222. Provide a description of the patient (age and gender) and suspected abductor, if known.
2. Report to assigned **Code Pink Station**
3. If you see a suspicious individual(s), report the location to the Communications Center. Non-security personnel shall not physically detain the abductor.

**Infant/Pediatric Security Plan Policy 403**

## DR REDWOOD – Mass Casualty Event

**Emergency Preparedness Manual Policy 401**

Provides guidance in the event of external or internal disasters. Departmental responsibilities and plans are found on the "**Emergency Preparedness Manual**" under "**Section IV – Mass Casualty Preparedness**".
**Immediate response** to your mass casualty station is required when a **DR REDWOOD** is announced.

## CODE 99 – Bomb Threat

Bomb threats usually come in by telephone. If you receive a bomb threat or any type of threatening phone call, **DO NOT HANG-UP!!** Listen carefully to the caller and obtain as much information as you can.

**ASK...**

1) When is the bomb going to explode?
2) Where is the bomb located?
3) What kind of bomb is it?
4) What does the bomb look like?
5) Where are you calling from?

**ATTRACT THE ATTENTION OF THE PERSON NEAREST TO YOU** to listen in on the conversation and have another person report the bomb threat to the Communications Center 647-2222.

- Turn off handheld radios and cell phones.
- Evacuate when directed.
- Bomb Threat Report worksheet should be posted close to your telephone.

**Emergency Preparedness Manual Policy 204**

- You have the **"Right to Know"** what hazardous materials you work with and/or are exposed to in your area. This includes any material that is labeled flammable, corrosive, poison, or irritant and should be approached with caution.

- **Safety Data Sheet (SDS)** is a required Fact Sheet on **ALL chemicals** used in your area.
- **ALL containers must be clearly labeled** as to their content and hazards.
- SDS are typically kept in a binder or manual in your area.
- **The SDS Manual in your area is located:**

  _____

## CODE YELLOW – Hazardous Spill/Leak

**What should you do if you have a hazardous spill in your area?**

1. If the spill is small (less than 50ml) and can be cleaned with a "spill kit" while not posing a threat to personnel or the environment, **Refer to SDS!!**
2. If a spill is **greater than 50ml**, evacuate all personnel and seal off the area as best as possible - call the Communications Center 647-2222 to announce the CODE YELLOW and report the following information:
   a. Location of spill
   b. Type of chemical or substance involved, if known
   c. Quantity of chemical or substance involved, if known
   d. Injuries to personnel, if any
   e. Name and Department of person reporting
3. Obtain the **SDS Sheet** if aware of the chemical content

## CODE BLUE – Cardiac/Respiratory Arrest

**1st Responder**

- Call for help. Initiate AHA Basic Life Support algorithm Compression-Airway-Breathing response for 5 cycles, or 2 minutes.

**2nd Responder**

- Press the "CODE BLUE" button
- Call the Communications Center 647-7200
  - Specify Adult or Pediatric
  - Specify Unit, room number and/or location
- Bring crash cart to room
- Hook the patient up to the defibrillator and analyze the rhythm
- Take over compressions until another responder arrives.

**Team Leader**

- Oversee CPR
- Provide a brief history of patient when CODE BLUE physician arrives.

## RRT – Rapid Response Team

- The RRT program provides early recognition and rapid intervention on hospitalized patients with evidence of deteriorating clinical conditions in an effort to improve outcomes and reduce the possibility of cardiac and/or respiratory arrests.
- The Unit Charge nurse or the primary nurse can activate the RRT when **one or more** of the **RRT** parameters are met, **OR** if the nurse is worried about the patient's condition.

- The RRT will assess, treat, stabilize, and when needed, transfer the patient to a higher level of care.
- The Unit Charge Nurse or the Primary Nurse can activate the RRT by calling 647-2222.

**Administrative Manual A-PS500**

## DR BURNSITE – Fire Procedures


What do you do in the event of a fire?
Where is the nearest extinguisher and pull station?
What is your role in the event of an EVACUATION?

**Safety and Security Manual – Policy 217**

## Environmental Health & Safety

**Fire Safety**

Fires in healthcare settings require a rapid, efficient response to limit injury and damage. Each inpatient nursing unit is physically designed to confine smoke or fire to a "smoke compartment" to minimize injury or damage.

**If necessary, how do you evacuate employees and patients?**

**Two ways to evacuate:**

1. Horizontal evacuation is the preferred method for departments located in buildings that are constructed to "Defend in Place." Move to a safe location on the same floor – past the next set of fire doors.
2. Vertical evacuation involves moving to a different floor or another building.
   *Elevators should not be used during a fire emergency. If evacuation is needed, the fire department will know how to use elevators safely.

**REMEMBER**

- ✓ Keep hallways and stairwells "clutter-free" from equipment and other items


- ✓ Do not block fire doors, fire extinguishers, fire alarm pull stations, fire panels, and sprinklers with items or equipment
- ✓ Make sure fire extinguishers are unobstructed.
- ✓ The Nursing Supervisor has the authority to turn off the medical gas in the hospital.


**Cylinder Status**

- Cylinders should be segregated and properly tagged
- "FULL" and "IN USE" $O_2$ cylinders must be kept separate from "EMPTY" $O_2$ cylinders.

| FULL | IN USE | EMPTY |
|---|---|---|
| Sealed | No Seal | No Seal |
| No Regulator | Regulator On | No Regulator |
| Tagged as FULL | Tagged as IN USE | Tagged as EMPTY |
|  |  |  |







**O2 Adaptors**

❑ Oxygen adapters (nipples) are **for single use/single patient use ONLY**.

# SURVEY READY CHECKLIST

## Environment of Care

- ❑ Evacuation route signage posted on unit
- ❑ Emergency exit signs lit and operable
- ❑ No equipment or supplies stored in stairwells or blocking fire doors
- ❑ Fire extinguishers secured, location identified, checked monthly
- ❑ Alarm pull stations visible and accessible
- ❑ Fire doors / linen chutes self-close and positively latch
- ❑ Nothing stored within 18" of the base of sprinkler heads
- ❑ No supplies stored directly on floor
- ❑ No obvious penetrations in walls / ceiling
- ❑ No items stored in egress corridors except for immediate use
- ❑ Medical gas shut off valves with distribution labels
- ❑ Oxygen cylinders in holders – not laying / standing on floor
- ❑ Medical equipment with current PM tags
- ❑ Equipment is clean and in proper working order
- ❑ Chemicals appropriately stored, labeled and contained
- ❑ Current MSDS available for chemicals in work area
- ❑ Security systems (if any) operational
- ❑ Electrical panels locked
- ❑ Non-approved electrical equipment removed from area
- ❑ Housekeeping carts have chemicals locked when unattended
- ❑ No outdated supplies (blood tubes, dressing kits, tubing, etc.)
- ❑ Alarms on clinical equipment activated and audible to staff

## Medications

- ❑ Medication room (storage areas) locked when unattended
- ❑ Medication carts locked / secured when unattended
- ❑ No medications left on top of carts
- ❑ All medications / syringes labeled
- ❑ Carts are clean and kept in orderly condition
- ❑ No outdated medications in carts, stock, or in refrigerator
- ❑ IV admixture area (if any) identified and kept in clean condition
- ❑ Open multi-dose vials clearly labeled with 28 day expiration date
- ❑ Narcotics / Schedule II drugs locked per federal / state regulations
- ❑ Narcotic log accurate, wastage countersigned
- ❑ No concentrated electrolytes on unit or clear warning labels attached
- ❑ Medication refrigerator temperature recorded daily
- ❑ Meds requiring refrigeration stored in refrigerator
- ❑ Internal / external medications stored separately
- ❑ Medication syringes labeled with drug, dose, and date
- ❑ Look alike / sound alike drugs stored separately from each other. Warning labels or other identification used
- ❑ If more than one concentration of a medication, concentrations are stored separately from each other.
- ❑ Fluids in warmers appropriately labeled / dated. Temperature of warmers recorded daily.

## Crash Carts / Emergency Drug Boxes

- ❑ Cart clean and kept in orderly condition

- ❑ Medication drawer (box) locked with Pharmacy supplied lock
- ❑ Earliest expiration date of medications listed on cart (box)
- ❑ Supply drawers locked
- ❑ Defibrillator (including paddle wells) clean and in working order
- ❑ Ambu Bag supplies (age appropriate) intact and ready to use
- ❑ Oxygen canister secured – not empty.
- ❑ Portable suction in working order with appropriate supplies
- ❑ Respiratory supplies fully stocked
- ❑ Plugged into outlet when not in use.
- ❑ Checks performed per policy
- ❑ Current resuscitation guidelines on cart. No outdated references.
- ❑ If Broselow system used for Pediatric carts, then most current tape on cart

**Patient Rooms / Treatment Bays**

- ❑ Bed in lowest position
- ❑ Call bell within patient's reach and in working order
- ❑ Clock in working order
- ❑ Phone in working order
- ❑ Privacy curtain intact and clean
- ❑ Room clean and orderly
- ❑ Bathroom clean and orderly
- ❑ Call bell in bathroom in working order
- ❑ Medical equipment plugged into electrical outlets
- ❑ Emergency outlets used for critical equipment
- ❑ Patient clean with hygiene needs met
- ❑ No tubes or drains touching the floor

- ❑ IV's labeled with patient name, date hung, and solution
- ❑ IV tubing labeled with date hung
- ❑ Sharps container < 3/4 full. Secured in room
- ❑ Waterless hand cleaning gel appropriately stored. Not expired
- ❑ No linen on floors
- ❑ Linen in rooms covered
- ❑ Trash bins not overflowing
- ❑ Nothing posted on patient doors or rooms that provide protected patient information (i.e. I&O sheets, charge sheets, etc.)
- ❑ Method to unlock bathrooms known and available to staff.

## Confidentiality of Information

- ❑ Assignment boards (in public view) do not link name to diagnosis
- ❑ No patient identifiable information in normal trash
- ❑ Computers (public view) do not display patient identifiable info.
- ❑ Audio / visual privacy provided in registration areas
- ❑ Registration logs hidden from view or peel off label system utilized.
- ❑ Charts not left in public view. Names hidden from view
- ❑ Charting areas do not have patient identifiable information in public view

## Manuals & Reference Tools

- ❑ Most Current
  - ❑ Department Policy and Procedures
  - ❑ Safety Manual / Emergency Preparedness Plan

- ❑ Infection Control Manual
- ❑ Diet Manual
- ❑ Hospital Formulary
- ❑ Drug Reference Tools
- ❑ Medical Staff Privilege Lists

## Infection Control / Point of Care Testing

- ❑ Biohazard waste storage room locked
- ❑ Linen carts covered with solid bottom shelf
- ❑ Supply carts covered with solid bottom shelf
- ❑ No soiled linen bags or trash bags on floor
- ❑ Soiled linen containers covered – not overflowing
- ❑ No patient care supplies / equipment under sinks
- ❑ Hand washing promotional signage above sinks
- ❑ Isolation carts fully stocked with appropriate supplies
- ❑ Isolation signage posted in primary / secondary language
- ❑ Negative pressure rooms (if any) with air flow testing validated
- ❑ Clean and soiled storage areas maintained separately
- ❑ Patient food refrigerators clean, temperature maintained, food labeled with date opened.
- ❑ Environment and equipment clean. No torn mattresses or gurney covers
- ❑ No dust on high horizontal surfaces in sterile procedure areas
- ❑ Hand cleaning gel in appropriate areas
- ❑ Quality control logs for each point of care test current
- ❑ QC strips / solutions for each point of care test current and dated as appropriate

# YOUR DEPARTMENT INFORMATION

**Department Duties: _____**

**Job Description: _____**

**Collateral Duties: _____**

**BLS Expires: _____**

**Where is the Patient Rights and Responsibilities?**

**_____**

**How do you handle Advance Directives?**

**_____**

**Who is the Safety Officer(s)? _____**

**Where are the following items located?**

- **Nearest Fire Alarm Pull Station: _____**
- **Nearest Fire Extinguisher: _____**
- **Medical Gas Shutoff Valve: _____**
  **(Only the Nursing Supervisor on duty has the authority to shutoff the medical gas)**

**Notes**