Introduction

Joint Commission accreditation is recognized nationally as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards. To earn and maintain The Joint Commission’s Gold Seal of Approval™, an organization must undergo an onsite survey every three years. In addition to patient care and medication safety standards, Joint Commission surveyors will focus on the following areas during their upcoming visit:

- Cleaning, disinfection and sterilization
- Hand hygiene
- Control of air flow in sensitive locations
- Fire safety and fire drills
- Patient flow/throughput (access to care, handoffs, discharge)
- Control of confidential information

This booklet is a resource for you to use as part of continuous survey readiness. You will find information about the areas of focus throughout this booklet and in the Frequently Asked Questions portion in the last pages of the booklet.

Communicating with surveyors

There is a good possibility that you will be approached by a surveyor and asked a few questions. It is understandable that you may be nervous. Just take a deep breath and take time to think before you answer. The surveyors will be asking you about your daily routine at work. They will not ask you any “trick” questions or try to confuse you; they want to give you the opportunity to share how you incorporate quality and safety into your daily duties.

Once you have answered the questions, stop. There is no need for you to fill any lull in the conversation.

If you don’t understand the question, ask the surveyor to repeat or rephrase it. If you are not sure of the answer, please remember:

Don’t say: “I don’t know.”

Say: “I can check with my supervisor for that information.”

Also, remember your reference materials available in your department and on the intranet.
Surveyors understand that patient care comes first. If you are in the middle of providing patient care, it is okay to say that you need to finish taking care of the patient and will answer their questions in a few minutes. This shows them that quality and patient safety are important to you.

The surveyors might also want to watch you go about your daily routine or ask you to show them how you perform certain tasks. Be confident and show your talents. There is no need for you to explain what you are doing.

The **Command Center (ext. 7310)** is the central location for help and information during the survey. Please call the Command Center if:

- You have questions about the survey process or concerns about something that has happened during the survey.
- You have information that you would like share with other areas of the medical center after the surveyors have visited your area (e.g., the surveyors are spending a lot of time on medication passes).

If the surveyors ask for documents or files, please let them know that the Command Center will provide the documents they need. Contact the Command Center right away to notify them of the surveyors’ request.

**Quality and patient safety**

**Improving performance through Lean Six Sigma**

There are several teams working to improve performance at UC Irvine Medical Center. The primary focus is to enhance the organization’s systems and processes.

The medical center uses the Lean Six Sigma methodology to identify and improve the quality and safety of our operations. Lean Six Sigma seeks to eliminate waste and redundancies in our processes to better meet our patients’ expectations.

**How does Lean Six Sigma work?**

Lean Six Sigma uses the DMAIC (pronounced “duh-may-ick”) model, a structured problem-solving process that is widely used in the healthcare industry. The acronym stands for the five phases of Six Sigma improvement—Define, Measure, Analyze, Improve and Control. These phases lead a team in a logical method, from defining a problem to creating sustainable solutions that enhance the patient experience.
**DMAIC phases**

- **Define**  
  the goals for the project

- **Measure**  
  the existing system

- **Analyze**  
  the system to identify ways to eliminate the gap between the current performance of the process and the desired goal

- **Improve**  
  the system. Be creative in finding ways to do things better, cheaper, faster

- **Control**  
  the new system. Develop supporting processes for a successful solution

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**Define**
- Project charter
- Voice of customer
- SIPOC
- Process map

**Measure**
- Data collection
- Validate measurement system
- Stability/capability tests
- C&E
- VSM

**Analyze**
- Quick hits
- VSM
- Fishbone
- Pareto
- FMEA
- Hypothesis testing

**Improve**
- Line balancing
- New VSM
- Kaizen event
- SS
- Lean Intervention
- Develop potential solutions

**Control**
- Control charts
- Poka-Yoke
- Control plan
- Handoff
Safety measures to ensure high-quality patient care

To ensure that we are delivering the highest quality of care, we have implemented the following safety measures:

Clinical alarms

One of the National Patient Safety Goals is to REDUCE the harm associated with clinical alarm systems by evaluating the appropriateness of all alarms and eliminating nuisance alarms that can lead to alarm fatigue.

Below are 5 key points to remember regarding alarm safety at UC Irvine Medical Center:

1. The best way to make sure your patient is safe is to respond to all alarms.

2. At handoff or any transfer of care, you should check your physiological alarm settings to make sure they are appropriate for your patient and within our default settings.

3. To reduce false alarms, make sure EKG leads are changed daily (Neonatal excluded) and pulse oximetry sensors are replaced when they no longer adhere properly.

4. We have a Clinical Alarms Policy which has details about who can change alarm settings, when alarm settings can/can’t be changed and what our default alarm settings should be.

5. We have a Clinical Alarm Safety Committee that looks into our alarm management throughout the hospital and has made alarm safety a hospital priority.

Patient Assessment

How do we assess patients at UC Irvine Medical Center?

We perform an interdisciplinary assessment on each patient admitted to the medical center. This assessment includes a physical, psychological, social, functional, educational, cultural, environmental and nutritional screening, as well as a discharge plan. The nurse assigned to the patient is responsible for the completion of the initial nursing assessment. The assessment provides triggers for other departments to further assess the patient.
When is reassessment of patients performed and who is involved?
Reassessment of patients occurs:
• Whenever there is a change in the patient’s diagnosis or condition
• Whenever there is a change in the level of care
• At regular intervals throughout the course of the treatment
• Whenever there is a need to determine a patient’s response to treatment

How do you plan and provide care, treatment and services?
Care is planned to respond to each patient’s unique needs and is customized to suit the appropriate age, disease, condition, impairment or disability. Care begins when appropriate settings and services are identified, planned and revised or maintained based upon the patient’s response to treatment. Care is continually assessed and reprioritized; decisions to not address certain needs are justified in the medical record. Care is planned and provided in an interdisciplinary, collaborative manner, involving the patient and/or the family members as much as possible. Refer to “Planning of Patient Care” section below.

Planning of care: developing an interdisciplinary, individualized Care Plan
The multidisciplinary team consolidates information from patient assessments to develop a comprehensive picture of the patient’s condition, and to identify, formulate and assign an individualized plan of care.

These plans can be found in the EMR on the Nursing Flow Sheet, Plan of Care Summary, and in the various services notes (physician, social worker, case manager, occupational and physical therapists, etc.)

Start with the Clinical Summary and the Plan of Care Clinical Summary if the surveyor asks you about the plan of care for your patient, as these two documents demonstrate interdisciplinary care planning.
The Plan of Care Clinical Summary provides interdisciplinary view of various discipline’s plan for the patient and auto-populates from the Nursing Plan of Care and the Interdisciplinary Progress Notes.

A new focus of The Joint Commission is that the plan of care must be individualized to each patient and the patient’s goals must be incorporated into the plan. One way to demonstrate that this is occurring is with the Nursing Plan of Care in the EMR.
Tips on how to individualize a nursing plan of care:

- Update the plan of care when the patient’s condition changes.
- Evaluate the patient’s progress during your shift and summarize progress or barriers in a short statement in the Nursing Shift Summary Note.
- Chart to the outcomes of the nursing care plan:
  - At the end of each shift, when evaluating the nursing care plan, write a brief **evaluative statement** of the patient’s progress or lack of progress that explains why you evaluated the patient as progressing or not progressing.
  - In the Individualized/Recommendations/Goals Sections, briefly write a statement that can assist the next nurse in providing care and progressing patient forward. See examples below. These statements will automatically populate the Nursing Shift Summary Note to eliminate duplicate documentation.
  - In the Goals section of the Nursing Plan of Care, it is best if the goal represents the patient’s goal, not the medical team’s goal.

**Evaluative statement in Evaluation Box:**

Patient continues to need reminders to call for nurse.
Nursing summary and recommendations in *Individualized Plan/Recommendations* section & *Goal* section:

**Individualized Plan/Recommendation Section:**
Turn patient to right and center only to offload pressure to right ischium for pressure ulcer. If redness develops consider turning more frequently.

**Goal Evaluation Comments:**
Patient tolerating turning to the right and center. No breakdown noted to these sites.

**Tips on incorporating patient goals into the Plan of Care:**
- **White Board:** The patient white board is a great place to incorporate the patient’s goals into the plan of care. The white boards can be used by all disciplines to document patient goals. The statements must be patient’s goals, not the medical team’s or nurse’s goals. The following are examples of patient goals:
  - My Pain Goal: 4 or less (Discuss the pain goal with the patient and together set a reasonable goal)
  - Go home
  - Walk around the unit 3 times
  - Learn how to care for my ostomy
- **Document patient’s goals in the Goals section of the Nursing Plan of Care**
Discharge Planning

Discharge planning is the process that begins upon admission to the hospital and is used to decide what the patient needs for a smooth transition from one level of care to another. The initial patient assessment and patient profile begin the discharge process. The discharge and transfers are coordinated by physicians, nurses, case managers and other ancillary disciplines, as applicable.

Planning for the patient’s discharge includes:

- Assessment and evaluation of the patient
- Discussion with the patient about his/her condition and needs
- Planning with patient and family for discharge to home or other facility
- Educating the patient and/or patient’s caregivers as needed
- Coordinating referrals for community resources as appropriate
- Working with patient and family to schedule follow-up appointments as appropriate

Ensuring the patient and family are knowledgeable and have the needed resources upon discharge can decrease the possibility of readmission to the hospital.

Advance health care directive (AHCD)

An advance directive gives patients the opportunity to disclose their healthcare preferences and the type of healthcare they do or do not want, in the event that they become unable to make their own decisions. A booklet entitled “Your Guide to Decision Making and Advance Directives” is available to patients in both the inpatient and ambulatory settings.

Within 24 hours of admission, all adult patients are asked whether they have an advance directive. Patients with an advance directive are asked to provide a copy if they have not previously provided it to us, and those who do not have one in place are offered the opportunity to prepare one.

The most up-to-date advance directive status for a current inpatient can be found on the “Clinical Summary” tab in the EMR. Upon admission, staff enters an advanced directive status on every patient, which the RN in charge views and updates when completing the patient profile. Once the patient profile is saved, the advanced directive status is available for viewing in the Clinical Summary tab. If there is an advanced directive, it is scanned at the time of admission and can be found on the “E-DOC” tab in the EMR. Patients are encouraged to attend the Advance Directive classes facilitated by Clinical Social Workers. Classes are offered every other month.
Pain Assessment and Management

Pain Assessment

Pain is considered a “Fifth Vital Sign,” and is assessed per nursing unit/division Standard of Care with each vital sign assessment. Clinicians screen for the presence of pain upon admission, or with first contact with the patient using an appropriate assessment tool based on age, developmental level and patient condition:

- Numeric Rating Scale (NRS) – Measures adult pain on a zero to 10 scale
- Non Verbal Pain Scale (NVPS) – For sedated or mechanically ventilated patients
- Face, Legs, Activity, Cry and Consolability Scale (FLACC) – Children from 2-7 months
- Wong-Baker Faces Scale (FACES) – Developed for children but can be used for cognitively impaired adults

Reassessment of pain is performed and documented in a manner appropriate to the route and method of pain control given. The patient’s goal for pain control should be written on the white board.

Pain Management

Nurses notify the physician if, during the initial assessment, the patient’s pain score is >4 and no pain medications are ordered or if pain remains greater than 4 following the administration of the pain medication. Non-pharmacological interventions can also initiated as needed:

- Positioning
- Relaxation/distraction
- Application of heat/cold
- TENS unit
- Comfort measures (holding, use of calm environment, music, etc.)

Restraints

A restraint is a method of physically restricting a person’s movement, physical activity or normal access to the body. Restraints may be justified in clinical situations when preventive and alternative strategies are not sufficient to keep the patient from interfering with therapy. This method is to be avoided whenever possible and should be applied only after a patient’s need has been assessed and alternative strategies have been explored.

Trained staff are required to document the preventive and alternative strategies implemented, as well as clinical justification for the use of restraint. Orders, monitoring and reassessment notes must also be documented in the medical record. An RN may place a patient in restraints for safety purposes prior to obtaining a physician’s order, but a physician’s order is required, preferably within one hour of restraint placement. Refer to “Restraint” policy for details.
Important Resources

Clinical Updates: Clinical updates are a communication tool used to inform staff and physicians of changes that impact the clinical staff. Clinical updates are sent to the manager or coordinator, who sends them to appropriate members of their staff, discusses them in pre-shift huddle and posts them in appropriate locations within the unit or ambulatory practice. The clinical updates are also posted on the intranet for future reference.

From the intranet site:

Step 1: Click on Sharepoint directory (found on left navigation bar)

Step 2: Select Clinical Updates

Step 3: View Clinical Updates under Shared Documents
Policies and Procedures

It is the responsibility of each staff member and physician to ensure they have knowledge and are following the policies and procedures that have been developed. Policies and procedures are developed based on the current best practices and evidence-based literature. When staff find new evidence, they are encouraged to bring the evidence or best practice forward to their department, the practice council or Clinical Nurse Specialist or Clinical Nurse Educator.

Nursing is responsible to follow all UC Irvine Policies as well as Mosby’s Nursing Skills. Policies and procedures are located on the intranet under Quick Links:

- Mosby’s Nursing Skills
- Policies and Procedures
Top ten points for readiness

1. Hand hygiene
   • Know your Five Moments for Hand Hygiene.
     1. Before touching a patient
     2. Before clean/aseptic procedures
     3. After body fluid exposure/risk
     4. After touching a patient
     5. After touching patient surroundings
   • Wash your hands before and after patient contact, and when moving from a contaminated area to a clean task.
   • Wash your hands with soap and water when leaving Spore Precaution rooms with patients with diarrheal illness.
   • Keep nails clean and trimmed. No artificial nails or chipped polish is allowed.
   • DO NOT forget to always wash your hands after removing gloves.
   • DO NOT use waterless hand scrub if hands are grossly contaminated. Use soap and water.
   • DO NOT wear gloves outside patient care areas. Remove them upon leaving the area or completing a task.
2. **Personal Protective Equipment (PPE)**

   It is the responsibility of the individual to use the appropriate PPE for their job assignment.
   - Wear gloves if exposure to non-intact skin, mucous membranes, or bodily fluid is likely.
   - Select the appropriate PPE based on the anticipated risk for exposure to blood, mucous membranes, non-intact skin or other potentially infectious material.
   - Put on the appropriate PPE just prior to entering an isolation room.
   - DO NOT allow the isolation gown to fall off your shoulders during use. Secure it ahead of time so it doesn’t fall during tasks.
   - DO NOT use your phone while providing patient care. If you must answer, clean the phone with disinfectant after use and before placing it back in your pocket.
   - DO NOT reuse PPE. Place it in a hamper or trash after use. Never hang or set it down in a patient care environment.

3. **Cleaning and low-level disinfection**

   - Clean shared patient equipment after use and between patient visits, especially when it comes in contact with blood, body fluids, or other potentially infectious material (e.g., glucometers, lift equipment).
   - DO NOT return equipment to the clean storage if it has not been cleaned and disinfected. Cleaning should also include the cords and bases.
   - Wipe down high-touch surfaces at the beginning of shift and as needed (when visibly soiled). Include items such as keyboards and telephone.
   - Remember the CaviWipes™ contact time (time surface stays wet) is three (3) minutes.
   - UC Irvine Health is transitioning to a general use disinfectant (Oxycide) which is sporicidal. Bleach will no longer be used for C. difficile rooms. Bleach will only be used in certain areas such as the laboratory.
   - DO NOT allow disinfectant wipes to dry out, or hand gel dispensers to go empty. Keep caps closed tight to prevent drying and notify EVS for refills on either product.
   - Always use appropriate PPE when cleaning and disinfecting equipment.
4. **Timeout**

The purpose of the “timeout” is to conduct a final assessment that the correct patient, site and procedure are identified. During a timeout, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site and procedure. The procedure is not started until all questions or concerns are resolved.

Timeouts are performed prior to:
- Bedside procedures
- Procedures in procedural areas and ambulatory practices (i.e., interventional radiology, CDDC, cath lab, physician offices)
- Procedures in the operating room or in an outpatient surgery setting

For more information see “Surgical/Procedural Verification” policy.

5. **Handoff communication**

Effective communication is one of the best ways to assure safe continuity of care. All members of the care team participate in handoffs. Handoffs can be structured or occur based on the patient’s needs. The important part of the handoff is that it should be interactive to allow for questions to be asked and answered.

Some important times handoffs occur:
- Among care providers at shift change and for break coverage
- From ED to inpatient units
- From operating room to the post-op care unit (PACU), and from the PACU to the inpatient unit
- When an inpatient is transferred to another location either temporarily (e.g., radiology) or permanently (change in level of care)

A good handoff includes at least the following information:
- Current clinical status, including current conditions
- Recent and anticipated treatment
6. Medication labeling
Medications must be labeled if not immediately administered. An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to the patient, and administers without any break in the process.

A medication label should include the following:
- Medication or solution name, strength and amount, if not apparent from the container
- Diluent name and volume, if not apparent from the container
- Date prepared
- Expiration date when not used within 24 hours
- Expiration time when expiration occurs in less than 24 hours

When medications are prepared for multiple patients or if the medications are prepared by someone other than the person administering it, the label also includes the following:
- Patient name
- Location
- Directions for use and applicable accessory, and cautionary instructions

7. Single and multi-dose vials
Multidose medications (e.g., insulin, ointments, creams, inhalers) may only be used up to 28 days after opening or by the manufacturer’s expiration date, whichever is shorter. They must be labeled with the expiration date, not the date opened.

Single dose medications shall be used for a single patient and discarded within one hour of opening the container.
8. High-Risk medications

High-Risk medications are drugs that bear a heightened risk of causing significant harm when they are used in error. Although mistakes may or may not be more common with these medications, the consequences of an error have a higher potential for adverse outcomes.

**High-risk medications at UC Irvine Medical Center:**

- Amiodarone
- Chemotherapeutic agents
- Concentrated electrolytes
- Digoxin injection
- Epidurals
- EPINEPHrine syringes drawn up or infusions prepared outside of Pharmacy
- Epoprostenol (Flolan), treprostinol (Remodulin)
- Heparin infusion, argatroban infusion, alteplase (t-PA) infusion
- Heparin flushes in NICU
- Hypertonic sodium
- Insulin
- Investigational medications
- Narcotic or sedative infusions and PCAs
- Neuromuscular blockers (NMBs)
- Warfarin

To minimize the potential for medication errors with the high-risk medications, a dose verification or independent double-check is required.

- **Dose verification:** Prior to administration, the administering practitioner prepares and obtains the medication, and a second qualified practitioner verifies that the intended medication and dose were prepared and obtained. **Documentation of a dose verification is not required.**

- **Independent double-check:** Prior to administration, the administering practitioner programs the pump, and a second qualified practitioner independently reviews the order, the medication and the pump settings. At handoff or shift change, a qualified practitioner reviews the order, the medication, and pump settings. **Documentation of a double-check is required.**

Medications requiring dose verification:

- IV push heparin
- SQ/IV push insulin
- IV push hypertonic 23.4% Saline
- EPINEPHrine syringes drawn up or infusions prepared outside of Pharmacy
Medications requiring independent double-check while programming an infusion pump:
- Amiodarone
- Chemotherapy infusions
- Epidural infusions
- Epoprostenol (Flolan)
- Heparin, argatroban and alteplase (t-PA) infusions
- Investigational medications
- Insulin infusions
- Patient-controlled analgesia (PCA) infusions
- Treprostinol (Remodulin)

9. **Private Health Information**
   - Organizations are required to maintain the privacy and confidentiality of patient information. When staff is not present to monitor medical records in clinical environments or in storage areas, alternative approaches may need to be designed to protect privacy and confidentiality.
   - Remember, in ambulatory practices, medical records must be stored after hours in designated locked areas, not in work stations or in unlocked, unsecured offices.

10. **Environment of Care**
    A safe, functional and supportive environment influences the quality and safety of the care we provide. The environment of care is made up of three core elements:
    - The building or space, including how it is organized, the unique features that protect patients, visitors and staff, and cleanliness.
    - Equipment used to support patient care or safely maintain the building or space.
    - People including staff, physicians, patients and visitors.

    All of us must be knowledgeable about the elements of a safe environment, and the processes for identifying, reporting and taking actions to ensure we are working together to maintain a safe environment. Below is a comprehensive checklist to guide you in your knowledge and the assessment of the safety of your environment.
Environment of Checklist

Remember, everyone can report Environment of Care concerns by calling 5700 or by informing their immediate supervisor of their safety concern.

**Key:** ◆ Staff knowledge  □ Inspection item

**Fire Safety**

◆ Code Red = Fire  
  • Know locations of fire extinguishers, pull stations, RACE and PASS  
◆ RACE = Rescue/Remove, Activate alarm, Confine, Extinguisher/Evacuate  
◆ PASS = Pull, Aim at the base, Squeeze, Sweep back and forth  
□ Exit corridors — Keep clear, do not prop doors open.  
□ 3-foot clearance — keep a 3-foot clearance around fire alarm pull station, fire extinguisher, electrical panels.  
□ Sprinkler heads — 18” clearance.  
□ Oxygen cylinder storage — Secure all cylinders; separate FULL (new/unused) cylinders from other cylinders.  
□ Oxygen cylinder segregation — Oxygen cylinders are stored separately from all other gasses.  
◆ Oxygen shut-off procedure  
  • When: Oxygen is fueling the fire and you are not able to stop the flow at the medical gas outlet.  
  • Who: Only the person in charge (or designee) shall authorize the shut-off of medical gas.  
  • Confirm: Shutting off oxygen will not affect other patients.

**Emergency Management**

◆ Code Blue/White = Resuscitation Adult/Child  
  • Note time, summon help, start CPR  
  • Inpatient and Procedural Area (B23 3rd Floor): call 6123  
  • Outpatient Areas: call 911  
◆ Rapid Response = Resuscitation Adult  
  • Recognize early warning signs of patient deterioration  
  • Call 6123
Code Triage = Alert, Internal, External, Surge
- Be prepared for increased activity.
- Stand by and wait for further instructions from the Command Center.

Earthquake
- Drop, cover, and hold on

Medical Equipment
- Medical equipment failure
  - Ensure continued life support.
  - Remove equipment from service, tag to prevent further use.
  - Notify your supervisor and complete an incident report.
- Visual inspection of equipment prior to use (do not use if there is evidence of damage).
  - Preventive maintenance tag — Ensure inspection tag is current.
  - RPTs (surge protectors/power strips) — clinical areas (patient care rooms, operating/procedure rooms) have biomedical inventory tag

Safety / Security
- Emergency Bathroom Access — Know how to access locked restrooms and where the access tool is located.
- Incident reporting — Contact your supervisor and complete an online SQIS incident report anytime deviations from the usual practice occur.
- Code Gray = Verbally aggressive, violent, or threatening person
  - Activate emergency call button if available, call 6123 for assistance.
  - Secure area to prevent others from entering location.
- Code Silver = Hostage/Weapon/Active Shooter
  - Activate emergency call button if available, call 6123 for assistance.
  - Do not interfere with person committing the crime/creating the disturbance.
  - Remember the 4 A’s — Accept, Assess, Act & Alert

Physical Environment
- Furnishings and equipment — Safe and in good repair.
- Patient areas — Clean and free of offensive odors.
- Lighting and ventilation — Suitable for services provided. Air vents are clean and free from dust.
- Floor, walls and ceilings — clean, dry, in good condition
Horizontal Surfaces (e.g. light fixtures, door frames, picture frames, shelves) — clean and free from dust

Work/Storage areas — clean, free from clutter/hazards (cardboard boxes not stored directly on the floor)

Common equipment — clean (THINK about items such as thermometer holders, glucometers, isolation carts, linen hampers)

Common use areas and common use sinks — clean and free from clutter

Trash cans and linen carts — not overflowing

Utility Systems

- Red outlets are for emergency power.
- Ensure proper airflow is maintained by keeping doors closed that are on an automatic closer. This is critical in sensitive areas (e.g. operating rooms, isolation rooms, clean and dirty utility rooms) or locations near sensitive locations.
- Utility failures
  - Ensure continued life support.
  - Utilize back-up sources (electrical — RED outlet, oxygen cylinders, portable suction, etc.).
  - Use downtime procedures

Hazardous Materials/Chemical Safety

- Hazard communication — Know the type of the chemicals you work with and the proper PPE for safe use.
- Code Orange = Chemical or radiation incident/spill
- SDS = Safety Data Sheet — access chemical information online.
- Eyewash stations — Weekly logs up-to-date documenting weekly flow.
- Medical waste — Stored appropriately:
  - In a secured area; labeled, rigid containers with lid.
  - Red bags not directly on the floor/ground; Containers not overflowing.
- Chemicals/hazardous waste
  - Labeled and stored properly.
  - Appropriate PPE is used.
  - Inventories are up to date (chemicals).
- Lead aprons — Should have an inventory number.
  - Lead aprons should be visually checked before each use.
Frequently Asked Questions

1. After I open a multi-dose vial of medication, what should I do?
   Label with expiration date, which is 28 days after opening or manufacturer’s expiration date, whichever is shorter.

2. What is exempt from the 28-day expiration dating?
   Vaccines and patient-specific allergens expire per manufacturer’s recommendation. Ophthalmic and otic drops and ointments used for more than one patient expire seven days after opening.

3. What is the difference between a dose verification and an independent double-check?
   **Dose verification:** prior to administration, the administering practitioner prepares and obtains the medication, and a second qualified practitioner verifies that the intended medication and dose were prepared and obtained. Dose verification is not an independent process and does not require documentation in the eMAR. A dose verification is only performed prior to administration of IV push heparin, SQ/IV push insulin, IV push hypertonic 23.4% saline, and EPINEPHrine syringes drawn up or infusion bags prepared outside of Pharmacy.

   **Independent double-check:** a process whereby, prior to administration, after the administering practitioner programs the pump, a second qualified practitioner independently reviews the order, the medication and the pump settings. An independent double-check requires documentation in the eMAR. An independent double-check should also occur at hand-off and at shift change. The medications that require an independent double-check are amiodarone, chemotherapy infusions, epidural infusions, epoprostrenol (Flolan), heparin, argatroban and alteplase (t-PA) infusions, investigational medications, insulin infusions, patient-controlled analgesia (PCA) infusions, and treprostinol (Remodulin).

4. When does a medication need to be labeled?
   Any time there is a break in the process between preparation and administration. Also, if the person preparing the medication is not administering the medication.

   During procedures, all medications removed from the original container must be labeled including syringes, medicine cups and basins.
5. **What should a medication label include?**
   - Medication or solution name, strength, and amount if not apparent from the container
   - Diluent name and volume, if not apparent from the container
   - Date prepared
   - Expiration date when not used within 24 hours
   - Expiration time when expiration occurs in less than 24 hours

6. **Why is Tall Man lettering used on medication labels?**
   Tall Man lettering is a safety strategy used for look-alike, sound-alike medications to draw attention to the dissimilarities between drug names by highlighting a unique portion of the drug’s name; therefore, reducing the risk of selecting the wrong medication.

7. **To whom do I report issues?**
   Think “chain of command” and what kind of communication exists between the leadership and the staff on your unit. We must have optimal communication based upon relative urgency. See “Chain of Command” policy. We also have the online Incident Reporting System, called SQIS (Safety & Quality Information System) which is located on the intranet home page.

8. **Where can patients find information about how to contact The JointCommission if they have concerns or comments?**
   Three places:
   - On the UC Irvine Health webpage (www.ucirvinehealth.org)
   - In the inpatient bedside guide
   - In the patient rights brochures, which are available in the ambulatory practices.

9. **What performance improvement activities is your unit/area participating in?**
   Your answer will be specific to where you work. You might be participating in efforts to reduce pressure ulcers, falls, VTE CAUTI or CLABSI. Perhaps you are working on improvements in early mobility throughput, discharge by 11 a.m., or efforts to ensure ambulatory visits with specialists happen quickly. Don’t forget to share information about our organizational goals such as efforts to improve hand-hygiene and HCAHPS inpatient “staff responsiveness.”
10. **Who can shut off the oxygen and when?**
   Only the person in charge or designee is allowed to authorize shutting off the oxygen. Any staff member can do this if authorized. Oxygen is shut off if the medical gas is fueling the fire.

11. **What do you do if there is a fire?**
   Follow hospital fire plan:
   **RACE**
   - **R**escue anyone in danger,
   - **A**ctivate the alarm by pulling the pull station or calling the emergency number,
   - **C**ontain the fire by closing the fire area door, and
   - **E**vacuate the area if fire/smoke spread or **E**xtinguish if trained and safe to do so using the **PASS** procedure
   **PASS**
   - **P**ull the pin,
   - **A**im the nozzle at the base of the fire,
   - **S**queeze the handle and
   - **S**weep from side to side

12. **What temperature should the blanket warmer be set at?**
   No greater than 130°.

13. **How are oxygen tanks stored and separated in patient care areas?**
   Oxygen cylinders must always be secured in a rack or appropriate portable storage device. FULL (new/unused) oxygen tanks are separated from all other tanks. This is done to ensure a full cylinder is always available when needed.

14. **How long can chlorhexidine (CHG) cloths stay in the warmer?**
   CHG cloths must be used within 84 of being placed in the warmer. The warmer light stays green for 84 hours and then turns red. Red light indicates the package should be discarded.

15. **Where do you get more information on what to do in an emergency?**
   Refer to the flip chart. Be able to identify where the flip chart is located in your area.

16. **How do I know if the patient has received immunizations?**
   Immunization records given can be found on the “Clinical Summary” tab on the “Significant Events and/or Health Management” tile.
17. How is “competency” determined?
Competency is the determination of an individual’s ability to perform the expectations of his or her job, to meet the needs of the patient served. The required competency skills are determined based on the population served. Competence of all staff is assessed, evaluated, maintained and improved continually. Job performance is evaluated on an annual basis.

18. What is “population specific” competency?
Population specific competency is developed to ensure that staff have the knowledge to care for the patients they encounter. Competencies include age-specific, gender-specific, culture, and disease specific such as heart failure, diabetes, obesity, etc. The purpose is to ensure that all aspects of a patient’s characteristics are taken into consideration when providing care.

19. How do I validate if a physician is competent to perform a procedure?
Physician professional privilege can be found on the intranet on the Medical Staff/Allied Health Professional Privilege page.
20. **What two patient identifiers are used when providing care, treatment, and services?**
   The two patient identifiers used are:
   - Patient’s name
   - Medical record number or date of birth

   A patient’s identity should be verified whenever the healthcare provider is administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatment.

21. **Do you have a diet manual on this unit?**
   Yes, it is available electronically and can be found on the Quick Links on the intranet.

22. **What is “culturally responsive care”?**
   It means providing personalized healthcare and services that acknowledge and respect the patient’s cultures, beliefs and practices, and improves intercultural communication skills.

23. **What is the policy regarding surgical attire?**
   Surgical scrubs (green) cannot be worn off campus or routinely in the Ambulatory Practices. Hats, masks and shoe covers must be removed when leaving the procedural area. Surgical scrubs should **NOT** be worn home, but should be returned to the ScrubEX at the end of the work day so they can be laundered in a hospital approved facility.

24. **When is pain assessed?**
   Pain is assessed with each set of vital signs. After pain medication is administered, reassessment is performed and documented in a manner appropriate to the route of pain control given.
25. When should I use an interpreter?

A medical interpreter is needed whenever the caregiver does not speak the preferred language of the patient.

Bilingual Staff:
- Bilingual staff may use their language skills to care for patients within their scope of practice.
- Bilingual staff cannot be used as third party interpreters unless they have been assessed for proficiency.
- Proficiency assessed bilingual staff may assist as interpreters.

Family members:
- Children can never be used as interpreters.
- Adult (18 years or older) cannot be used as interpreters, except in emergency situations where there is no other alternative.

Language preference is found in the Clinical Summary:

<table>
<thead>
<tr>
<th>Item</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Language</td>
<td>English</td>
</tr>
<tr>
<td>Interpreter Needed</td>
<td>no</td>
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<tr>
<td>Education Method Preference</td>
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<tr>
<td>Education Barriers</td>
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</tr>
<tr>
<td>Preferred Language</td>
<td>English;</td>
</tr>
</tbody>
</table>

26. Where do I find information about a patient’s code status?

The patient’s code status can be found under the following three tabs in the EMR:
- Document Tab
- Orders Tab
- Handoff Tab
Document Tab

- It is documented on the structured note, Code Status Determination.

Orders Tab

- It displays at the top of the Orders sections under Patient Safety.

Handoff Tab

- It displays under Code Status.