GUAM MEMORIAL HOSPITAL AUTHORITY

CIHQ-SIG

EST 1946

Center for Improvement
CIHQ
in Healthcare Quality

STAFF INFORMATION GUIDE

QUICK- REFERENCE FOR STAFF AND LICENSED INDEPENDENT PRACTITIONERS

Table of Contents

INTRODUCTION

USE OF THIS GUIDE

This guide has been developed to provide you with critical information on a variety of standards and requirements necessary for our organization to provide safe and quality care to our patients. You are encouraged to review the information contained in this guide – particularly those subjects that directly influence your job function.

While we have attempted to provide you with a wide variety of information, there may be other requirements, issues, or subject matter of importance that are not addressed in this guide. We encourage you to contact your supervisor if you have any questions or concerns.

OVERVIEW OF THE ACCREDITATION / CERTIFICATION SURVEY PROCESS

Federal law requires that any organization billing Medicare for services meet Conditions of Participation that govern quality patient care. On a triennial basis, the federal government (or an authorized entity of the federal government called a "deemed status agency" or "accrediting organization") performs a survey to assess our compliance with regulations. There are currently four deemed status agencies:

CIHQ – The Center for Improvement in Healthcare Quality
HFAP – Healthcare Facilities Accreditation Program
TJC – The Joint Commission
DNV Healthcare – Det Norske Veritas, National Integrated Accreditation for Healthcare Organizations

Survey Activity

While survey activities vary depending on the size and complexity of the organization, most surveys consist of the following:

- Review of key policies and procedures and other documents
- Tour of patient care and support areas
- Observation of patient care related tasks (e.g., medication administration, procedural time-outs, etc.)
- Review of medical records
- Interview of staff and physicians on different topics
- Interview of patients
- Review of staff personnel files
- Review of provider credential files

HOW TO INTERACT WITH SURVEYORS

The Surveyor's job is to determine if the organization is meeting standards and regulations. The survey is not designed to try to trick you or be hostile. In fact, do not hide from the surveyors, but welcome them and support each other in your interactions with them. The Surveyors simply want to know that you understand your job and its impact on patient care, treatment, and service.

Be Honest

If you are unsure of the answer to a question, it is okay to say so. Do not make up an answer. Instead, say something like: "I'm not certain of the answer to that question, but I know that I can go to the policy located in my department to find the answer". It is important that you know the correct process, so know what resources you have available and know how to access them during a survey. Know how to access policies and procedures and other important documents!

Ask for Clarification

If you do not understand a question posed by a Surveyor, ask them to repeat or rephrase the question. Ask them to give you an example of what they are asking for.

Answer Questions Completely

It is important to answer a Surveyor's question completely. However, do not provide any additional information or information that is not necessary to sufficiently answer the questions.

Be Proud of the Good Work You Do

Speak with pride about the care and service you provide. It is okay – in fact it is great – to talk about how you made a positive difference in a patient's care experience. Talk about what your department or work area has done over the past year to improve care or increase patient safety.

Know Your Patients

If you provide patient care, it will be critically important that you are familiar with your patients. Surveyors may ask you about the following:

- Why the patient is in the organization or seeking care?
- What are the patient's major health problems?
- What type of care the patient is receiving?
- What your role is in providing care to that patient?
- If other disciplines are involved in the patient's care, what care and services do they provide?
- How you work together to assure that the patient's healthcare needs are met?
- Early on how do you start to think and plan for a patient's discharge?

Prepare Your Work Area to Receive the Surveyors

Surveyors are likely to visit your department or work area. Making a "good first impression" will help surveyors understand your commitment to providing top quality care. You can help prepare your department or work area for a visit by reviewing the Appendix C of the Administrative Policy A-LD-600, Unannounced Accreditation/Certification Survey Readiness Plan and by also doing the following:

- Keep your area clean and organized
- Assure that all quality control activities have been appropriately documented
- Follow good infection control practices
- Keep medications secured

In order to stay prepared, it is a good idea to perform environmental rounds of your area/department on a routine basis. You do not want any surprises when your survey team arrives!

LEADERSHIP & PERFORMANCE IMPROVEMENT

MISSION, VISION, AND VALUES

Our Mission is:
"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."

Our Vision is:
"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."

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.

List two ways that you support the Mission and Vision of our organization, or how you live out our Values in work life:

- _____
- _____

CONFLICT OF INTEREST

A conflict of interest occurs when leadership, or staff enter into a relationship with another organization or individual(s), which, in its content or process may adversely affect or have the appearance of adversely affecting the staff's commitment to the hospital and to the culture of safety and quality. Hospital policy requires any employee disclose a potential conflict of interest. The policy is entitled **A-LD200 Conflict of Interest** and is located in the **Administrative Manual**.

If you have a potential conflict of interest, you should contact your Division Head to report it.

CODE OF CONDUCT

All staff and physicians are expected to display professional and appropriate behaviors in their interactions with patients and each other. Our organization has a policy that outlines expected and unacceptable behaviors. The policy is entitled **A-LD300 Code of Ethical Conduct** and is located in the **Administrative Manual**.

If you experience unacceptable behavior by a co-worker or by a member if the medical staff, report the incident to your immediate supervisor or on the **Safety Learning System**.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT PROGRAM (QAPI)

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, as well as any problems or new issues that arose during the test/change
  - 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 the test was successful, will the change be adopted into existing or new processes? Will the change be tested in other areas (beyond the pilot area)?
    - If the test was not successful, what modifications to the plan or change will be done before starting the next PDSA cycle?

Staff play an important role in performance improvement by:

- Bringing ideas or suggestions for improvement to the attention of leadership
- Implementing performance improvement action plans
- Being educated and familiar with performance improvement activities

Indicate how your department/unit is integrated into the QAPI program?

_____

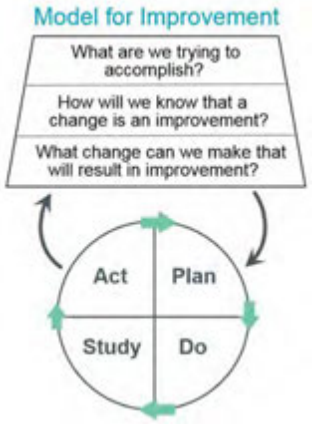
List two performance improvement efforts that have occurred in your department or work area in the past year.

1. _____

2. _____

REPORTING QUALITY & SAFETY CONCERNS, INCIDENTS, & UNUSUAL OCCURRENCES

Staff members are the eyes and ears of our organization. Often, you are the first to become aware of something unusual or a potential safety or quality of care issue. It is important to report these issues or concerns in a timely manner so that corrective action can be taken. The GMHA Safety Learning System, or SLS, is the reporting platform used for reporting such events. These events are incorporated in the organization-wide QAPI program in order to identify opportunities for improvement.



To report a quality or safety concern, take the following steps:

1. _____
2. _____
3. _____
4. _____

ENVIRONMENT OF CARE & EMERGENCY PREPAREDNESS

GENERAL SAFETY & SECURITY

Our organization maintains an active program to provide a safe and secure environment on a routine basis as well as during the activation of our emergency preparedness plan. The Environment of Care Committee (EOCC) is a multidisciplinary body that monitors the vital functions of the environment of care.

Your contact to report issues in the physical environment is: **William Kando, EOCC Chairperson**.

Identifying Hazards in Your Work Environment

It is critically important that you are aware of potentially hazardous conditions in your work environment. Different work areas and job functions have may have different hazards. When you were hired and perhaps frequently thereafter, you were trained on how to identify and deal with these hazards.

List three potential hazards in your work environment and the actions that have been taken by the organization to assure your safety and the safety of co-workers and patients:

Hazard	Safety Action
1. _____	_____
2. _____	_____
3. _____	_____

Providing for a Secure Environment

Our organization conducts periodic assessments to identify potential security risks. We then establish policies, procedures, and other actions to protect our patients, staff, and visitors. Below are basic actions that staff can take to provide for a secure environment:

- Always wear your identification badge
- Question the presence of individuals in your work area that are unfamiliar to you or lack proper identification
- Report any suspicious individuals or activity to your immediate supervisor or to Security.
- Keep your personal articles and valuables secure. Do not bring personal items of value to work with you.
- Lock desks or doors to offices when not in use.
- All medical records must be kept secured and confidential
- Secure equipment in their appropriate area(s)
- If you have any questions or concerns about security issues in your work area, contact your immediate supervisor for assistance

Infant & Child Abduction

Keeping babies and kids safe is very important to us. We have established formal policies and procedures to prevent the abduction of infants and children while they are hospitalized. Everyone has a role in protecting infants and children. **Policy 403, Infant and Pediatric Security Plan,** in the GMHA Safety & Security Manual identifies Describe what you are required to do if you become aware of a possible infant or child abduction.

_____

_____

_____

Violence in the Workplace

Violence in the workplace is an unfortunate reality in today's environment. Protecting patients and staff from workplace violence is a top priority in our organization. **Policy A-HR2900, Domestic Violence in the Work Place** and **Policy A-HR3000, Workplace Violence Prevention Plan**, both address how to prevent, respond and report violence in the workplace.

MANAGEMENT OF HAZARDOUS MATERIALS & WASTE

Safety Data Sheets

Safety Data Sheets (SDS) provide information on chemicals found in your work area. The SDS give basic information about the chemical and how to use it safely. Here is the process to access the SDS for hazardous chemical in your work area, _____

Management of a Chemical Spill

GMHA's policy and procedure for managing a chemical spill can be found in the **Hazardous Materials and Waste Management Manual, Policy HZ111, Code Yellow**.

For small spills (less than 50 milliliters in size), the following procedures may be followed to manage to spill:

- Contain the spill and evacuate the area if necessary
- Obtain a copy of the Safety Data Sheet (SDS) on the chemical or material in question.
- Obtain the necessary clean up supplies and personal protective equipment
- Clean the spill per instructions on the clean-up kit and/or SDS

Any hazardous material or waste spill greater than 50 milliliters in size requires the immediate attention of the hospital's Spill Response Team to prevent contamination of the environment. The person discovering the spill should call the Safety Administrator via the Communications Center to report the "Code Yellow". Be prepared to respond to questions that may be asked.

FIRE SAFETY

Fire Response Procedure- RACE

The hospital has developed a formal procedure called "Dr. Burnsite". If a fire occurs in your work area, you should do the following:

- **RESCUE** – Remove people from the immediate area of the fire. You may need to evacuate your area either horizontally to the next smoke compartment, or vertically to a lower floor.
- **ALARM** – Pull the nearest fire alarm and dial the emergency number: **671-647-2222**
- **CONFINE** – Close doors to prevent the spread of smoke and fire
- **EXTINGUISH** – Put out the fire if you are able to do so using **P.A.S.S.**
    - **PULL** the pin
    - **AIM** the extinguisher to the base of the fire
    - **SQUEEZE** the handle of the fire extinguisher
    - **SWEEP** side-to-side at the base of the flame

Assuring a Fire Safe Work Area

Staff can take the following actions:

- Know where the fire alarm pull stations are located in your work area. In general, these are located near the exits and the elevators.
- Know where the exits are from your work area. There are two exits from each department. You should be familiar with both locations.
- Know the location of fire extinguishers in your work area.
- Know where your smoke compartment starts and ends.
- You can help keep your work area fire safe by taking the following actions:

- Do not store equipment or supplies in fire egress corridors unless for immediate use
- Do not store supplies within 18 inches of sprinkler heads.
- Keep areas around fire extinguishers and alarm pull stations clear.
- Do not block fire or smoke doors. Do not disengage the self-closing mechanism

MEDICAL EQUIPMENT

Assuring that equipment used on patients is safe and properly maintained is critical to providing a safe environment of care. Staff' plays an important role in safely managing medical equipment.

Using Medical Equipment

Whenever you use medical equipment, they should assure the following:

- Use equipment only for its intended purpose.
- Follow manufacturer instructions and/or our procedures when using equipment.
- Inspect the equipment prior to use. Look for obvious break down or disrepair such as frayed cables, broken dials, cracked housing, etc. if there is any question as to the safety of the equipment, do not use it. Pull it from service and notify Biomedical Engineering.
- Check to see if the equipment has been electrically safety checked and maintained. Each piece of equipment has a sticker that tells you whether or not it was checked / maintained. If you are unsure, contact Biomed before you use the equipment.
- Medical Equipment found to be beyond the inspection due date must be pulled from patient use and reported to Biomed.
- If patients are allowed to use home equipment, we need to ensure that it is safe to use.

Note: If a patient safety related event involves a medical equipment, that piece of equipment must be pulled from use and inspected by Biomed.

Do not use equipment that you have not been trained to use or are not competent to use. See your Supervisor if you require additional training.

Equipment Failures

- Know what actions to take before the equipment fails. Be familiar with failure response procedures.
- Make sure you have the standby supplies and equipment you need in case of failure.
- Support the patient and provide for immediate care needs.
- Pull the equipment, mark it as "out of service" and notify Biomed.

UTILITIES

Maintaining functional and appropriate utility systems is an important part of maintaining a safe environment. The key thing that staff' need to know is what to do in the event of a utility failure. The table below lists the different types of utilities and what to do if a failure occurs:

Type of Utility (Policy associated with Utility)	What to do if a Failure Occurs
1. **Electricity** (Emergency Preparedness Manual Policy No. 201, Loss of Electrical Service)	
2. **Water** (Emergency Preparedness Manual Policy no. 202, Loss of Water Service)	
3. **Medical Gases** (Emergency Preparedness Manual Policy, No. 203, Loss of Medical Gas)	

4. Cooling (Facilities Maintenance Manual Policy No. AM6480-519, Failure of Air Conditioning System)	
5. Suction (Facilities Maintenance Manual Policy No. AM6480-510, Failure of Medical Vacuum System)	
6. Emergency Power (Emergency Preparedness Manual Policy No. 201, Loss of Electrical Service)	
7. Communication System (Emergency Preparedness Manual, Policy No. 205, Loss of Communication Systems)	
8. Sewer Services (Emergency Preparedness Manual, Policy No. 208, Loss of Sewer Service)	
9. Loss of Surveillance/CCTV and Access Control Systems (Emergency Preparedness Manual, Policy No. 210, Loss of Surveillance/CCTV and Access Control System)	
10. Other	

EMERGENCY PREPAREDNESS

Critical Areas of Emergency Planning

We have developed specific policies, plans, and procedures to address six critical areas of emergency preparedness:

- Communication during an emergency
- Managing resources and assets
- Managing utilities
- Managing security and safety
- Managing staff
- Managing patients

Emergency Preparedness Plan

Because you can't always predict the nature of an emergency, organizations – including ours – establish an emergency preparedness plan that allows us to respond effectively regardless of the nature of the emergency. This plan can be found in the Emergency Preparedness Manual, under Policy No. 101, Emergency Management Plan.

Specific Emergency Response Procedures

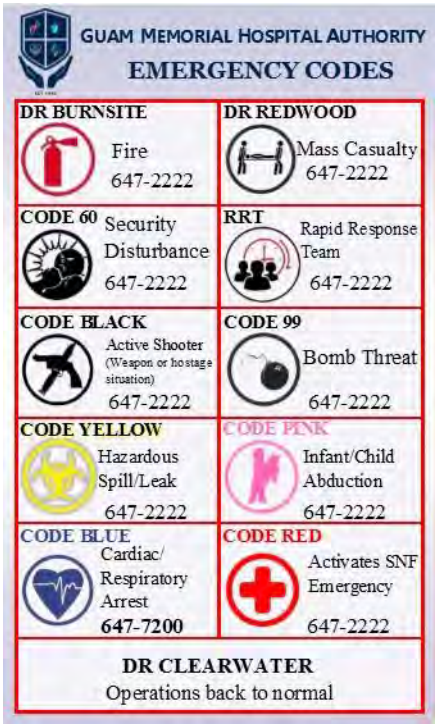
Our organization conducts a hazard vulnerability analysis annually to identify specific types of emergencies that we are likely to face. Based on that analysis, we develop specific preparations and response procedures for each of these emergencies. The table below lists the most likely types of emergencies our organization will face, and what staff are expected to prepare or respond to them.

Type of Emergency	What to Do to Prepare or Respond
• **Naturally Occurring Events** i. Pandemic Influenza ii. Tropical Cyclone iii. Inundation of Rising Sea Levels iv. Earthquake	

v. Epidemic(Community) vi. Flood (External)	
• **Technological Hazards** i. Loss of Water Services ii. Loss of Information Services iii. Loss of Air Conditioning iv. Loss of Telephone Services v. Loss of Code Blue	
• **Human Hazards** i. Terrorism, Cyber ii. Terrorism, Explosive (Bomb Threat, actual or perceived) iii. Labor Action or Existing Staff Shortages iv. Mass Casualty Incident v. Hostage Situation	

EMERGENCY CODES

In order to rapidly notify key personnel of a specific emergency, we have developed a code system. The different codes and their meaning are noted below:



REMEMBER: CALL 647-2222 FOR ANY EMERGENCY LISTED ABOVE

PATIENT RIGHTS

PATIENT RIGHTS & RESPONSIBILITIES

Patients have a wide variety of rights. Our organization respects patient rights. Some of these rights include, but not limited to:

- Confidentiality and privacy of patient information
- Effective management of pain
- Right to refuse care
- Receive information about their care.
- Having a support person with them when receiving care, treatment, or service
- Right to formulate an advanced directive
- Right to designate a representative to participate in their care decisions
- Right to have their representative, family or their own physician notified of their admission
- Right to receive the "Important Message from Medicare" within 2 days of admission and again within 2 days of discharge when the admission is longer than 2 days

Patients have the responsibility to:

- Provide information about their condition
- Follow organization policies
- Inform staff of changes in their condition

The policy on Patient's Rights and Responsibilities is located in the GMHA Administrative Manual (**A-RI200, Patient's Rights and Responsibilities**). Patients receive written information about their rights and responsibilities at the time of admission or presentation for care. This is accomplished by giving handouts, signage, etc.

The process for informing patients of their rights and communicating, when a representative or support person has been identified, is initiated upon registration with the Patient Registration Department.

ADVANCE DIRECTIVES

An advance directive is either a written or verbal statement by a patient or their authorized designee regarding care issues. Types of advance directive include:

- Living Wills
- Durable Power of Attorney for Healthcare
- Patients are asked if they have an advance directive when they are admitted to the organization.
- If the directive is with them, a copy is placed in the record and the Physician is notified of the contents**.** If the copy is not available, the patient is asked to bring it in.
- A directive can be changed at any time. This can either be done verbally or in writing. If a patient wishes to change their directive, the Physician should be notified.

The policy on Advanced Directives is located in the Administrative Manual **(A-RI400, Patient Self-Determination (Advance Directives)**.

INFORMED CONSENT

A patient signing the consent form is signifying that he or she has been provided with sufficient information to make an informed decision about the proposed treatment or procedure. If there is any question or concern, the patient's Physician should be contacted.

Informed consent is usually provided by the physician or other practitioner involved in performing the procedure. The patient signed form is an acknowledgement that the patient has been informed about the risks, benefits, alternatives, and other important information about the treatment or procedure. Informed consent must occur before the treatment or procedure begins.

The policy on Informed Consent is located in the Administrative Manual **(A-RI300, Informed Consent for Treatment and Procedures).**

INFORMING PATIENTS ABOUT ERRORS IN CARE

Our organization requires that patients be informed of significant errors in care. The Risk Management Program Officer is responsible for assuring that the patient is informed.

When an error in care occurs, the following actions should be taken:

- The patient is provided with whatever care is necessary.
- Any evidence regarding the error is saved for follow up investigation
- The Physician is informed
- An unusual occurrence or incident report should be generated
- The patient will be informed of the error in accordance with policy.

The policy on Informing Patients about Errors in Care is located in the Administrative Manual **(A-PS810, Disclosure of Unanticipated Outcomes)**.

PATIENT COMPLAINTS & GRIEVANCES

Both federal law and organization policy give patients the right to file a complaint or grievance. A complaint is usually something minor in nature and is resolved by staff present at the time the complaint is reported, while a grievance is something more serious – often involving a potential violation of a patient's rights. However, any complaint received in writing, no matter how seemingly minor, is considered a grievance**.** Ensure that you know the difference between a complaint and a grievance. These two issues are handled in a different manner from a compliance perspective.

If a staff member becomes aware of a complaint or grievance, the following actions should be taken:

- If you are able to resolve the issue immediately, then do so.
- If you cannot resolve the issue immediately, then:
    - Report the complaint to your immediate Supervisor or the Guest Relations Coordinator
    - The complaint will be investigated by the organization
    - The patient will be informed of the results of the investigation and any actions taken.
    - If the patient wants to file a formal complaint with the regulatory agencies, they are allowed to do so.

The policy on Patient Complaints and Grievances is located in the Administrative Manuel (**A-RI1000, Patient Grievance/Complaints)**.

HOW TO ACCESS MEDICAL INTERPRETERS

Medical Interpreters can be accessed as follows:

- For Certified/Qualified Medical Interpreters:
    - Contact Cyracom Language Services by telephone or cellphone/tablet App
        - Through the Communications Center, 671-647-2309 to be connected
        - By calling Cyracom directly: 1-866-745-5010
        - By Scheduling an Appointment: support@cyracom.com
        - By using the Cyracom International App. Download the app on your cellphone or tablet. Log in details: Username: gmhavri@cyracomvri.com Password: cyracom1
            - Choose the microphone for telephone interpreting
            - Choose the video for video interpreting. For example for ASL.
- For in-house bilingual staff, contact the Guest Relations Department
- For an in-person ASL interpreter, contact the EEO Office.

The use of family members and/or friends to provide interpretive services for medically related care needs is strongly discouraged. Family may be used for non-medical related interpretive services (e.g. explaining visiting hours, orientation to the room environment, etc.).

Should your patient require communication assistance due to a visual or hearing impairment, please contact the following:

To obtain sign language services contact: GMHA EEO Officer/ADA Coordinator

To obtain text phone services contact: GMHA EEO Officer/ADA Coordinator

To obtain written material in Braille contact: Patient Registration Department

To obtain printed materials in large font contact: GMHA EEO Officer/ADA Coordinator

PATIENT CARE

Assessment & Reassessment of Patients

Patients receive an initial assessment upon admission or when presenting for care. The scope and time frame for completing the initial assessment varies depending on the discipline involved and the care setting.

Key Point

It is very important for staff to know the time frames for conducting initial assessments for their discipline.

It is also important to know when it is necessary to contact other disciplines for specialized assessments.

While the scope and depth may vary depending on the care setting, initial nursing assessments includes the following:

- Physical assessment
- Psycho-social assessment
- Victims of abuse screen / assessment
- Pain screen / assessment
- Nutrition screen / assessment
- Functional screen / assessment
- Fall risk screen / assessment
- Cultural and spiritual needs screen / assessment
- Communication needs screen / assessment
- Discharge planning screen / assessment

The frequency of reassessment varies depending on the care setting and the needs of the patient. In general, a patient is reassessed:

- When there is a significant change in condition
- The patient is transferred to a different level of care
- Due to the performance of treatments or procedures
- At regular intervals as determined by discipline / department specific policy or standards of care

ASSESSMENT & MANAGEMENT OF PAIN

ALL patients will be assessed for the presence of pain during the initial general admission process. Pain Assessments and Reassessments are defined in the policy entitled "Pain Management" located in the Nursing Services Manual.

Patients should also be screened for pain:

- On admission and per policy thereafter
- After invasive treatments and procedures
- Routinely during care when vital signs are taken.

If a patient reports pain, they should receive an assessment that addresses:

- Location, severity, and duration of pain
- What precipitates the pain
- What alleviates pain

We use patient age appropriate pain scales to assess the level of pain. For example:

- 1 – 10 Pain Scale
- Wong-Baker Pain Scale (faces)
- Neonatal Infant Pain Scale
- Non-verbal / non-communicative pain assessment tools

It is very important that pain be effectively managed. We employ a variety of treatment modalities to combat pain:

- Medication
- Relaxation techniques
- Application of heat and cold

- Be aware of opioid overuse. You want to monitor this to ensure that it is being used appropriately.

Key Point

Make sure that documentation of the following is complete in each medical record:

- Initial screen / assessment of pain
- Ongoing assessments of pain
- Pain interventions (i.e. medications given)
- Response to pain interventions
- Notation on the patient's plan of care

VICTIMS OF ABUSE

Patients are screened upon admission to the organization or upon presenting for care. This screen is conducted by qualified staff' (usually the Physician or Nurse). Patient care staff is trained on recognizing specific types of abuse.

If you suspect a patient may be a victim of abuse, notify your immediate supervisor so that a further assessment and possible intervention can occur.

The policy on Abuse can be found in the Administrative Manual (A-RI800, Patient/Resident Abuse and Neglect Prevention).

CARE PLANNING

Care planning is interdisciplinary in nature. Each discipline may identify care problems as the result of their assessment activities; these must be documented in the Interdisciplinary Plan of Care.

The care plan must meet the required regulatory standards including but not limited to the following:

KEY POINT

Make sure that all identified patient care problems are documented on the plan of care, and that care plans are reviewed and updated as required by policy

- The care plan must be initiated on admission or establishment of care.
- The care plan must address each patient's current nursing care needs, including care goals, as well as planning for discharge to meet post-hospitalization needs.
- The care plan must be based the patient's care needs (not solely those needs related to the admitting diagnosis) and developing appropriate interventions in response to those needs.
- The care plan must be updated or revised in response to ongoing assessment findings.
- The care plan must part of the patient's medical record.

PATIENT DIET & FOOD STORAGE

Inpatients are provided a diet designed to maximize their recovery. Diets – including supplements and/or outside food – are ordered by the physician or individual responsible for the patient's care. While a Dietitian can independently change the texture of a diet, they cannot change the diet itself or provide supplements without orders.

If the patient or family wishes to bring in food, it must be consistent with the ordered diet. Any food brought in for the patient should be identified with the patient's name, date provided, and appropriately stored.

Any food left in refrigerators must be covered and dated when opened Perishable food items that are not consumed within 24 hours and/or food found to be unlabeled are to be discarded.

PREVENTING PATIENT FALLS

The organization has implemented the following strategies to reduce both the likelihood and severity of patient falls:

- Inpatients identified as a fall risk will have a specific plan of care developed to address his or her risk issues. The plan of care will outline applicable safety interventions such as;
    - Visually identifying the patient as a fall risk
    - Communicating the fall risk to members of the healthcare team
    - Increasing the frequency of observation and assistance to the patient for care needs and ambulation
    - Implementing actions to prevent falls or to reduce the potential severity of a fall.

An assessment of patient care areas should be conduct to determine environmental factors that may contribute to a risk of falling. As appropriate, the following steps should take to address environmental factors.

- Beds are maintained in the lowest position
- Beds have split side rails with the bottom side-rail in the lowered position
- Beds wheels are locked
- Floors are not overly waxed, and glare is kept to a minimum
- Floors are uncluttered and trip hazards mitigated
  Note: you should follow the steps in your policy as it pertains to the prevention of falls.

RESPONDING TO UNANTICIPATED CHANGES IN PATIENT CONDITION

The organization has established a Rapid Response Team (RRT) to respond when the health care staff, patients and or families have concerns about the patient's condition and / or unanticipated changes in the patient's condition. The RRT team is available to health care staff, patients, and families in all inpatient units as well as outpatient areas that are contiguous with the main campus.

It is expected that staff will not hesitate to request the RRT team assistance, and staff are empowered to do so. It is also expected that patients and families will be empowered to request RRT team assistance should they have concerns about the patient's condition. Staff is expected to facilitate such assistance if requested.

The RRT team can be accessed by dialing 647-2222 and requesting a "Rapid Response Team." The operator will overhead and/or otherwise page the RRT team to the requesting location.

The policy for Rapid Response Team is located in the Administrative Manual **(A-PS500, Rapid Response Team).**

PATIENT EDUCATION

Our patients receive education necessary to allow them to effectively participate in their care. Patients are assessed for education needs as part of the assessment activities. Needs include, but are not limited to knowledge of disease, medication use, equipment uses, rehabilitative techniques, diet, and access to community resources.

- Once identified, education is provided in a timely manner and in a manner in which the patient can understand.
- GMHA subscribes to Krames-on-Demand for patient education materials which are available 24/7. Contact the Education Department with questions. Handouts include Health sheets and Medication sheets.
- The Dietary Department uses patient education resources from the Nutrition Care Manual.
- The Rehab Department used patient education resources from HEP 2 GO.
- If you are responsible for patient education, you should clearly document both the education provided in the patient's medical record, as well as whether or not the patient comprehended the education in their medical record.

USE OF RESTRAINTS

Patients have the right to be free of restrains. We believe that the use of restraints is a last resort only after other clinical interventions have been considered or attempted. Use must be limited to clinically justifiable situations only and never for convenience, punishment, or coercion.

*GMHA does not seclude patients and has no policy to support seclusion.

Clinical Justification for Use

There are two basic reasons to place someone in restraint:

Non-violent / Non-behavioral such as:

- Pulling out tubes, drains, or lines necessary for medical care
- Risk of fall, attempting to ambulate, and non-compliant with safety instructions (if restraints are used for these or any other reason please document well to show why the restraints was implemented)

Behavioral Health Purposes such as:

- Harming staff or others
- Attempting to mutilate or harm self (if restraints are used for these or any other reason please document well to show why the restraints was implemented

Orders for Restraint

If a patient needs to be placed in restraint, an order must be obtained. If it is an emergency, staff can place the patient into restraint and then obtain the order immediately afterwards**.** PRN orders are **NEVER** allowed.

****** Note that the "trial removal" of restraint or seclusion is considered a PRN use and is not permitted ******

Restraint orders for non-violent or non-behavioral purposes must be re-ordered every 24 hours.

Restraint orders for violent or behavioral purposes must be re-ordered every:

- Every 4 hours for an adult (18 years and above)
- Every 2 hours for a child age 9 - 17
- Every 1 hour for a child under the age of 9

What is Considered Restraint?

A restraint is a mechanical device that is intended to restrict a patient's movement or access to their body. In general, the following are considered restraint:

- Posey vests
- Limb immobilizers
- Freedom splints
- Veil beds
- Use of all 4 side rails in the raised position (certain exceptions apply)
- Bed sheets tucked so tightly that the patient cannot move

Monitoring of the Patient Placed in Restraints

The patient placed in non-violent/non-behavioral purposes, restraints will be monitored every 2 hours using the Behavioral Activity Assessment.

The patient placed in violent/ behavioral purposes, restraints will be monitored every 15 minutes using the Behavioral Activity Assessment.

Plan of Care
Restraints are used based on a written modification to the patient's plan of care. We accomplish this in the inpatient units by documenting restrain use in the EHR. We accomplish this in the Emergency department by documenting restrain use in the ePOWER.

The policies on restrain use in the hospital are located in the Nursing Services Manual **(6301-II C-16, Restraints for Non-Behavioral Reasons)**, and in the Administrative Manual **(A-PC1500, Restraint Use for Behavioral Health Purposes)**.

PROCEDURAL SEDATION

We have established clear requirements for caring for patients receiving procedural sedation.

- A patient must receive a pre-sedation assessment to assure that he/she is an appropriate candidate for the use of sedation.
- Informed consent for the use of sedation is required.
- Emergency equipment must be readily available.
- The Physician or a qualified RN throughout the procedure must monitor the patient's cardiovascular and respiratory status.
- The patient must be recovered using the same standard of care used to recover patients from anesthesia
- Only qualified staff may monitor and recover a patient from procedural sedation
- A Safety Learning System report should be generated for any patient that requires the use of a "reversal agent" or suffers an untoward effect as the result of sedation.

The policy on Procedural Sedation is located in the Administrative Manual **(A-PS1100, Procedural Sedation).**

CONTINUUM OF CARE / DISCHARGE PLANNING

Our organization assures that patient's receive appropriate care during and after their stay by providing the following:

- Transfer and referral agreements exist with other healthcare organizations to assist the patient if it is more appropriate for care needs to be met elsewhere.
- Discharge planners, case managers, and social workers are available to assist with post-care needs

Patients with the same care needs receive the same level of care regardless of location. This is done by:

- Establishing common policy and procedure
- Establishing similar competencies and training of staff
- Communicating and coordinating care among the various disciplines

MEDICATION USE

STORING & SECURITY OF MEDICATIONS

Medication Storage

We have developed specific policies to assure that medications are appropriately stored. These policies require that:

- Internal and external medications should not be mixed together
- Medications requiring refrigeration must be stored in refrigerators. The temperature of the refrigerator must be monitored in accordance with policy.
- Store medications that are light sensitive appropriately
- Medications are made available in the most "ready to use" form as possible.
- Medications are provided in unit dose form whenever possible
- Pharmacy staff' makes routine inspections of medication storage areas to assure compliance with policy.
- "Look alike" and "sound alike" medications are stored with special precautions to alert staff to the potential for retrieval errors
- Check medication storage areas for expired drugs and return them to pharmacy for disposal.

Medication Security

We have developed specific policies to assure that medications are appropriately secured. These policies require that:

- Medication rooms and carts are to be locked unless under visual observation of authorized staff.
- Only authorized staff are permitted access to medication storage areas
- Emergency medication carts and tackle boxes are to be checked per policy
- No medications are kept on top of medication carts or in patient rooms unsecured
- Controlled substances must be locked when not under direct visual observation of authorized staff

The policy on Storing and Security of Medications is located in the Pharmacy Department Manual **(610, Storage and Security of Drugs)**.

ORDERING OF MEDICATIONS

Medications may only be administered upon an order by the physician or other authorized prescriber. The Computerized Physician Order Entry (CPOE) is the preferred mechanism to generate a medication orders. Otherwise, physicians shall write all medication orders on the approved GMHA physician's order form (manual process).

- PRN orders must have the indication for use written as part of the order (e.g. "PRN for pain").
- Duplicate therapy (e.g. two or more PRN orders for the same clinical indication) must be written in a manner that provides sufficient direction to staff to determine which medication or the order of medications to be given.
- Orders that direct the implementation of a protocol must specifically state that the protocol is to be used (e.g. "Start Dopamine drip per protocol")
  Note: The protocol must be added to the patient's medical record at the time of initiation.
- Titration orders must note the parameters for titration
- Medication orders with dose and/or frequency ranges (range orders) are prohibited. For example, Morphine 2-4mg IV a4h prn Pain is **NOT** an acceptable order. An appropriate order would be:
  - Morphine 2mg IV q4h prn mild pain
  - Morphine 4 IV q4h prn moderate pain

Medication orders are unclear or not written appropriately should be clarified with the prescriber prior to administration.

The policy on Ordering of Medication is located in the Administrative Manual **(A-MM100, Medication Orders)**.

LABELING OF MEDICATIONS

Medications must be labeled anytime they are prepared but not immediately administered. All medications prepared must be correctly labeled with the following:

- Medication name, strength and amount (if not apparent from the container).

- Expiration date
- Expiration time when expiration occurs in less than 24
- The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas
- If IV fluids or irrigation solutions are placed in warmers, the fluid or solution must be dated appropriately so they are not stored any longer than permitted by the manufacturer

The policy on Labeling of Medications is located in the Pharmacy Department Manual **(708, Labeling Standard for Medications)**.

ADMINISTRATION OF MEDICATIONS

We have developed specific policies to guide staff in administering medication. Key steps to safely administering medication include:

- Wash your hands.
- Correctly identify the patient using two patient identifiers.
- Verify that you have the correct medication / dose / route against both the drug label and the medication order.
- Check the expiration date on the drug to make sure it is still good. Do not use if the drug has expired.
- As appropriate, visualize the medication for stability (i.e., color, clarity, presence of particulate matter). Do not use if the medication appears to be compromised.
- Check the patient's medical record to make sure there are no contra-indications to giving the medication.
- Verify that you are giving the medication at the proper time.
- Advise the patient of the purpose of the medication, and, as appropriate, of any potential adverse reactions or side effects.
- If it is the first time the patient is receiving the medication, be prepared to describe how you monitor the patient's reaction.
- All medications shall be administered using the six (6) rights of medication and administration:
    - Right dose
    - Right time
    - Right method/route
    - Right patient
    - Right medication
    - Right documentation

If you have any questions or concerns regarding the medication, discuss them in advance with the Physician or call the Pharmacist for assistance.

The policy on Administration of Medications is located in the Nursing Administrative Manual **(6301-II C-8, Medication Administration and Documentation)**.

MEDICATION ERRORS / ADVERSE DRUG REACTIONS

The following strategies have been developed to spot potential adverse drug reactions

- Pay particular attention to the first time a patient receives a medication.
- Monitor for allergic reactions such as fever, rash, anaphylaxis.
- Monitor for hypersensitivity to a drug such as changes in vital signs, acute or severe manifestations of side effects.
- Look for drug intolerance – a lowered threshold to the normal pharmacological effect of the drug.
- Look for idiosyncratic reactions – an uncommon response by a patient to a drug given at normal doses.
- Staff should take the following actions when there is a suspected adverse drug reaction or medication error:
- Support the patient. Assess the patient for untoward effects. Notify the patient's attending physician.
- Complete an occurrence report in the Safety Learning System (SLS), which would be forwarded to Risk Management.
- Document the pertinent facts in the patient's medical record

PATIENT'S OWN MEDICATIONS

Patients may only use their own medications if ordered so by the physician. If a patient is permitted to use their own medication, staff are to do the following:

- Physician or designated nurse will list down all the medications needed to be continued on the physicians order form including the name of the medication, strength, dosage and frequency
- The nurse will send the patient's own medication to pharmacy for verification before they can be administered to the patient
- Pharmacy will verify and insure the drug in the container is the correct drug the physician ordered
- If the medication is "Non-Formulary", the pharmacist will affix a "Non-Formulary" label on the container of the non-formulary drug(s) that are to be administered and pack all other patient owned medication in a plastic bag and affix a "Send Home" label on the plastic bag.
  Pharmacist shall not re-label the medication and shall keep the original label intake
- In the event the patient has run out of the non-formulary drug while he/she is still in the hospital, the attending physician may either consider to substitute with a formulary drug or write a prescription for the patient's family to obtain outside.

The policy on Patient's Own Medication is located in the administrative Manual **(716, Patient's Own Medication).**

MANAGEMENT OF HIGH RISK MEDICATIONS

There are certain medications that the organization has determined to be of high risk. The table below lists those medications and summarizes steps that need to be taken to safely manage them.

High Risk Medication	Safety Strategies
• Amphotericin B; • Insulin, subcutaneous and IV; • Iron dextran; • Magnesium sulfate injection; • Methotrexate; • Oxytocin; • Phenytoin; • Nitroprusside sodium for injection; • Potassium chloride for injection concentrate; • Potassium phosphate injection; • Promethazine, IV; • Sodium Chloride for injection, hypertonic (greater than 0.9% concentration); • Sterile water for injection, inhalation, and irrigation (excluding pour bottles) in containers of 100 mL or more.	A. A double check by two licensed caregivers is done prior to administration of any high alert medication. B. For all high alert medications, the double check includes the 5 Rights: 1. Right patient 2. Right medication 3. Right dose 4. Right time 5. Right route 6. Right documentation C. An electronically controlled infusion device (IV pump) is used to administer all infusions of high alert medications. IV pump settings are double-checked by two licensed staff. D. Administration sets are labeled with the drug name at both the distal end and at the pump channel. E. When patients are transferred while receiving high alert medication infusions, endorsement between nurses should emphasize the presence of the medication and review the 5 Rights as described above.

The policy on Management of High Risk Medications is located in the Administrative Manual **(A-MM300, High Risk/High Alert Medications)**.

MANAGEMENT OF MEDICATIONS THAT LOOK-ALIKE OR SOUND ALIKE

Medications that look or sound alike carry a high risk for errors. Our organization has selected combinations of drugs that look or sound alike. The tables below list these drug combinations and the strategies we have taken to prevent errors.

Table I (Critical Access Hospital, Hospital, Office-based Surgery)			
Plantinol (cisplatin)	Paraplatin (carboplatin)		
Concentrated liquid morphine products vs. conventional liquid morphine concentrations:	Concentrated:	Roxanol, MSIR	
	Conventional:	morphine oral liquid	
ephedrine	Adrenalin (epinephrine)		
Sublimaze (fentanyl)	Sufenta (sufentanil)		
Dilaudid (hydromorphone injection)	Astramoprh	Suramorph	Infumorph (morphine injection)
Humulin (human insulin products)	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)		
Lipid-based daunorubicin and doxorubicin products vs. conventional forms of daunorubicin and doxorubicin:	Lipid-based:	Doxil (doxorubicin liposomal)	Daunoxome (daunorubicin citrate loposomal)
	Conventional:	Cerubidine (daunorubicin, conventional)	Adriamycin, Rubex (doxorubicin, conventional)
Lipid-based amphotericin products vs. conventional forms of amphotericin:	Lipid-based:	Ambisome (amphotericin B liposomal)	Abelcet (amphotericin B lipid complex) Amphotec (amphotericin B cholesteryl sulfate complex for injection)
	Conventional:	Amphocin	Fungizone Intravenous (amphotericin B desoxycholate)
Taxol (paclitaxel)	Taxotere (docetaxel)		
Velban (vinblastine)	Oncovin (vincristine)		

Table II (Ambulatory Care, Assisted Living, Behavioral Health, Disease Specific Care, Home Care, Long Term Care)			
Avandia (rosiglitazone)	Coumadin (warfarin)		
Catapres (clonidine)	Klonopin (clonazepam)		
	Conventional:	morphine oral liquid	
Dilaudid (hydromorphone injection)	Astramoprh	Suramorph	Infumorph (morphine injection)

Humulin (human insulin products)	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)		
Zyprexa (olanzapine)	Zyrtec (cetirizine)		
acetohexamide	acetazolamide		
Bretyllium	Brevibloc		
chlorpropamide	chlorpromazine		
Clonazepam	Lorazepam	diazepam	
Diflucan	Diprivan		
folic acid	leucovorin calcium ("folinic acid")		
heparin	Hespan		
idarubicin	doxorubicin	daunorubicin	
Leukeran	leucovorin calcium		
Prilosec	Prozac		
Primacor	Primaxin		
Retrovir	Ritonavir		
tizanidine	tiagabine		
Zantac	Xanax		
Zantac	Zyrtec		

REVIEW OF MEDICATION ORDERS BY PHARMACY

Our policy requires that Pharmacy review all new medication orders before staff may give the first dose. That means that staff cannot take the medication from stock until Pharmacy has reviewed the order. There are some exceptions:

- The Physician is in control of the medication process such as in during surgery, invasive procedures, etc.
- There is a clinical emergency and there is no time for Pharmacy to review the order (i.e. Code Blue, impending cardiovascular or respiratory failure, etc)

IV ADMIXTURE OUTSIDE OF PHARMACY

It is expected that the admixture of IV medications occurs in the pharmacy whenever they are open. In emergency situations, IV admixture of medications may occur outside of the pharmacy provided the following is assured:

- Only staff who have been trained and deemed competent to perform IV admixture may do so
- The admixture must be done in a functionally clean and designated area using aseptic technique
- The medication is administered within one-hour after the start of preparation

INFECTION CONTROL

UNIVERSAL PRECAUTIONS

Universal precautions are the standard precautions that are to be taken with any patient to prevent the spread of infection. Basic universal precautions consist of:

Component	Recommendations
Hand hygiene	After touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between patient contacts
Personal protective equipment (PPE)	
Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin
Mask, eye protection, face shield	During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions
Gown	During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions and excretions is anticipated
Soiled patient-care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visible contaminated; perform hand hygiene
Environmental control	Develop procedures for routine care, cleaning and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only; use safety features when available; place used sharps in puncture-resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient Placement	Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminated the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection
Respiratory hygiene/cough etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter, i.e., triage and reception areas in emergency departments and physician offices)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, greater than three (3) feet if possible

The policy on Universal Precautions is located in the Infection Control Manual **(6201-230, Standard Precautions/Respiratory Hygiene and Cough Etiquette)**.

USE OF ISOLATION

Certain patients may require isolation. The table below lists the various types of isolation used in our organization and the specific precautions that must be taken: ****Note: Best practice guidelines such as the CDC should be followed*****

Type of Isolation	Specific Precautions
Contact Precautions	• Wear gloves • Wear an Isolation Gown • Wash and/or Sanitize your hands
Droplet Precautions	• Wash and/or Sanitize your hands • Wear a Surgical Mask
Airborne Infection Isolation	• Wear an N95 Mask • Keep the Door Closed • Wash and/or Sanitize your hands

The policy on Use of Isolation can be found in the Infection Control Manual **(6201-240, Transmission Based Precautions (Contact Precautions, Droplet Precautions, Airborne Infection Isolation))**.

HAND HYGIENE

Washing your hands is the single most effective way of preventing the spread of infection among staff and patients. Our organization adheres to the CDC recommendations for good hand hygiene:
Wash hands or use the gel / foam sanitizer:

- Prior to direct contact with patients
- Before donning sterile gloves for procedures
- After having contact with a patient's skin
- After contact with blood or body fluids
- After having contact with equipment near the patient
- After removing gloves
- You must wash your hands with soap and water for any of the following:
  - Engaged in food preparation
  - After using the restroom
  - If your hands are visibly soiled
  - Caring for a patient with C-Difficile

The policy on Hand Hygiene is located in the Infection Control Manual **(6201-120, Hand Hygiene Policy)**.

CLEANING & DISINFECTING OF EQUIPMENT

It is important to assure that equipment, patient's care environment is appropriately cleaned and disinfected. The cleaning agents routinely used in patient care areas (i.e. cleaning wipes) all carry what is called a "wet contact" time. This is the minimal amount of time that the surface being cleaned **must** remain visibly moist before it can be considered appropriately disinfected.

Staff' who are responsible for cleaning and disinfecting equipment and environmental surfaces must be aware of the wet contact time of the agents they are using and follow manufacturer instructions for use of the cleaning agents.

TYPE OF DISINFECTANT	CONTACT TIME
PDI SANICLOTH	**3** MINUTES
CLOROX BLEACH GERMICIDAL WIPES	**3** MINUTES

HB QUAD SPRAY SOLUTION	**10** MINUTES
CLOROX BLEACH SOLUTION **(Reconstitution: 1 part bleach : 10 parts water)**	**10** MINUTES

The policy for Cleaning and Disinfecting of Equipment is located in the Infection Control Manual **(6201-180, Guidelines for Cleaning, Disinfection, and Sterilization)**.

MANAGING MULTI-DRUG RESISTANT ORGANISMS

Our organization performs periodic assessments to identify the risk of acquisition and transmission of multi-drug resistant organisms (MDRO). Based on this assessment, the organization has identified the following MDRO to be of epidemiologic significance:

- MRSA (*methicillin resistant Staphylococcus aureus*)
- VRE (*vancomycin resistant Enterococcus*),
- CDI *(Clostridium difficile)*
- Other: _____

To effectively reduce the risk of transmitting or acquiring an infection from these organisms, the following measures have been employed:

Hand Washing

Staff and physicians should adhere to appropriate CDC recommendations on hand hygiene consistent with organization policy in this area. Touching environmental surfaces such as bedside rails and other patient equipment after hand washing should be avoided.

Patient Placement

When possible, patients should be placed in a private room. When a private room is not available, patients with a MDRO infection may be placed with other patients with active infection in the same site and organism and no other infection. Patients with colonization may be placed with other patients with colonization, as long as neither patient is being treated.

Isolation Precautions

Patients (both colonized and infected) shall be placed on contact isolation (precautions). Droplet isolation (precautions) should be instituted if the patient has known or suspected positive respiratory cultures. \

Patients with positive cultures should remain in appropriate isolation (precautions) for the duration of their present admission and any future admissions to the hospital. Patients may be removed from isolation with the approval of the treating physician or Infection Control Professional

Use of Personal Protective Equipment

Gloves, gowns, and masks should be worn as appropriate to the specific MDRO being treated. Consult appropriate infection control policy if you have any questions.

Use of Antibiotics

The selection and ordering of antibiotics may be restricted as determined by the organization and medical staff. Adherence to these restrictions is expected.

Patient Transport

As much as possible, necessary treatments and procedures should be performed at the patient's bedside. If essential tests must be performed in another area, the department should be notified that the patient has an MDRO prior to transporting the patient to the department.

PREVENTING CENTRAL LINE INFECTIONS

It is the policy of our organization to implement practices consistent with evidence-based standards of care to reduce the risk of central venous catheter associated blood stream infections. These practices include, but are not necessarily limited to, the following:

Equipment & Supplies
The organization has assured that equipment and supplies are available when a central line is inserted. At a minimum this includes:

- Central venous catheter
- Central venous catheter insertion kit
- Sterile drapes
- Barrier protection
- Antiseptic skin preparation agent
- Line maintenance anticoagulant appropriate to the line type and patient age / presentation
- Site dressing

Central Venous Catheter Insertion
Whenever a central venous catheter is inserted, the following shall occur:

- If possible, the procedure should be explained to the patient and family. Appropriate consent – if required – should be obtained for non-emergent need.
- Hand hygiene must be performed by all staff involved in the procedure prior to catheter insertion

Maximum barrier precautions shall be deployed, including hair cover, masking, and sterile gowning / gloving of all personnel involved in the procedure, as well as sterile prepping and draping of the insertion site.

- If body hair needs to be removed, it should be clipped rather than shaved
- An evidence-based antiseptic skin preparation shall be used.
- Catheters should not be inserted into the femoral vein unless other sites are not available
- Catheters should be secured in place and a sterile occlusive dressing applied following insertion.
- Confirmation of proper placement (e.g. x-ray or another test) may be performed.

Accessing Central Venous Catheters
To reduce the risk of infection, accessing central venous catheters should be limited to necessary use. Catheter hubs and injection ports must be appropriately disinfected prior to use.

Dressing Changes
Dressing changes are to occur as required by policy.

Removal of Central Venous Catheters
Catheters should be evaluated routinely and removed as soon as the patient's clinical status and needs will allow. Non-essential catheters should be removed.

The policy on Preventing Catheter Line Associated Infections is located in the Infection Control Manual **(6201-270, Guidelines for Prevention of Intravascular Device Related Infections)**.

PREVENTING SURGICAL SITE INFECTIONS

We are committed to reducing the incidence of surgical site infections. Please note the following evidence-based practices:

Preparation of the Patient

Whenever possible, infections remote to the surgical site should be identified treated before elective procedures. Elective procedures should be postponed – if necessary – until the remote infection has resolved.

Consideration should be given to having patients shower or bathe with an antiseptic agent on at least the night before the operative day.

Hair should not be removed preoperatively unless the hair at or around the incision site will interfere with the operation. If hair must be removed, it should occur immediately before the operation, preferably with electric clippers. Shaving is not an appropriate method for hair removal.

The area around the intended incision site should be thoroughly washed and cleaned to remove gross contamination before performing antiseptic skin preparation. Alcohol-based, chlorhexidine-based, and iodine-based are acceptable for use as antiseptics. When an antiseptic agent is applied, the prepared area must be large enough to extend the incision or create new incisions or drain sites, if necessary.

Antisepsis for Operative Personnel

Nails should be kept short. Artificial nails should not be worn. Personnel should perform a preoperative surgical scrub for at least 2 to 5 minutes using an appropriate antiseptic. Hands and forearms should be scrubbed up to the elbows. After performing the surgical scrub, hands should be kept up and away from the body (elbows in flexed position) so that water runs from the tips of the fingers toward the elbows. Hands should be dried with a sterile towel and staff should then don a sterile gown and gloves.

Postoperative Incision Care

For an incision that has been closed primarily, the site should be protected with a sterile dressing for 24 to 48 hours postoperatively. When a dressing must be changed, sterile technique should be deployed. Staff should follow appropriate hand hygiene practices when checking or changing dressings.

The policy on Preventing Surgical Site Infections is located in the Infection Control Manual **(6201-265 Guidelines for Prevention of Surgical Site Infections)**.

PREVENTING URINARY TRACT INFECTIONS

Our organization has implemented evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI). We have implemented a process to insert indwelling urinary catheters according to established evidence-based guidelines that include:

- Limiting use and duration to situations necessary for patient care
- Using aseptic techniques for site preparation, equipment and supplies.

Our process to manage indwelling urinary catheters according to established evidence-based guidelines address the following:

- Securing catheters for unobstructed urine flow and drainage
- Maintaining the sterility of the urine collection system
- Replacing the urine collection system when required
- Collecting urine samples.

In order to evaluate our program we measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas.

The policy on Preventing Urinary Tract Infections is located in the Infection Control Manual **(6201-290, Guidelines for Prevention of Catheter-Associated Urinary Tract Infections (CAUTI)).**

MANAGEMENT OF INFORMATION & THE MEDICAL RECORD

CONFIDENTIALITY OF INFORMATION

Our goal is to protect the confidentiality of patient information. Actions that staff can take in this area include:

- Do not discuss patient information in public places or with individuals who are not involved in caring for the patient.
- Keep medical records secure. Do not leave the record out in public areas.
- Dispose of any paper waste containing patient information into the secure recycle bins. Do not throw into the normal trash.
- Do not leave patient identifiable information in ways that can be seen by visitors or unauthorized personnel. For example:
    - Leaving patient labels out in the open for anyone to see
    - Leaving the patient Medication Administration Record (MAR) on the medication cabinets while administering medications to the patient
    - Not logging out of the EHR while away from the computer
- Be aware of patients that have requested "no information" or "limited information".

The policy on Confidentiality of Information is located in the Medical Record Department Manual **(6433-05, Confidentiality of Information – General Issues)**.

PROHIBITION ON UNACCEPTABLE ABBREVIATIONS

The following abbreviations, acronyms, symbols and dose designations are prohibited from use:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO_4
- $MgSO_4$

Note: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

The policy on Prohibition on Unacceptable Abbreviations is located in the Administrative Manual **(6433-75, Use of Abbreviations, Acronyms, Symbols, and Dose Designations)**.

READ BACK OF ORDERS

It is our policy that the use of verbal (including telephone) orders is discouraged. When possible, orders should be written by the practitioner providing the order.

Only personnel authorized by policy may receive a verbal order. The person receiving the order must write down the order and then read the order back verbatim to the practitioner. The practitioner should then verbally confirm that the order is correct.

USE OF VERBAL ORDERS

The use of verbal (in-person face to face) orders should be limited to emergent situations or during times (such as procedures) where the physician cannot write the orders into the record. The use of verbal (in-person) orders for routine care is not permitted.

ENTRIES INTO THE MEDICAL RECORD

Authorization to Make Entries into the Medical Record

Only members of the medical staff, allied health practitioners, organization employees, contract staff, and students - consistent with their job function - may make entries into the medical record. Other individuals may make entries into the medical record in special circumstances if approved by the Director of Health Information Management Services

Legibility of Entries

Entries into the medical record must be legible. A legible entry is defined as one that can be read and understood by at least two different clinical practitioners. Entries that are not considered legible should be re-written or clarified as warranted.

Identifying the Author of an Entry

Authentication of medical record entries may include written signatures, initials, computer key, or other code. For authentication, in written or electronic form, a method must be established to identify the author. When rubber stamps or electronic authorizations are used for authentication, such use shall be only by the individuals whose signature they represent. There shall be no delegation of stamps or authentication codes to another individual.

The policy on Entries into the Medical Record is located in the Administrative Manual **(A-RC200, Entries in the Medical Record)**.

AUTHENTICATION OF ENTRIES INTO THE MEDICAL RECORD

All entries into the medical record must be authenticated (signed), dated, and timed by the individual who made the entry. The date and time should reflect when the actual entry was made – even if the content of the entry refers to care / treatment that has or will be provided. A single signature and date are sufficient for entries that are sequentially timed (e.g. flow sheets, vital sign records, etc.)

The requirements for dating and timing do not apply to orders or prescriptions that are generated outside of the organization until they are presented to the organization at the time of service. Once the organization begins processing such an order or prescription, it is responsible for ensuring that the implementation of the order or prescription by the organization is promptly dated and timed in the patient's medical record.

PATIENT SAFETY

USE OF TWO PATIENT IDENTIFIERS

Our policy requires using two patient identifiers when giving medications, obtaining specimens, and administering treatments. The approved patient identifiers are:

- In-patients
  - Patient 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 Name
  - Date of birth

The policy on Use of Two Patient Identifiers is located in the Administrative Manual **(A-PS100, Patient Identification for Clinical Care and Treatment)**.

MANAGEMENT OF BLOOD TRANSFUSIONS

Before initiating a blood or blood product transfusion, the patient will be objectively matched to the blood or blood product using a two- person bedside or chair side verification process.

The two person verification process must be performed after the blood or blood component –that matches the order – has been dispensed from the blood bank. One of the individuals involved in the verification process, must be an individual qualified by licensure and scope of practice to administer blood and blood components, and who will actually be the one to administer the blood or blood component.

The second individual must be qualified to participate in the verification process. This second individual must be a licensed physician, physician assistant, or nurse.

The verification process will consist of both individuals actively confirming and agreeing on the following:

- The blood or blood product to be administered matches the blood or blood product ordered.
- The patient who is to receive the blood or blood product is the same patient for whom the blood or blood product has been ordered. At least two unique identifiers must be used to correctly confirm the patient.
- The blood or blood product, unit number, blood type, ABO/RH compatibility, and expiration date of the unit matches the information on the blood or blood product dispensing slip from the blood bank.

If there is any conflicting, inaccurate, or incomplete information in the verification process, the blood or blood product is not to be transfused until all discrepancies have been resolved

The patient's medical record must contain documentation showing that the verification process was performed by two qualified individuals.

The policies on Management of Blood Transfusions are located in the following:

- Nursing Administration Manual **(6301-II C-13, Transfusion of Blood and Blood Products-PEDS/Adults)**
- Laboratory Department Manual **(UM136.01, Transfusion of Blood and Blood Product)**
- Hemodialysis Department Manual **(6335-II-C-8, Transfusion of Blood and Blood Products During Hemodialysis Treatment)**

REPORTING OF CRITICAL RESULTS

Critical results are defined as the results of a diagnostic test requires immediate clinical intervention to prevent or address a life threatening condition.

The time frame for a critical result is from the time the result is identified (even if from a routine test) to the time it is reported to the responsible care provider. The table below outlines the time frame reporting requirements for critical results for each diagnostic modality.

Diagnostic Modality / Types of Tests	Time Frame for Reporting a Critical Result
CLINICAL LABORATORY TESTS 1. Please see Clinical Laboratory policies for this information.	**5 minutes**
DIAGNOSTIC IMAGING TESTS 1. Radiographic Film 2. MRI 3. CT 4. Ultrasound	**Upon completion of exam reading**
CARDIOLOGY TESTS 1. EKG 2. Echocardiogram	**Upon completion of exam**
CARDIO-PULMONARY TESTS 1. Arterial/Capillary/Venous Blood Gas	**5 minutes**
OTHER	

The policy for Reporting of Critical Results is located in the Administrative Manual **(A-PS400, Critical Results of Tests and Diagnostic Procedures)**.

LABELING OF MEDICATIONS ON & OFF THE STERILE FIELD

Labeling of medication on & off the sterile field applies to all services and care settings where operative or invasive procedures are performed that require the presence of a sterile field.
The following requirements shall be relative to labeling medications placed on or off a sterile field;

- Medications and solutions both on and off the sterile field should be labeled even if there is only one medication being used.
- Labeling must occur when any medication or solution is transferred from the original packaging to another container. The only exception to the labeling requirement is when a medication or solution is prepared (drawn up or poured) and immediately administered. In this context, "immediately" means with no intervening other activity.
- Labels must include the drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.
- Labels can be developed by the organization or sterile labels can be purchased commercially.
- All labels will be verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication. No more than one medication or solution is labeled at one time.
- Any medications or solutions found unlabeled are immediately discarded.
- Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
- At shift change or break relief, all medications and solutions – both on and off the sterile field, and their labels are reviewed by entering and exiting personnel.

MEDICATION RECONCILIATION

A list of the medications that the patient is currently taking is documented whenever the patient is admitted or seen in an outpatient setting.

The patient is given a list of the medications that he/she should be taken at the time of discharge or end of the outpatient encounter.

The patient will be instructed on the importance of giving the list of current medication to his/her primary care physician; that the list should be kept current when medications are added, discontinued, or doses change; and the list should be carried with the patient at all times in case of an emergency.

The policy on Medication Reconciliation is located in the Administrative Manual **(A-PS600, Medication Reconciliation)**.

ASSESSING PATIENTS AT RISK FOR SUICIDE

A suicidal potential assessment / reassessment must be completed on any patient who fall under the responsibility of the clinical/nursing departments of the GMHA.

- The type of patient risk assessment tool used should be appropriate to the patient population, care setting and staff competency (list tools used).
- Patients identified as being at risk should be reassessed at least daily in an inpatient setting, and with each visit in an outpatient setting.

MANAGEMENT OF ANTICOAGULATION THERAPY

Patients receiving anticoagulant therapy shall have these medications ordered, prepared, dispensed, administered, and monitored in accordance with guidelines.

Anticoagulant therapy will be initiated and maintained for specific conditions in accordance with evidence-based standards of care via the use of established protocols. These protocols are _____.

PREVENT WRONG PATIENT/WRONG-SITE PROCEDURES

The organization has established, implemented and enforces a process to prevent the performance of a procedure on the wrong patient and/or a procedure on the wrong side/site of a patient.

The established process includes:

A process to assure that pertinent and relevant information necessary to assure the correct procedure is performed on the correct patient is verified prior to the procedure. This is accomplished by completing the Operative/Invasive Procedure Verification Checklist or the Pre-Procedure Verification Checklist for Invasive Procedures Outside the Operating Room.

A process to mark the side and/or site of the procedure prior to the start of the procedure. This is performed by the physician/surgeon prior to entering the procedure/operating room.

A process for all practitioners involved at the start of the procedure verify and agree on the following: Immediately prior to the start of a procedure:

- The correct patient
- The correct side/site
- The correct procedure
- The correct patient position
- The correct radiographs
- The correct implants and equipment
- Any Special Requirements

The policy on Preventing Wrong Patient/Wrong Site Procedures is located in the Administrative Manual **(A-PS200, Universal Protocol Correct Site)**.

HUMAN RESOURCES

Employee Orientation

All new employees, volunteers, contract employees, students, interns/externs and members of the medical staff are required to participate in the orientation programs. The orientation will be of sufficient scope and duration to inform each individual about his/her organizational responsibilities and how to fulfill those duties and responsibilities.

Training and Development

Employee development is a strategic tool for GMHA's continuing growth and productivity. The GMHA Human Resources Department will ensure that all employees receive/acquire the training, certifications, and licenses they need to do their job and remain legally compliant. GMHA will also assist in ensuring said training, certifications and licenses are renewed before they expire.

Please reference the following GMHA Human Resources Policies:

- License, certification, registration and education verification (Policy #A-HR2100)
- Competency assessment/validation (Policy #A-HR300)
- Special staff development programs (Policy #8650-1.209)

Employer-Employee Relations

GMHA is committed to building strong relationships between managers and employees based on fairness, trust and mutual respect. Good employee relations increase positivity, improve communication and collaboration which ultimately improve productivity.

In addition, it is a primary tenant of the GMHA Human Resources Department to ensure that the hospital is fair and equitable to all its employees. Therefore, it is the policy of the Guam Memorial Hospital Authority that there will be no discrimination in employment against any applicant or employee because of race, age, sex, including sexual harassment and orientation, gender identity, change of sex, and/or transgender status, color, religion, national origin, physical/intellectual disability, genetics, marital status, veteran status, political affiliation and retaliation.

Create a Safe Work Environment

Workplace safety is a process that seeks to eliminate or reduce risks of injury or illness to employees. The chief aim of workplace safety is to protect GMHA's most valuable asset—its employees. GMHA workplace safety is achieved through a variety of methods, including the following policies and procedures.

Please reference the following GMHA Human Resources Policies:

- Drug free workplace (Policy #8650-1-210)
- Background screening/criminal charges or conviction (Policy #8650-1-205)
- Behaviors that undermine a culture of safety (Policy #A-LD500)
- Domestic violence in the workplace (Policy #6100-32)
- Workplace violence prevention plan (Policy #A-HR3000)

Managing Workplace Conflict

There is no single strategy to create a positive workplace climate. A number of tools are used in various combinations to stimulate employee engagement and to minimize conflict.

The GMHA Human Resources Department has a leadership responsibility to develop and implement workplace conflict policies and procedures and to create and manage conflict-resolution programs. These policies and procedures are essential to provide guidance to managers and employees on how conflicts and other issues should be handled. These policies include formal mechanisms to help employees resolve differences and provisions to prohibit retaliation against employees who raise concerns.

Please reference the following GMHA Human Resources Policies:

- Disciplinary action policy and procedure (Policy #8650-1-212)
- GMHA Interim Personnel Rules and Regulations

USEFUL TOOLS

PATIENT CARE AREA ENVIRONMENTAL REVIEW FORM

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,, accessible, 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/stains in walls and/or ceiling
- ❑ No items stored in egress corridors except for immediate use
- ❑ Medical gas shut off valves accessible and with distribution labels
- ❑ Oxygen cylinders in holders (not laying / standing on floor) and properly segregated (Full and Empty)
- ❑ Medical equipment with current PM tags
- ❑ Equipment is clean and in proper working order
- ❑ Chemicals appropriately stored, labeled and contained
- ❑ Current SDS available for chemicals in work area
- ❑ Security systems (if any) operational
- ❑ Electrical panels locked and accessible
- ❑ 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

Patient Rooms / Treatment Bays

- ❑ Bed in lowest position and locked
- ❑ 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 and pull string no more than 6" off the floor
- ❑ 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
- ❑ Soiled Linen bin 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.)
- ❑ Key or tool to unlock bathrooms known and readily available 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.

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 / Practice Protocols for AHP'

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
- ❑ Manual Resuscitator Bag supplies (age appropriate) intact and ready to use
- ❑ Oxygen canister secured – not empty.
- ❑ Oxygen canister properly labeled (i.e., full, in-use, etc.) and correct cylinder tag attached
- ❑ 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.

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, gurney covers, chairs, wheelchairs, and recliners
- ❑ No dust on high horizontal surfaces in sterile procedure areas
- ❑ Hand cleaning gel in appropriate areas and not expired
- ❑ Quality control logs for each point of care test current
- ❑ QC strips / solutions for each point of care test current and dated as appropriate

LIFE SAFETY TESTING DOCUMENTATION REQUIREMENTS

Based on requirements from NFPA 101-2012 and its references

Fire Alarm System	Devices	Frequency	NFPA Standard
Supervisory Signal Devices	Pressure supervisory indicating devices	Quarterly	NFPA 72-2010 14.4.5
	Water level supervisory indicating devices	Quarterly	NFPA 72-2010 14.4.5
	Water temperature supervisory indicating devices	Quarterly	NFPA 72-2010 14.4.5
	Room temperature supervisory indicating devices	Quarterly	NFPA 72-2010 14.4.5
	Other suppression system supervisory initiating devices	Quarterly	NFPA 72-2010 14.4.5
	Tamper switches	Semi-annually	NFPA 72-2010 14.4.5
Initiating Devices	Water-flow switches	Semi-annually	NFPA 72-2010 14.4.5
	Smoke Detectors	Annually	NFPA 72-2010 14.4.5
	Heat Detectors	Annually	NFPA 72-2010 14.4.5
	Duct Detectors	Annually	NFPA 72-2010 14.4.5
	Manual pull stations	Annually	NFPA 72-2010 14.4.5
	Electromechanical releasing device	Annually	NFPA 72-2010 14.4.5
Notification Devices	Strobes	Annually	NFPA 72-2010 14.4.5
	Horns	Annually	NFPA 72-2010 14.4.5
	Bells	Annually	NFPA 72-2010 14.4.5
	Chimes	Annually	NFPA 72-2010 14.4.5
Control Panel Batteries	Charger Test	Annually	NFPA 72-2010 14.4.5
	Discharge Test	Annually	NFPA 72-2010 14.4.5
	Load voltage test	Semi-annually	NFPA 72-2010 14.4.5
Smoke detector sensitivity test	2-Years *Note 1: After 2nd consecutive passing test, time frame may be extended to every 5 years.* *Note 2: Not required if detector causes a signal at fire alarm control unit when sensitivity is outside of its listed range.*		NFPA 72-2010 14.4.5
Off-premises monitoring transmission equipment		Annually	NFPA 72-2010 14.4.5

Fire Suppression System	Devices	Frequency	NFPA Standard
Water-based suppression system	Fire pump churn test	Monthly	NFPA 25-2011 8.3.1
	Control valve inspection	Monthly	NFPA 25-2011 13.3.2.1.1
	Pressure gauge inspection	Monthly	NFPA 25-2011 13.2.7.1
	Fire department connections	Quarterly	NFPA 25-2011 13.7.1
	Fire hose valve-inspection	Quarterly	NFPA 25-2011 13.5.6.1
	Pre-action/Dry pipe valve priming water test	Quarterly	NFPA 25-2011 13.4.3.2.1
	Sprinkler inspection	Annually	NFPA 25-2011 5.2.1
	Piping & hanger inspection	Annually	NFPA 25-2011 5.2.2
	Pre-action/Dry pipe valve trip test	Annually	NFPA 25-2011 13.4.3.2.2
	Main drain test	Quarterly	NFPA 25-2011 13.2.5.1
		Annually	NFPA 25-2011 13.2.5
	Control valve exercise	Annually	NFPA 25-2011 13.3.3.1
	Backflow preventer	Annually	NFPA 25-2011 13.6.2
	Anti-freeze test	Annually	NFPA 25-2011 5.3.4
	Private service fire hydrants	Annually	NFPA 25-2011 7.3.2
	2-1/2 inch fire hose valve – test	Annually	NFPA 25-2011 13.5.6.2.1
	Fire pump flow test	Annually	NFPA 25-2011 8.3.3
	Occupant use fire hose – inspected	Annually	NFPA 1962-2008 4.3.4
	1-1/2 inch fire hose valve – test	3-Years	NFPA 25-2011 13.5.6.2.2
	Occupant use fire hose – pressure test	5-Years, then every	NPA 1962-2008 4.3.2
	Check valve inspection	5-Years	NFPA 25-2011 13.4.2.1
	Pressure gauge calibration	5-Years	NFPA 25-2011 5.3.2
	Standpipe waterflow test	5-Years	NFPA 25-2011 6.3.1
	Private fire service mains	5-Years	NFPA 25-2011 7.3.1
	Internal inspection of piping	5-Years	NPFA 25-2011 14.2.1
Portable fire extinguishers	Inspection	Monthly	NFPA 10-2010 7.2.1.2
	Maintenance	Annually	NFPA 10-2010 7.3.1.1.1
Alternative suppression systems	Kitchen hood system – inspection	Monthly	NFPA 17A-2009 7.2.1
	Kitchen hood system – test	Semi-annually	NFPA 17A-2009 7.3.3
	Halon system – inspection & test	Semi-annually	NFPA 12A-2009 6.1.1
	CO2 system – inspection	Monthly	NFPA 12-2011 4.8.1
	CO2 system – tank weigh	Semi-annually	NFPA 12-2011 4.8.3.5.1
	CO2 system – test	Annually	NFPA 12-2011 4.8.3.2
	Clean agent system – inspection	Semi-annually	NFPA 2001-2012 7.1.3
	Clean agent system – test	Annually	NFPA 2001-2012 7.1.1

Tracer Activity Tool – Building Tour

Indicator	Yes	No	NA
GENERAL COMPLIANCE			
• Fire alarm pull stations are clearly identified and easily accessible			
• Medical gas shut-off valves are clearly identified with the areas that it controls and is easily accessible.			
• Sprinkler piping is not used to support anything (i.e. wires). This includes the hangars holding the piping in place.			
• Junction boxes are covered and not exposing wires.			
• Penetrations through any fire and smoke barriers are sealed with an approved fire proofing material.			
• Fire rated doors have a visible and readable rating label present.			
• Fire rated doors have less than a 1/8" gap between the pair of doors.			
• Fire rated doors have less than a ¾" gap from the bottom of the door to the floor.			
• Fire rated doors positively latch when they are closed from their fully open position.			
• A smoke detector is present within 5 feet of a fire rated door. *Note: This is only required if the corridor is not protected throughout with smoke detectors.*			
• Corridors are free of clutter. *Note: Wheeled equipment is permitted providing it meets the following requirements:* o *The equipment does not reduce the width of the corridor to less than 5 feet.* o *The relocation of the equipment is included in the fire response plan and staff are trained.* o *Wheeled equipment is limited to:* ▪ *Equipment in use and carts in use* ▪ *Emergency equipment not in use* ▪ *Patient lift and transport equipment*			
• Projections into the corridor do not exceed 6-inches. *Note: Projections are limited to 4-inches when located between 27-inches to 80-inches above the floor.*			
• Corridors that are at least 8 feet wide are permitted to have fixed seating provided the following are met: o The fixed furniture is securely attached to the floor or to the wall. o The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 feet. o The fixed furniture is located only on one side of the corridor. o The fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. o The fixed furniture groupings are separated from each other by a distance of at least 10 feet. o The fixed furniture is located so as not to obstruct access to building service and fire protection equipment. o The corridors are protected throughout with smoke detectors or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. o The smoke compartment is protected throughout with a supervised automatic sprinkler system.			
• Spaces unlimited in size that open to the corridor other than patient sleeping rooms, treatment rooms, and hazardous areas are protected with a smoke detector. *Note: Only permitted if the following criteria is met:* o *The corridor that the space opens to is protected with smoke detectors.* o *The space is protected with sprinklers or the space is arranged so that the items located are of such minimum combustibility that the likelihood of a fully developed fire is low.* o *The space does not obstruct access to required exits.*			
• Soiled utility rooms test as negative pressure.			

• Soiled utility rooms have biohazardous waste labels on the outside of the room when storing biohazardous waste.			
• Clean utility rooms test as positive pressure.			
• Medical gas piping is labeled with the gas or its chemical symbol no more than every 20 feet. *Note: Additionally, piping must be labeled at least once in or above every room, on both sides of walls or partitions penetrated by the piping, and at least once in every story height traversed by risers.*			
• Sprinkler heads have escutcheon plates present and are not loaded with any foreign material or paint.			
• Trash compactors are locked and secured from unauthorized access to start the compactor.			
• Nurse call systems are working properly when activated. This includes a chiming and visual indicator outside of the room and at the nurse station.			
• Patient bathrooms that can be locked from inside are able to be unlocked in a timely manner by staff during an emergency.			
• Medical gas outlets inside the patient rooms are not leaking.			
• Electrical panels are locked except when behind a secured door.			
• Electrical circuits within electrical panels have current directories indicating what each circuit controls. This includes circuits identified as spares.			
• Sleeping rooms used for on-call staff are protected with a smoke detector that alarms in the room. *Note: The smoke detector is not required to be part of the fire alarm system.*			
• Trash containers and soiled linen containers greater than 32 gallons are kept in a hazardous room when not in use.			
• There are no items stored inside a stairwell.			
• There are no cameras located in a stairwell.			
FIRE EXTINGUISHERS			
• Fire extinguishers are clearly identified and current with monthly and annual inspections.			
• Fire extinguishers located in areas where visual obstructions cannot be completely avoided have signage to indicate the location of the extinguisher.			
• Fire extinguishers that do not exceed 40 lbs. are installed so that the top of the extinguisher is not more than 5 feet above the floor.			
• Fire extinguishers that exceed 40 lbs. are installed so that the top of the extinguisher is not more than 3 ½ feet above the floor.			
• Fire extinguishers are not installed where the bottom of the extinguisher to the floor is less than 4 inches.			
• Fire extinguishers are located so that the maximum travel distance to the nearest extinguisher is 75 feet.			
• Fire extinguishers are positioned so that the operating instructions are located on the front of the extinguisher.			
GENERATOR			
• A remote manual stop button is available for each generator. *Note 1: Only required for generators installed since 1985.* *Note 2: For generators located outdoors, the button cannot be installed on the exterior of the weatherproof enclosure.* *Note 3: For generators located indoors, the button must be outside of the room.*			
• Batteries for the generator are not older than 24-30 months.			
• Rooms housing the generator are not used to store anything other than items pertinent to the generator.			
• The generator is equipped with a remote alarm panel that is working properly.			
• The generator does not have evidence of any fresh leaks and is free of any debris around the ventilation louvers.			

• For generators that are located indoors, the space is equipped with battery powered lighting.			
BULK OXYGEN STORAGE TANK			
• The enclosure around the bulk oxygen tank has NO SMOKING signs present.			
• The enclosure is secured from unauthorized access.			
• There are no gaps in the enclosure that would allow for tampering with controls.			
• The bulk oxygen tank is constructed to prevent vehicular damage. *Note: This can be accomplished with concrete bollards or a brick fence.*			
• There are no vehicles parked within 10 feet from the bulk oxygen tank.			
• There are no waste containers (i.e. dumpsters) located within 50 feet from the bulk oxygen tank			
• An emergency oxygen supply connection is located on the exterior of the building that is accessible by emergency supply vehicles at all times in all weather conditions.			
• The emergency oxygen supply connection has a physical protection to prevent unauthorized tampering.			
• There is a minimum of 3 feet of clearance around the emergency oxygen supply connection.			
FIRE ALARM CONTROL PANEL			
• A smoke detector is present in the location of the fire alarm control panel. *Note: Not required if the room is constantly staffed.*			
• The location of the electrical panel that serves the fire alarm control panel is documented on the panel.			
• The batteries for the fire alarm control panel are not older than 5 years.			
• The circuit breaker for the fire alarm control panel is labeled and RED in color.			
MECHANICAL SPACES			
• Extension cords are not being used as permanent wiring.			
• Oxidizing chemicals are stored at least 20 feet away from any flammable materials.			
• Eye wash stations are located within 10 seconds or 55 feet from where caustic/corrosive materials are used.			
• Storage within a mechanical space is not present if the space opens onto an exit enclosure.			
• Storage within a mechanical space (for spaces that do not open onto an exit enclosure) are neat and orderly.			
• Electrical panels have a clearance of 36” in front and 30” to the side.			
CYLINDER STORAGE ROOM			
• Cylinder storage rooms have a precautionary sign readable from 5 feet, displayed on each door or gate to the storage room that states: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING			
• Storage rooms for class 1 central supply systems or cylinders containing only oxygen or medical air has a sign on the door(s) that states: MEDICAL GASES NO SMOKING OR OPEN FLAMES			
• Empty and full cylinders located in the same room shall be physically segregated from each other.			
• Empty cylinders are marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.			
• A mechanism is in place so that cylinders can be used in the order in which they are received from the supplier.			
• Cylinders stored outdoors are protected as follows: o Against extremes of weather and from the ground beneath to prevent rusting. o During winter, against accumulation of ice or snow.			

o During summer, screened against continuous exposure to direct rays of the sun in those localities where extreme temperatures prevail.			
• Freestanding cylinders are properly chained or supported in a proper cylinder stand or cart.			
• Cylinders, even if they are considered empty, are not used as rollers, supports, or for any purpose other than that for which the supplier intended them.			
• Locations where cylinders are stored (indoor and outdoor) are constructed of noncombustible or limited-combustible materials, with doors (or gates outdoor) that can be secured against unauthorized entry. *Note: This is for locations that store between 300 cubic feet to 3000 cubic feet of nonflammable gases (12 e-size cylinders equals 300 cubic feet).*			
• Locations where greater than 3000 cubic feet but less than 30,000 cubic are have the following features: o Secured with lockable doors or gates. o Indoor locations must have walls, floors, ceilings, and doors that are a minimum 1-hour fire resistance rating.			
KITCHEN			
• Items are not stored within 18-inches from the bottom of a sprinkler head.			
• Sprinklers located within walk-in refrigerators and freezers are free from ice build-up or any foreign materials that would prevent it from working.			
• Slicer machines are unplugged when not in use.			
• The kitchen hood sprinkler nozzle blow-off caps are intact and free from damage.			
• The kitchen hood sprinkler nozzles are appropriately positioned to cover the intended areas they were installed for (i.e. grills have not been repositioned after cleaning).			
• Class K fire extinguishers are located within 30 feet from grease producing locations.			
• Class K fire extinguishers have warning signs that instruct employees to activate the suppression system before using the extinguisher.			
• There is a minimum of 16 inches of space between the fryer and the surface flames of adjacent cooking equipment. *Note: It is permitted to use a tempered glass baffle plate between the fryer and surface flame of adjacent cooking equipment.*			
OPERATING ROOM			
• Power strips that are used within the patient care vicinity meet the following requirements: o UL1363A listed device o Permanently affixed to a rack, pole, table, etc. (some power strips have a knob that tightens a bolt to a pole. Not acceptable if the knob can be turned by hand) o Not daisy chained o Does not create a tripping hazard o The devices that are plugged in to power strip do not exceed 75% of the rating for the power strip			
• Temperature and humidity logs are available for operating rooms, sterile storage, and decontamination rooms. When levels are out of acceptable ranges there is a documented corrective action and a retest.			
• Operating rooms test as positive pressure.			
• Sterile storage areas test as positive pressure.			
• Decontamination area test as negative pressure.			
• Medical equipment is current with required preventive maintenance			
• An eye wash station is available in sterile processing			
SUITES			
• Non-sleeping suites are no larger than 10,000 square feet. *Note: Non-sleeping suites are areas such as the Operating Room, PACU, Emergency Room*			
• Sleeping suite sizes are limited to the following:			

o 5,000 square feet o 7,500 square feet if the space is protected by either quick response sprinklers, or standard response sprinklers and a smoke detection system. o 10,000 square feet if there is direct observation from the nurse station to every room, protected with an automatic sprinkler system, and a smoke detection system.			
• For suites greater than 1,000 square feet there are two exit access doors			
• Patient rooms in a sleeping suite that does not have direct supervision from a normally attended location is required to have a smoke detector in the patient room.			
• Doors separating suites from the corridor and/or from one suite to the next must be positive latching.			
IMAGING SERVICES			
• MRI is secured from entrance by unauthorized/unscreened individuals.			
• MRI quench exhaust pipe is labeled where it exits the building.			
• A non-ferrous fire extinguisher is available near the MRI.			
• The hot lab is secured from entrance by unauthorized individuals.			
• Inspection logs are available for all lead aprons.			
• Preventive maintenance documentation is available for all imaging equipment.			
PEDIATRIC UNITS			
• Receptacles in patient rooms, bathrooms, playrooms, and activity rooms are listed as tamper-resistant or shall employ a listed tamper-resistant cover.			
• Delayed egress locks have a sign stating: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS *Note: The time can be extended to 30 seconds if approved by all authorities having jurisdiction.*			
FIRE PUMP/SPRINKLER RISER			
• The fire pump/sprinkler riser is free of any leaks.			
• There are spare sprinkler heads available for each type of sprinkler within the facility. *Note: The number of spare sprinkler heads is based upon how many sprinklers are within the facility. For under 300 sprinklers – no fewer than 6 sprinklers; for 300 to 1000 – no fewer than 12 sprinklers; and for over 1000 sprinklers – no fewer than 24 sprinklers*			
• Spare sprinklers are kept in a cabinet located where the temperature where they are subjected will at no time exceed 100 degrees F.			
• One sprinkle wrench for each type of sprinkler is provided in the cabinet for each type of sprinkler installed.			
• A list of sprinklers installed in the facility is posted in the sprinkler cabinet. *Note: The list shall include the following:* o *Sprinkler ID Number if equipped; or the manufacturer, model, orifice, deflector type, thermal sensitivity, and pressure rating.* o *General description* o *Quantity of each type to be contained in the cabinet* o *Issue or revision date of the list.*			
REHABILITATION UNITS			
• Dryers have a routine preventive maintenance performed to clean the lint from the line behind the dryer through the wall.			
• Patient lift systems have a preventive maintenance performed per manufacturer requirements.			
• All equipment, including weight and cardio equipment, are included in the facilities equipment inventory.			
• When residential cooking equipment is used for food warming or limited cooking the following requirements are met: o The space does not serve more than 30 beds.			

o The cooktop or range is equipped with a range hood of a width at least equal to the width of the cooking surface, with grease baffles or other grease-collecting and cleaning capability. o If the hood system is not ducted to the exterior it will be equipped with a charcoal filter to remove smoke and odor. o The cooktop or range is protected with a fire suppression system. o Deep-fat frying is prohibited o Portable fire extinguishers are located in the kitchen area. o A locked switch (or a switch located in a restricted area) is provided that will deactivate the cooktop or range. The switch is used to deactivate the cooktop or range when the kitchen is not under staff supervision. The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. o Not less than two AC-powered photoelectric smoke alarms, equipped with a silence feature, are located not closer than 20 ft. from the cooktop or range. o The smoke compartment is protected throughout with a sprinkler system.			
ALCOHOL BASED HAND RUB DISPENSERS			
• Alcohol-based hand-rub dispensers are installed under the following conditions: o When installed in a corridor the width of the corridor is at least 6 feet. o The maximum capacity for a single dispenser is 1.2L for dispensers in rooms, corridors, and areas open to corridors. The max capacity is 2.0L for dispensers in suites of rooms. o Dispensers are separated from each other horizontally no less than 48 inches. o No more than 10 gallons is permitted to be in use outside of a storage cabinet within a smoke compartment. o One dispenser located in each room or a suite of rooms is not included in the 10-gallon requirement listed above. o Dispensers are not installed in the following locations: Above an ignition source within a 1-inch horizontal distance from each side of the ignition source; To the side of an ignition source within 1-inch horizontal distance from the ignition source; Beneath an ignition source within 1-inch vertical distance from the ignition source. o Dispensers are not installed over carpeted floors unless the smoke compartment is sprinkled. o The solution does not exceed 95 percent alcohol content by volume. o Operation of the dispenser complies with the following: ▪ The dispenser doesn't release the contents unless it is activated. ▪ Any activation occurs only when within 4 inches of the sensing device. ▪ Anytime an object is left in the activation zone it only allows for one activation. ▪ The dispenser does not dispense more solution than what is required for hand hygiene consistent with the manufacturer. ▪ The dispenser is not designed, constructed, and operated in a manner that ensures accidental or malicious activation is minimized. ▪ The dispenser is tested in accordance with the manufacturer each time a new refill is installed.			

Indicator	Yes	No	Comments
Food Storage			
Refrigerator/Freezer Storage			
1. All prepared or opened food items placed into storage are dated with the date of opening or a beyond use date.			
2. All prepared or opened food items placed into storage are covered and food is protected against negative outcomes such as, drying out, and change in color or freezer burn.			
3. Potentially hazardous foods like uncooked meat, poultry, fish, and eggs that are stored separately from other foods (e.g., meat is thawing so that juices are not dripping on other foods) Ready-to-eat foods stored above raw food.			
4. Food storage areas are clean, and food is not in contact with soiled surfaces or rust.			
5. Refrigeration fans clean and in good repair.			
6. Food is not stored directly on the floor.			
7. Food is stored at least 6 inches off the floor.			
8. Food products that have been damaged or expired in refrigerators or freezer have been removed from inventory and discarded or returned to the supplier.			
9. Temperature of all refrigerators is maintained at 38 to 41˚F or according to policy.			
10. Refrigerator temperatures documented out of the acceptable range have documented actions taken and subsequent monitoring to assure that food is maintained at the appropriate temperature.			
11. Temperatures of all freezers is maintained at 0 to -10˚F or according to policy.			
12. Freezer temperatures documented out of the acceptable range have documented actions taken and subsequent monitoring to assure that food is maintained at the appropriate temperature.			
13. Refrigerators/freezers are clean, in good working order and are free of rust.			
Dry Storage			
1. The organization has implemented a system to assure that food placed into dry storage areas are rotated to prevent expiration (e.g., FIFO)			
2. Food placed into the dry storage areas is not stored directly on the floor.			
3. Food and paper supplies are stored at least 6” off the floor.			

Indicator	Yes	No	Comments
4. No bulging or leaking canned goods.			
5. Food that is placed into storage after opening is dated with the date of opening or a "beyond use" date.			
6. Food is covered and protected from contamination.			
7. Food removed from original containers and placed into plastic bins i.e., flour, sugar, rice, cornmeal etc. are dated with the date placed into the container and a "beyond use" date of 6 months. Staff can articulate a process for discarding contents, sanitizing, and refilling every 6 months.			
8. Opened dry spices are dated with the date of opening and/or a "beyond use" date which is one year from the date of opening or according to the organization's policy.			
Food Preparation/Holding			
Warming Cabinets Storage			
1. Warming cabinets are maintained at a holding temperature of 135˚F or higher.			
Tray Line Storage			
1. Hot tray line temperatures are documented and maintained according to policy or at least to 135˚F.			
2. Cold tray line temperatures are documented and maintained according to policy or less than 41˚F.			
3. Food service is started within 30 minutes of food being placed on a tray line.			
General Food Preparation			
1. Food that is cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165˚F for at least 15 seconds before holding for hot service.			
2. Ready-to-eat foods that require heating before consumption are best taken directly from a sealed container (secured against the entry of microorganisms) or an intact package from an approved food processing source and heated to at least 135˚F for holding for hot service.			
3. Food is cooked in a manner to conserve nutritive value, flavor, appearance, and texture.			
4. Food reaches an internal temperature for at least 15 seconds and temperature of at least: • Poultry / Stuffed Foods = 165˚F • Ground meat / Eggs = 155˚F • Fish / Pork / Other Meats = 145˚F			
5. Potentially hazardous foods that are cooled from 135° Fahrenheit to 70° Fahrenheit within 2 hours; from 70° Fahrenheit to 41° Fahrenheit within 4 hours; the total time for cooling from 135° to 41° Fahrenheit should not exceed six hours.			

Indicator	Yes	No	Comments
6. Thermometers used to temp food products are calibrated according to the manufacturer's instructions for use.			
7. Surfaces are thoroughly cleaned after preparation of fish, meat, or fowl.			
8. Cutting surfaces that are sanitized between uses.			
9. Burners on stoves are clean and fee of debris.			
10. Exhaust hood is clean and inspected every 6 months.			
Equipment Use and Food Preparation Areas			
1. Cooking equipment/surfaces are free of dirt, grime, and rust.			
2. Fans in food prep areas that are clean.			
3. Utensils/equipment that are cleaned and maintained to prevent food borne illness.			
4. Food trays, dinnerware, and utensils that are clean and in good condition (e.g., not cracked, or chipped, etc.).			
5. Meat cutters are locked out or not plugged in when unused.			
6. Bucket type ice machines have documented routine cleaning according to the manufacturer's instructions for use.			
7. Filters on bucket type ice machines are cleaned according to the manufacturer's instructions for use. The cleaning is documented and there is no visible debris build-up on filter.			
8. The organization has determined the point at which appropriate hair covering is required.			
9. All individuals entering the kitchen had appropriate hair covering.			
10. Ceiling tiles in food storage and preparation areas and cleaning areas are free of mold or water stains.			
Dishwashing and Sanitization			
1. Dishwasher temperatures that are at 150° Fahrenheit wash, 180° Fahrenheit rinse OR 120° Fahrenheit wash + 50 ppm (parts per million) Hypochlorite			
2. If a manual method is used – after washing and rinsing, dishes are sanitized by immersion in either: • Hot water (at least 171˚F) or • A chemical sanitizing solution. If explicit manufacturer instructions are not provided, the recommended sanitation concentrations are as follows:			

Indicator	Yes	No	Comments
− Chlorine: 50 – 100 ppm minimum 10 second contact time − Iodine: 12.5 ppm minimum 30 second contact time − QAC space (Quaternary): 150 – 400 ppm concentration and contact time per manufacturer's instructions			
3. Water in sinks is clean and free of debris.			
4. Dishes, food preparation equipment, and utensils are not towel dried (Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination.)			
5. Clean and soiled work area are separated.			
6. Dishware is stored to prevent contamination. (In a clean, dry location, not exposed to splash, dust or other contamination and covered or inverted on bottom shelves lacking a solid bottom.)			
7. Dishware and cookware are not nested while wet in the dishwashing area or in storage.			
8. Sanitizer used for food preparation surfaces for example in buckets has been QC tested to verify efficacy from 150 – 200ppm.			
Staff Hygiene Practices			
1. Staff properly wash hands with soap and water to prevent cross contamination (i.e., between handling raw meat and other foods)			
2. Staff utilize hygienic practices (e.g., not touch hair, face, nose etc. and then handle food)			
3. All individual observed entering the kitchen perform hand hygiene.			
Garbage Storage/Disposal and Pest Control			
1. Garbage and refuse are disposed of properly in a covered container.			
2. Trash cans are clean and routinely emptied.			
3. Loading dock and dumpster area are clean			
4. Box crusher has a mechanism to prevent operation by unauthorized personnel (e.g., no key in place and not locked into the on position)			
5. Food storage, preparation and service areas are free of visible signs of insects and/or rodents.			
6. Wet trash is removed from the kitchen in a timely manner.			
7. There is no evidence of insects, rodents, or animals.			

Indicator	Yes	No	Comments
Delivery of Meal Trays			
1. Meal trays are delivered within the maximum time interval allowed between meals as required by law and regulation (e.g., 14 hours) Request policy.			
2. The organization confirms that meals are delivered within appropriate temperature requirements for hot and cold items.			
3. Staff adhere to appropriate infection control and hand hygiene practices when passing meal trays.			
4. There is a mechanism to match the ordered diet with the meal that is being provided to the patient.			
5. Diets and diet supplements are ordered by either an LIP or a registered dietician if privileged by the medical staff or state law to do so.			
Diet Manual & Menu Planning			
1. Menus are based on current national standards for recommended dietary allowances such as the current Recommended Dietary Allowances (RDA) or the Dietary Reference Intake (DRI) of the Food and Nutrition Board of the National Research Council.			
2. Current menus must be posted in the hospital kitchen.			
3. Meals are designed to meet the nutritional needs of the patient in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients.			
4. A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing and food service personnel. • The publication or revision date of the approved therapeutic diet manual must not be more than five years old. • The therapeutic diet manual must be available in each patient care area where nutrition services are provided. • If the manual is provided in an electronic format, there must be at least one paper copy available for use during prolonged periods of power disruption or when computer systems are not functional.			
Care Environment/Life Safety			
1. Staff can locate the Safety Data Sheets (SDS) for corrosive materials found during the building tour of the kitchen.			
2. Eyewash/Shower station is in a location that is unobstructed and in good working order.			
3. Eyewash/Shower stations can be accessed within 10 seconds of where the hazard is located.			

Indicator	Yes	No	Comments
4. The inspection log for the eyewash/shower station is completed and current.			
5. The freezer is free of any ice buildup.			
6. There is a minimum of 18-inches from the bottom of the sprinkler heads to the top of any items.			
7. A mechanism is in place to ensure staff do not get locked in the freezers. Staff are aware of the mechanism.			
8. The kitchen is in good repair. There are no broken tiles, flaking walls, etc.			
9. A Class-K fire extinguisher is located within 30 feet of grease producing equipment.			
10. The K-extinguisher has a placard conspicuously displayed that educates the staff to activate the fire suppression system before using the extinguisher.			
11. Staff know how to activate the kitchen suppression system (ANSUL).			
12. Instructions for how the staff are to activate the kitchen suppression system are conspicuously posted where it can be reviewed by staff.			
13. The gas valve is accessible for emergency shutoff by staff.			
14. Staff know where the gas valve is located and how to turn it off.			
15. The emergency shutoff is properly labeled.			
16. The hood is clean and does not have any evidence of grease buildup.			
17. Inspections for grease buildup are conducted at least every six months.			
18. Grease producing equipment is located properly below the hood.			
19. Equipment is repositioned to its proper design location to ensure coverage from the sprinkler system after cleaning.			
20. An approved method is in place to ensure that the organization positions the equipment back in the proper location to ensure coverage from the sprinkler system.			
21. Deep fat fryers are positioned at least 16-inches away from any surface flames. *Or a steel or tempered glass baffle plate is installed a minimum of 8-inches in height between the deep fat fryer and a surface flame.*			

Indicator	Yes	No	Comments
22. The year of manufacture and date of installation of the fusible links are marked on the kitchen suppression system tag.			
23. The inspection tag is signed or initialed by the installer.			
24. Electrical panels have a clear space that is at least 36-inches in front of and at least 30-inches to the side.			
25. Compressed gas cylinders are properly secured to prevent falling over.			