Observer Orientation
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* Indicates forms to be printed and returned
Observation/Shadowing Application

Name: ____________________________________________

Address: ____________________________________________

Phone: ____________________________________________

Reason for Request: ____________________________________________

Area of Interest: ____________________________________________

List of Requirements for Shadowing

_____ Release Form Signed

_____ Confidentiality Statement/Ethical Standards/Service Excellence Signed

_____ Orientation Test Completed

_____ Immunizations with Documentation

_____ Urine Drug Screen within 6 months

_____ Background check (within 1 year)
CONFIDENTIALITY/NON-DISCLOSURE AGREEMENT

Confidential information is valuable, sensitive, and protected by law as well as by St. Anthony Shawnee policies. The intent of these laws and policies is to assure that confidential information will remain confidential and will be used only as necessary to accomplish St. Anthony Shawnee business. Failure to keep confidential information confidential could cause harm to the patient, family, or the hospital and could also result in a lawsuit against the hospital and/or the employee who disclosed the information.

Through my affiliation with St. Anthony Shawnee, I may gain access to confidential information including, but not limited to; patient information both written and spoken, financial information, employee personnel records and/or salary information, strategic business initiatives, quality improvement activities, or other information. Accordingly as a condition of my employment-affiliation and in consideration of my privileges to access confidential information I agree to abide by the following:

1. I will not access confidential information for which I have not legitimate need to know. Accessing information without a job related need is prohibited.

2. I will not at any time during or after my employment at St. Anthony Shawnee divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as specifically authorized by the law, Hospital, or by the President or Vice-President of St. Anthony Shawnee.

3. I will not disclose my computer password to anyone else for any reason, nor will I utilize another user’s password in order to access the computer system. I accept the responsibility for all activity occurring under my password.

4. I will not operate any non-licensed software on any computer.

5. I understand that all electronic communications may be monitored and is subject to audits.

6. I understand that disclosing confidential information could result in damages being sought against myself and/or the hospital. I agree to indemnify and hold St. Anthony Shawnee harmless against any loss or liability (including costs and expenses of litigation) resulting from my unauthorized disclosure of confidential information.

7. I understand that failure to comply with this agreement will result in disciplinary action, which may include, but is not limited to, termination employment affiliation at St. Anthony Shawnee.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE AGREEMENT AND PROMISE THAT I WILL ABIDE BY THE ABOVE TERMS AND WILL MAINTAIN CONFIDENTIAL INFORMATION AT ALL TIMES.

__________________________             __________________________
Signature                                      Date

__________________________             __________________________
Printed Name                                 Affiliation with SASH
St. Anthony Shawnee
Shadowing/Observation Program Release

I, _______________________, as part to the Shadowing/Observation Program, desire to observe health care professionals at St. Anthony Shawnee. I acknowledge that I am voluntarily participating in this program under my own free will and not pursuant to the advice or direction of anyone at St. Anthony Shawnee. I further acknowledge that I am not an employee of St. Anthony Shawnee.

By signing this release form, I understand and acknowledge that any information regarding a patient of St. Anthony Shawnee, including but not limited to the patient’s condition, care or status is considered confidential information and is not to be discussed with anyone except those authorized to deal with the patient. I understand that I am not authorized to by St. Anthony Shawnee to discuss a patient’s confidential information and that by doing so I would be immediately excluded from any further observation privileges and would be subjecting myself to personal liability to the patient and a possible lawsuit by the patient. I further acknowledge that I am not to perform any “hands on” patient care during the observation.

I hereby release and agree to hold harmless St. Anthony Shawnee from any and all liability demands, suits, claims or judgments of any nature with arise out of my participation in the Shadowing/Observation Program at St. Anthony Shawnee.

My signature verifies that I have read, understood and agree with the contents of this form and I agree that this shall be binding on me, my heirs, assigns and personal representative.

____________________________________
Signature

____________________________________
Date
In order to comply with the mandatory health requirements according to the Oklahoma State Department of Health and our hospital policies, you must provide copies of official documentation of your immunity status by providing one of the types of documentation as listed below. Indicate which type of documentation you are providing by placing the dates in the columns provided and **ATTACH ALL COPIES** of original documentation to verify dates. School records are transcribed records and are **not** considered official documentation.

Name: ______________________________________________________ Date: __________________

Phone Number: ___________________ DOB: ___________________ Dates of Observation: ___________________

<table>
<thead>
<tr>
<th>Please provide a copy of your documented immunity to the following:</th>
<th>Give Dates</th>
<th>Give Dates</th>
<th>Give Dates</th>
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<tbody>
<tr>
<td>School transcripts with <strong>NOT</strong> suffice. <strong>MUST</strong> have copies of official documentation.</td>
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<tr>
<td><strong>I.</strong> 2 TB skin tests, latest less than 365 days old, second must be less than 365 days from the current. <strong>OR</strong> IGRA. If TST past positive, current CXR <strong>or</strong> current approval from local Health Department (less than 1 year old).</td>
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<td><strong>II.</strong> Rubella (3-day) Measles Immunity:</td>
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<tr>
<td>a. Positive serological titer - IgG</td>
<td></td>
<td></td>
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<tr>
<td>b. Documented evidence of Rubella vaccination on or after 12 months of age.</td>
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<tr>
<td><strong>III.</strong> Rubeola (Hard) Measles Immunity:</td>
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<tr>
<td>a. Positive serological titer - IgG</td>
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<tr>
<td>b. Documented evidence of 2 Measles vaccination on or after 12 months of age.</td>
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<td><strong>IV.</strong> Mumps Immunity:</td>
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<tr>
<td>a. Positive serological titer - IgG</td>
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<tr>
<td>b. Documented evidence of 2 Mumps vaccination on or after 12 months of age.</td>
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<td><strong>V.</strong> Varicella (Chicken Pox) Immunity:</td>
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<tr>
<td>a. Positive serological titer - IgG</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Documented evidence of 2 Varicella vaccination on or after 12 months of age.</td>
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<tr>
<td><strong>VI.</strong> Hepatitis B immunity:</td>
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<tr>
<td>a. Positive serological titer - HBsAb</td>
<td></td>
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<tr>
<td>b. Documented evidence of 3 vaccines received</td>
<td></td>
<td></td>
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<tr>
<td>c. Declination form signed with copy attached</td>
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<td><strong>VII.</strong> Influenza vaccination Oct – June. Flu shots can be declined for a medical reason, but must be accompanied by a physician’s note detailing the reason. Religious declinations must be signed by the clergy stating church doctrine.</td>
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<tr>
<td><strong>VIII.</strong> Tdap vaccination. Again, can be declined for a medical reason, but must be accompanied by a physician’s note detailing the reason. Religious declinations must be signed by the clergy stating church doctrine.</td>
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This criterion must be met and documentation provided prior to be granted privileges at SASH. If you have any questions regarding the above requirements, please feel free to call Cleda Byrum, RN Employee Health Nurse at 214-1569. Please provide documentation at least 2 weeks in advance of clinicals. Health Information **ONLY** may be faxed to 878-3427. **No packets may be faxed to this number**, health records only. It can also be e-mailed to Cleda.byrum@ssmhc.com. Packets are faxed to 405-878-3465.
COMMITMENT TO OUR PATIENTS AND THEIR FAMILIES – Everything we do is designed to provide exceptional care for our patients, their families, and the communities we serve. We reflect ethical and proper business practices in all we do.

BUSINESS ETHICS – All employees must represent SSM Health Care accurately and honestly and must not engage in any activity intended to defraud anyone of money, property, services, or care. All SSM Health Care employees must pay careful attention to business transactions with suppliers, contractors, and other third parties. Employees must not accept offers that would result in personal benefit. This includes gifts, favors and other incentives to perform work in a way that benefits outside parties. Only trivial items like pens and pencils may be accepted from a vendor.

LEGAL COMPLIANCE – SSM Health Care is committed to conducting all of its activities in compliance with applicable federal, state and local laws. These laws pertain to human resource activities, fraud and abuse in the Medicare and Medicaid programs, lobbying and political activity, and many other areas. See the attached written information about SSM Health Care’s commitment to compliance with federal and state laws related to the false claims and whistleblower protection.

CONFIDENTIALITY: PRIVACY & SECURITY OF INFORMATION – All SSM Health Care employees must maintain the confidentiality of patient information (HIPAA) and of confidential information concerning employees.

CONFLICTS OF INTEREST - A conflict of interest is any situation where an employee has a financial or business interest that might be in conflict with the financial or business interests of SSM Health Care. All employees must avoid conflicts of interest or the appearance of conflicts of interest. If a potential conflict of interest exists, make people aware of it, as well as the impact it could have on our patients and their families or on the organization. Talking about conflict-of-interest issues with your supervisor, other entity managers, or the Corporate Vice President – Corporate Responsibility can clarify whether a true conflict exists.

HARASSMENT – SSM Health Care policies forbid harassment or sexual harassment and all individuals shall refrain from engaging in any of the activities including, but not limited to: intimidation, hostile acts relating to employee’s race, color, gender, religion, national origin, age or disability, unwelcome sexual flirtation, propositions or sexual degrading words.

DUTY TO REPORT – Employees and contract employees are obligated to report to their immediate SSMHC supervisor, senior manager, Corporate Responsibility Office (314-994-7724) or the CRP Help Line (1-877-4CRP-ASK), any matter which they believe is an ethical, legal, regulatory or policy matter which may be a violation. It is prohibited in any way to harass, discipline or apply pressure from any source in the organization to any employee who reports a matter he or she believes in good faith requires investigation.

ONE LEVEL OF PATIENT CARE – All SSM Health Care operating entities will provide patient care services at the same level to all patients with the same health care problems regardless of the source of payment. Furthermore, it is our policy that insurance status, ability to pay, race, and other such issues are irrelevant to the need to provide emergency medical services.

My signature below indicates my agreement with the following three statements:

1. I have read and understand the above SSM Health Care policies and any other department policies that have been given to me, and I agree to abide by them.

2. To my knowledge, I have not been excluded from participation in any Federal Health care program, or any form of State Medicaid program, and to my knowledge, there are no pending or threatened governmental investigations that may lead to such exclusion.

3. I understand that I am obligated to notify you within seven (7) business days, if I have received notification of exclusion from any Federal health care program or any form of State Medicaid program during the completion of my work assignment at any SSM Health Care Entity.

SIGNATURE: ___________________________ DATE: ___________________________

PRINT NAME: ___________________________
SSM Health Care Exceptional Service Standards
By signing below, you agree to comply with SSM’s Exceptional Service Standards

COMPASSION – We reach out with openness, kindness and concern.
1. **Be friendly** to patients, families and co-workers. **Smile** and **use greetings** such as good morning, good afternoon, etc. When providing service, **introduce yourself**, **explain your purpose**, and ask, **“How may I help you?”**
2. **Avoid delays**, but if they happen, **apologize for any problems** they may cause.
3. **Show concern** for patients, families, physicians, and co-workers. When they are upset or anxious, **listen closely** to what they have to say and be **supportive**.
4. Do your part to **make sure that everyone feels appreciated**, valued, and that they belong. Do not offend, embarrass, or gossip about the people around you or anyone else.

RESPECT – We honor the wonder of the human spirit.
1. **Respect the privacy** of our patients, families, physician and co-workers. Share information only on a need-to-know basis. Knock on doors before going in – including patient rooms or offices.
2. When you are talking, always **use words like “please” and “thank you”, “ma’am” and “sir”**. Avoid using slang words, acronyms or confusing terms. Use appropriate surnames such as Ms., Mrs., Mr., or Dr., unless asked to do otherwise. Don’t use words that could be demeaning like “honey” or sweetie”.
3. **Be open to new ideas** and different points of view.
4. **Discuss and resolve differences constructively**. Go directly to the person(s) involved and share concerns or go to the appropriate manager.

EXCELLENCE – We expect the best of ourselves and one another.
1. Use best practices and Continuous Quality Improvement (CQI) to change and make things better. **Look for ways to improve and share good ideas**.
2. **Meet the needs of our patients, families, physician and co-workers**. Never say, “It’s not my job.” If you cannot help with something, find the person who can.
3. **Help each other keep the standards of behavior**, and follow policies and procedures.
4. **Accept responsibility** for doing your job the right way; be proud of your work. Learn from your mistakes and help others who are learning from their mistakes.

STEWARDSHIP – We use our resources responsibly.
1. **Use resources wisely and responsibly**. Help eliminate waste and share cost saving ideas.
2. **Be open to new ways of doing things**. Accept that there may be changes in direction, priorities, schedules, and responsibilities.
3. **Maintain a well organized environment**. Pick up trash and pick up after yourself. A clean work area is the responsibility of every one.

COMMUNITY – We cultivate relationships that inspire us to serve.
1. **Welcome new people**. Be supportive. Offer to help and set an example of cooperation.
2. **Thank patients, families, physicians and all customers for the opportunity to serve them**.
3. **Let patients, families and visitors enter or exit elevators or doors first**.

Signature: _______________________________          Date: _______________________________
Name ____________________________ Date __________________________

**General Safety Questions:** You must score a 90% on this test or will have to repeat the test.

1. When a fire is in your area, the appropriate response at St. Anthony Shawnee is **Remove-Alarm-Confine-Extinguish.**
   
<table>
<thead>
<tr>
<th>True</th>
<th>False</th>
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2. Code Red is the code announced in the event of a fire.
   
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<th>False</th>
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3. To call a Code Blue at the hospital, the correct number to dial is 1000.
   
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<tr>
<th>True</th>
<th>False</th>
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4. Code Blue is announced indicating a patient medical emergency.
   
<table>
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<tr>
<th>True</th>
<th>False</th>
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5. A Code Orange is called when there is an assaultive potentially injurious situation.
   
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<tr>
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<th>False</th>
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6. If a patient raises a fist as if to hit you, step closer to the patient to calm them down and attempt to grab the closed fist.
   
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<tr>
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7. The single most important strategy for preventing infection in the hospital is handwashing.
   
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8. The patient admitted with a diagnosis of “Chickenpox” should be placed in Standard and Airborne Precautions only.
   
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<tr>
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<th>False</th>
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9. A student must wear a surgical mask when entering the room of a patient in “Airborne Precautions”.
   
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<tr>
<th>True</th>
<th>False</th>
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10. The symptoms of Tuberculosis are: shortness of breath, increase appetite and diarrhea.
    
    | True | False |
    |------|-------|
    |      |       |

11. It is appropriate to discuss patient information in the elevator and cafeteria.
    
    | True | False |
    |------|-------|
    |      |       |
12. Security is increased when you use common sense such as, locking your car, parking in lighted areas, and securing your belongings.

   True   False

13. SDS stands for Safety Data Sheet.

   True   False

14. If you need to access an SDS, you can find it on-line.

   True   False

15. The NFPA (National Fire Protection Association) label on chemicals identifies the information you need to know about that chemical.

   True   False

16. In the event of a hazardous material spill your responsibility is to clean up the spill.

   True   False

17. If you are involved in an exposure incident, the first person you call is your instructor.

   True   False

18. “Code Pink” is the security code called for an infant cardiac arrest.

   True   False

19. What are the two safety areas that we ask you to align with us on?

   ____________________________________________________

   ____________________________________________________

HIPPA Questions:

20. What does the acronym HIPAA stand for?

   ____________________________________________________

21. Under the HIPAA Privacy Rule, PHI is health information which can be linked to a particular person including the individual’s past, present or future physical or mental health or condition.

   True   False

22. It is permissible to look up a patient’s electronic medical record on the computer when:

   a. The patient is my family member and I am concerned about their health
   b. The patient has an interesting health history and I can learn from reviewing their record
   c. The information I access pertains directly to the care I am delivering to the patient
   d. All of the above
23. Which of the following statements is NOT true regarding the access and/or disclosure of PHI?
   a. Since the HIPAA Privacy Rule protects only electronic and paper PHI, you may discuss patient information with your family and friends as long as you trust them to keep it confidential.
   b. Criminal penalties can range up to $250,000 and or up to 10 years in prison for inappropriate release of PHI.
   c. The HIPAA Privacy Rule protects all PHI in any form or media, whether electronic, paper or oral.
   d. Students may be disciplined up to and including termination of clinical placement for improperly accessing or disclosing PHI.

24. What recent legislation is resulted in significant changes to HIPAA Privacy and Security standards?

________________________________________________________________________

25. It is alright to tell friends on Facebook that you cared for a patient with HIV in your clinicals today, without mentioning any names.
   True          False

26. Effective February 17, 2010, Business Associates are now liable for a breach of privacy under HIPAA.
   True          False

27. Employees and others who wrongfully obtain or disclose PHI held by a covered entity cannot face criminal penalties.
   True          False

28. What is the maximum penalty allowed per violation for a breach that is determined as “willful neglect and not corrected”?
   __________________________________________________________________________

29. ARRA mandates that HHS conduct __________________ to ensure that covered entities are in compliance with HIPAA Privacy and Security requirements.

30. Phone numbers can be considered private information and covered under the HIPAA guidelines.
   True          False

31. If you have diarrhea or vomiting, when may you return to observing:
   a. The day after your symptoms resolve
   b. When Employee Health gives the okay
   c. It is alright to stay and finish your shift
   d. All of the above

32. It is appropriate for an observer in a clinical area to wear artificial nails or gel nails as long as they are not chipped.
   True          False

33. If you have tattoos, they must be covered regardless of whether or not you are touching a patient.
   True          False
Welcome to St. Anthony Shawnee!

Our Mission

Through Our Exceptional Health Care Services, We Reveal the Healing Presence of God

OUR VALUES

In accordance with the philosophy of the Franciscan Sisters of Mary, we value the sacredness and dignity of each person. Therefore, we find these five values consistent with both our heritage and ministerial priorities.

***

COMPASSION

We reach out with openness, kindness and concern.

RESPECT

We honor the wonder of the human spirit.

EXCELLENCE

WE expect the best of ourselves and one another.

STEWARDSHIP

WE use our resources responsibly.

COMMUNITY

We cultivate relationships that inspire us to serve.

We want to welcome you to St. Anthony Shawnee. St. Anthony Shawnee is a progressive healthcare facility striving to be the best we can be.

It is our desire for you to positively impact your life as well, by providing a positive learning experience while at our facility. To prepare your observation/shadowing experience, you must complete an orientation to our facility.

Please read the packets material and sign the forms. When you have completed, return the proper forms to the coordinator.

If you have questions, please make note so they can be addressed when you arrive.
Confidentiality

Webster defines confidential as that which is communicated as secret; information which is not to be divulged.

The Patient’s Bill of Rights provides the patient with the right to privacy and confidentiality. In 1996 the Health Insurance Portability and Accountability Act (HIPAA) was put in place. HIPAA’s privacy and security regulations govern the release and use of protected health information. Protected health information (PHI) is anything that can be used to identify a patient or a patient’s condition.

In an effort to protect this right, as well as comply with HIPAA regulations, all patient information is confidential, which means the information you might gain during your clinical rotation is not to be divulged to others. If documenting a journal or discussing cases in a clinical group, use only initials or diagnosis to identify your patient. Also it is not permissible to copy any patient information, chart, etc. This is property of the patient and/or hospital.

When on a break in the snack bar, while eating in the cafeteria, or while in the elevators, please be cautious about discussing patient information. It is also important to be discreet on the nursing units and in the halls when discussing the patients.

In an attempt to assure confidentiality, hospital employees, students, instructors and contract personnel must sign a Non-Disclosure Agreement (confidentiality form). This form is included in this packet. This must be returned to the hospital and kept on file.
Culture of Safety

At St. Anthony Shawnee, it is our goal to provide a safe environment for all those who enter our doors. We always try to keep our patients safe, but we wanted to improve. We knew it would be a challenge and would take time and effort on the part of everyone. We would have to think safety at all times, and it would be a culture change. So the concept of the “Culture of Safety” was born.

A Culture of Safety is not just spoken into existence. It takes each person aligning their thoughts and practices with the “Culture of Safety” on a continual basis.

The commitment began with the board of directors, administration and directors. Then the personnel were asked for a commitment. So on a daily basis we work together to strive for a “Culture of Safety”.

As a student, we ask that while you are here, align with our “Culture of Safety” and think and practice safety at all times.

Part of the “Culture of Safety” is that we adopted the National Patient Safety Goals (NPSG) as our own. On the following page you will find a list of them.

There are two areas of safety that we ask you to align with as you are delivering services. Those are:

1. Wear your St. Anthony Shawnee identification badge at all times
2. Use a double identifier with the patients with who you are working

Also on the following pages are some of the emergency codes and your responsibilities.
Fire/Life Safety

According to The Joint Commission on the Accreditation of Hospitals Organization (TJC), Life-safety is providing a fire-safe environment for care.

To help ensure this, St. Anthony Shawnee conducts fire drills. The drill or the “real thing” will be announced as, “Code Red”.

At St. Anthony Shawnee Hospital a Code Red can be called by dialing 1000 and give the location. This is repeated three (3) times.

At the Clinic, Dial 0 to report a fire.

The response to fire at St. Anthony Shawnee is:

R - Remove everyone from immediate danger.
A - Activate the nearest fire alarm. One employee should do this while another makes the call to report the fire.
C - Confine the fire. All doors and windows should be closed to prevent a spread of smoke and flames.
E - Extinguish/Evacuate - Extinguish if the fire is manageable such as a wastebasket. If possible two employees should fight the fire together using two fire extinguishers.

As a student when a Code Red is called, report to the department manager or their designee for your assignment.

St. Anthony Shawnee is a smoke-free environment. If you want to smoke, you need to go off campus.
Code Blue

At St. Anthony Shawnee, a Code Blue is a medical emergency situation with a patient, in which resuscitation may or may not have to be implemented.

Because there are two campuses, there are two methods to call a Code Blue.

Dial extension 1000 and give the location.

At the Clinic, it is called a Code 99. Dial 0 to report an unresponsive patient.

While you are here as an Observer you will not respond to a Code Blue unless your hospital staff partner is caring for that particular patient, or if you are directed to do so by the manager or their designee. You may not assist in any way with the code.
Hazardous Materials
Right to Know

People who work with hazardous substances have a legal right to know about the hazards they face on the job. They also have a right to know how to protect themselves - and others - from those hazards.

The OSHA Hazard Communication Standard gives you the right to know about chemical hazards. Manufacturers must provide hazard information on labels and material safety data sheets (SDS). St. Anthony in turn provides the employee, student, contract service personnel and physician access to any appropriate SDS.

In each department of the hospital there is a SDS book. In this book an SDS for any chemical utilized in that particular department is present. It is your responsibility to know the location of the book and use the provided information. We also have an on-line portal that can be utilized to look up an SDS if you have computer access.

NFPA (National Fire Protection Association) labels are provided to label any containers which do not already have such labeling. The labels address hazards and safety issues about the chemical.

In all areas where chemicals are used, an eye wash station is nearby. Locate the eye wash station in your area, and request a demonstration on how it is used.

In the event of a spill of a hazardous material, (Code Orange), these are the steps to follow.

1. Evacuate or leave the area.
2. If the area has a door, close the door behind you.
3. Rinse chemical from any exposed body area and from clothing.
4. Notify the supervisor or Safety Officer (878-3491) immediately for a spill response.

A Code Orange is only called on the authority of the highest Administrative person on duty at the time.
**Security**

It is important to stay safe while you are at clinicals. If you see someone acting in a threatening, hostile or belligerent manner in possession of a weapon, immediately move a safe distance from the individual. If possible without putting yourself in danger, move others away from the area also. Call 9-911 from a hospital phone or 911 from a cell phone.

There are certain security issues which you should be aware of while here as a student.

Wear your name badge so everyone will know your name and in what capacity you function.

Please secure your belongings while you are here. You can secure them in the department where you are doing your clinical, or in the trunk of your car.

If you should be doing clinical rotations in the evening or at night, park your vehicle in a lighted area. The front parking lots are lighted at night. There is also a security guard available to observe while you walk to your car.

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**Code Brown**

A bomb threat is called a Code Brown. If you happen to receive the call or receive information that there is a bomb in the area, get as much information as possible. Try to remember the sound of their voice – male or female, accent, serious or laughing, etc. Dial 1000 at the hospital or 0 at the Clinic.
Code Pink – Infant/Child Abduction

The purpose of the “Infant/Child Abduction Plan – Code Pink”, is to ensure a timely, efficient, and appropriate response to an infant or child abduction and to facilitate rapid recovery of the abducted infant/child. The process is as follows:

**Activation**
- Anyone who has knowledge of or suspects an infant/child has been abducted or is missing, has the authority to activate the “Code Pink”.
- Immediately notify the police department by dialing 9-911.
- Do not talk to or make a statement to the press or media; all releases will be made from Administration.

**Securing the Crime Scene or Location**
- Secure the crime scene or the location from with the infant/child is missing.
- Allow nothing to be touched or remove unless directed by the police department.
- Remove parent(s) from the room (location) and place in a private area.
- Assign and employee to stand at entrance to room/area and allow no one to enter without police authorization.

**Monitoring Exits**
- All exits from the building shall be monitored by employees and strongly request that all persons remain within the building until released by the police.
- Departments are assigned an exit to monitor depending on the time of day or day of week the alleged abduction occurred. You maybe asked to assist in this effort.

**Search Response**
- Employees not assigned to an exit will begin a search of the building for the infant/child, suspicious persons, or persons carrying backpacks or packages, etc.
- Upon completing search of assigned area, the Area Search Team Leader will contact the Incident Command Center (8110) and relay results.
- Upon finding the infant/child the Area Team Leader will immediately notify the Incident Command Center.

**Sighting of the Suspect**
- Shout “STOP” ; drawing attention to suspect.
- Shout for “HELP”.
- If you cannot safely detain the suspect without harm to self or child, wait for others to come and assist.
- Never attempt to physically take the infant/child from the abductor. Attempt to talk the abductor into voluntarily handing the infant/child to staff.
- Never confront or attempt to detain in anyway an armed suspect.

**All Clear**
- Once the missing infant/child has been located or the facility has been completely searched and the police have determined the child is not the building the Incident Commander will authorize an “All Clear Code Pink” announcement.
- The operator will announce “All Clear Code Pink” three times overhead.
Infection Control

St. Anthony Shawnee Infection Control Program encompasses the surveillance, prevention, and control of infection in all patients, employees, physicians, contract service personnel, volunteers, students, and visitors.

Our Infection Control policies/procedures comply with the guidelines/standards of practice of the regulatory agencies including, but not limited to, the CDC (Centers for Disease Control and Prevention), OSHA (Occupational Safety and Health Administration), TJC (The Joint Commission on the Accreditation of Hospitals Organization), OSDH (Oklahoma State Department of Health), and APIC (Association for Professionals in Infection Control and Epidemiology, Inc.), etc.

The elements covered on the pages that follow are policies with which you must be familiar while fulfilling your clinical at St. Anthony Shawnee.

Infection Control Policies

There are several Infection Control policies which are available as resources.

Please ask the supervisor of the department in which you are doing clinicals to ascertain the location of these policies.

Doing Clinical While Ill

It is never okay to do clinical when you are ill. If you have fever of 100.5, vomiting or having diarrhea, you must contact the Employee Health Nurse at 214-1569 to find out when you may return. As a general rule, you are contagious for up to 72 hours AFTER your symptoms resolve. You may not return until given permission from Employee Health or Infection Control.
OSHA Bloodborne Pathogens Standard

We adhere to the guidelines recommended by the CDC and OSHA Bloodborne Pathogens Standard. Remember, **HANDWASHING is the single most important measure to reduce the risk of transmitting disease from one person to another.** It is extremely important to wash your hands after removing gloves, before and after each patient contact, as well as after contact with blood, body fluids, secretions, excretions and equipment or articles contaminated by them. Alcohol Hand Rub is now available for use and should be limited to circumstances in which your hands are not significantly soiled.

In keeping with the OSHA Bloodborne Pathogens Standard, we do handle our linen differently than most other healthcare institutions. As you may know, the risk of disease transmission by soiled linen is negligible if it is handled and transported properly. Our laundry (commercial laundry) treats all the linen that it receives as contaminated with HIV, Hepatitis B, Hepatitis C, etc, and the individual in “receiving” wears the protective gear required for handling “contaminated linen”.

Because of the above-mentioned reasons, we place all of our linen, clean or soiled, into the blue, plastic linen hamper bags. If it is wet, then we roll it to the inside and drop it inside the leak proof linen hamper bag. We do not color-code or label our contaminated linen. Of course, one must be careful not to contaminate one’s uniform while handling the linen.

It is especially important that you **do not place** any linen inside a red, biohazard bag. Articles placed in red bags are incinerated!

All sharps (needles, etc.) are to be discarded in a needlebox. In the event you find a sharp not disposed of in a needle box, place the sharp in a “safe container”, and bring it to the Infection Control office.

**In case of an exposure contact Employee Health at ext 1569.**
OSHA TB Standard

Symptoms of active Tuberculosis Disease may include, but are not limited to the following:
- productive cough (greater than three weeks)
- night sweats
- loss of appetite
- malaise

In keeping within the OSHA TB Standard, no healthcare personnel will be allowed in an Airborne Precautions room unless that individual has been fit-tested and is wearing either a N95 or HEPA particulate respirator.

There are no exceptions to this rule.
Exposure Protocol

If you are unfortunate enough to receive an “exposure to blood/body fluids” here at St. Anthony Shawnee, you need to follow the EXPOSURE PROTOCOL CHECKLIST (see policy attachment). You must contact your instructor if you are involved in an exposure incident. You may report to the Employee Health Department or your private physician for assessment and follow-up care, etc. You will be held responsible for all charges incurred for this visit.
Standard & Transmission-Based Precautions

We are now using the new Standard and Transmission-Based Precautions (see attachment) recommended by the Hospital Infection Control Practices Advisory Committee, in conjunction with the Centers for Disease Control and Prevention.

**Standard Precautions** incorporates the major features of the “old” Universal Precautions and Body Substance Isolation Precautions. Standard Precautions are used with all patients.

**Transmission-Based Precautions** are implemented in addition to Standard Precautions. Transmission-Based Precautions are designed for patients documented or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens. There are three types of precautions:

1. **Contact Precautions**
2. **Droplet Precautions**
3. **Airborne Precautions**

(See attached for signs and symbols which are posted on the doors of patient rooms).

Our Infection Control Committee has also chosen to use Protective Precautions in order to protect our immunosuppressed/susceptible patients from diseases. These diseases are induced by pathogens in the environment or by people to who the patient is exposed.

The following pages are examples of the charts for each precaution.
Standard Precautions

STANDARD PRECAUTIONS

FOR THE CARE OF ALL PATIENTS

Handwashing
  Wash Hands after touching blood, body fluids, secretions, excretions and contaminated items. Wash hands immediately after removing gloves and between each patient contact.

Gloves
  Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and nonintact skin. Always change gloves between patients.

Mask & Protective Eyewear or Face Shield
  Wear mask & protective eyewear or face shield to protect mucous membranes of the eyes, nose, and mouth during procedures that cause splashes or sprays of blood or body fluids, secretions, or excretions.

Gown
  Wear gown to protect skin and prevent soiling of clothing during procedures and patient activities that may cause splashes or sprays of blood, body fluids, secretions, or excretions. Remove soiled gown as promptly as possible and wash hands.

Patient – Care Equipment
  Handle used patient-care equipment and articles soiled with blood, body fluids, secretions, or excretions carefully, prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to patients and environments.

Environmental Control
  Follow hospital procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds bedrails, bedside equipment, and other frequently touched surfaces.

Linen
  Handle and transport used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membranes exposures and contamination clothing, and that avoids transfer of microorganisms to other patients and environments.

Occupational Health & Bloodborne Pathogens
  Take care to prevent injuries from needles, scalpels, and other sharp instruments or devices Never recap needles using both hands Place sharps in needlebox immediately after use! Use mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth.

Patient Placement
  If possible, place a patient who contaminates the environment in a private room
Stop Sign Precautions

This sign is to be placed on the patient door to alert staff and visitors that the patient is in Contact, Droplet, Airborne, and Protective Precaution. One of the icons will then be placed on the door to identify which type of “Precaution” protocol to follow. The drop is for “DROPLET PRECAUTIONS. The Cloud represents “AIRBORNE PRECAUTIONS. The hand is the reminder for CONTACT PRECAUTIONS. The umbrella represents PROTECTIVE PRECAUTIONS.
Contact Precautions
This sign is placed in the room.

CONTACT PRECAUTIONS
(In addition to Standard Precautions)

PATIENT PLACEMENT
Private room, if possible. When a private room is not available, cohort with patient who has active Infection with the same microorganisms.

HAND WASHING
Wash hands with an antimicrobial soap immediately after glove removal and before leaving the patient’s room. After glove removal and handwashing, ensure that hands do not touch contaminated environmental surfaces or items in the patient’s room to avoid transfer of microorganisms to other patients or environments.

GLOVES
Wear gloves when entering the room if you anticipate any contact with the patient or the patient’s environment. Change gloves after having contact with infective material. Remove gloves before leaving patient room.

GOWN
Wear a gown when entering the room if you anticipate that clothing will have any contact with the patient, environmental surfaces, or items in the patient’s room. Remove gown before leaving patient room and ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other patients or environments.

PATIENT TRANSPORT
Limit the movement/transport of patient from room to essential purposes only. During transport, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other patients and contamination of environmental surfaces and equipment.

PATIENT - CARE EQUIPMENT
Dedicate the use of noncritical patient-care equipment (e.g. stethoscope, blood pressure cuff, bedside commode, thermometer, etc.) for each single patient. If common equipment is used, clean and decontaminate between patients.
Droplet Precautions
This sign is placed inside the patient room.

DROPLET PRECAUTIONS
(in addition to Standard Precautions)

Patient Placement
Private room, if possible. When a private room is not available, cohort with patient who has active infection with the same microorganism. Maintain spatial separation of 3 feet from other patients or visitors, if private room is not available.

Mask
Wear surgical mask when entering a patient room.

Patient Transport
Limit transport of patient from room to essential purposes only. Use surgical mask on patient during transport.
**Airborne Precautions**

This sign is placed inside the patient’s room

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**AIRBORNE PRECAUTIONS**

*(in addition to Standard Precautions)*

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**Patient Placement**

Use private room that has:
- Monitored negative air pressure,
- 6 to 12 air changes per hour,
- Discharge of air outdoors or HEPA filtration if recirculated.

*Keep room door closed and patient in room.*

**Respiratory Protection**

Wear an **N95 or HEPA-filter particulate respirator** when entering the room of a patient with known or suspected infectious pulmonary tuberculosis.

Susceptible persons should not enter the room of patients known or suspected to have measles (rubeola) or varicella (chickenpox) if other immune caregivers are available. If susceptible persons must enter, they should wear an **N95 particulate respirator**. (Respirator or surgical mask not required if immune to measles and varicella).

**Patient Transport**

Limit transport of patient from room to essential purposes only. Use **N95 particulate respirator** on patient during transport.
Protective
Precautions
This sign is placed in the patient’s room.

PROTECTIVE PRECAUTIONS
(in addition to Standard Precautions)

Handwashing
Wash Hands with an antimicrobial soap immediately after glove removal and before leaving the room.

Gloves
Wear gloves when entering the room. Change gloves after having contact with infective material. Remove gloves before leaving patient room. Put on clean gloves just before touching mucous membranes and nonintact skin.

Mask
Wear mask when entering the room. Remove mask after leaving patient room.

Gown
Wear gown when entering the room. Remove gown after leaving patient room.

Patient Transport
Limit transport of patient from room to essential purposes only. Use surgical mask on patient during transport.

Patient – Care Equipment
Dedicate the use of noncritical patient-care equipment (e.g. stethoscope, blood pressure, cuff, thermometer, etc) for each patient.

Patient Placement
Private room, if possible. Keep room door closed and patient in room.
1. Skin/wound exposure: WASH exposed skin WITH SOAP AND WATER ONLY; Eye exposure: FLUSH exposed eye(s) FOR 15 MINUTES.

2. CALL LABORATORY and give laboratory technician source patient's name and room number; if known. If unknown, DO NOT call the laboratory. DO NOT GO TO THE LABORATORY at this time, because testing will only be performed on the source patient.

3. NOTIFY EMPLOYEE HEALTH/INFECTION PREVENTION & CONTROL of exposure by phone.
   a. During day shift:
      1. North/South Campus - Call Ext. 1569
   b. During night shifts, weekends, or holidays:
      1. NOTIFY HOUSE SUPERVISOR so that he/she may call the Employee Health Nurse/Director of Infection Prevention & Control. If you have not received a call from either of them within 15 minutes, go to the Employee Locator and call Cleda Byrum at (420-9567). If no response, call Vicki Milliken (990-1170).

****If the source patient is a known HIV-positive reactor, contact Employee Health/Infection Control immediately!!!****
HAND HYGIENE POLICY

PURPOSE: To provide an effective hand care regimen for all healthcare professionals that will promote skin health/integrity while producing reductions in patient morbidity and mortality from healthcare-acquired infections.

POLICY: Hand hygiene is generally considered the single most important procedure for preventing healthcare-acquired infections. In an effort to reduce the risk of healthcare-acquired infections, St. Anthony Shawnee personnel shall comply with the current CDC Hand Hygiene Guidelines (as listed below):

A. Indications for Handwashing and Hand Antisepsis

1. If hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, hands should be washed with either a non-antimicrobial soap and water or an antimicrobial soap and water.
   a. Below are listed situations in which soap and water must be used to decontaminate hands:
      i. When hands are visibly soiled
      ii. Before eating.
      iii. After using the restroom.
      iv. If exposure to Bacillus anthracis is suspected or proven.*
      v. When caring for any patient that has suspected or known Clostridium difficile.*

2. If hands are not visibly soiled, an alcohol-based handrub is recommended for the routine decontamination of hands in all other clinical situations described in items B.1-B.10. Alternatively, hands may be washed with an antimicrobial soap and water in all clinical situations described in items B.1-B.10.
   a. Before coming on duty.
   b. Before and after direct patient contact; if gloves are worn during patient contact, before donning and after removing gloves.
   c. Before donning sterile gloves when inserting a central intravascular catheter.
   d. Before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure.
   e. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, or lifting/moving a patient).
   f. After contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings, as long as hands are not visibly soiled (e.g., handling sputum containers, bedpans, urinals, and catheters, etc.)
   g. After working on a contaminated body site and then moving to a clean body site on the same patient.
   h. After contact with inanimate objects (including medical equipment/supplies) in the immediate vicinity of the patient.
   i. Before caring for patients with severe neutropenia (low white blood cell count of <1,000/cu mm) or other forms of severe immune suppression.
   j. After removing gloves.

3. In situations where soilage has occurred and there is a water shortage, one may use potable water and paper towels to physically remove all proteinaceous material, then follow with an alcohol-based handrub.

4. Although an alcohol-based hand rub is highly preferable, hand antisepsis using a non-antimicrobial/antimicrobial soap and water may be considered in the following settings:
   a. When time constraints are not an issue and there is easy access to a sink.
   b. In rare instances when a healthcare worker is intolerant of alcohol-based hand rubs.
B. "Routine" Hand Hygiene Techniques
   1. When decontaminating hands with an alcohol-based hand rub apply product to the palm of one hand and rub hands together, covering all surfaces of hands, fingers and wrists until hands are dry and all moisture has evaporated (approximately 15-30 seconds).
   2. When washing hands with a non-antimicrobial or antimicrobial soap and water
      a. Wet hands and wrists thoroughly (with warm water), holding them downward over the sink.
      b. Apply proper amount of soap to hands (depending upon whether you are washing with foam or liquid soap).
      c. Rub hands vigorously (for at least 15 seconds), creating as much FRICTION and LATHER as possible until all areas of the wrists, fingers, and hands are cleaned.
         i. Wash the palm and back of each hand.
         ii. Scrub at least 1 inch above each wrist.
         iii. Interlace the fingers and thumbs and move the hands back and forth.
         iv. If necessary, clean nails with the forefinger of the other hand. DO NOT use an orange stick or brush!
      d. Rinse hands and wrists thoroughly so as to avoid skin irritation, dermatitis, and chapping; at this point, try to hold your fingertips/hands above the level of your elbows so water will run from your clean hands to your dirty wrists and elbows.
      e. In order to conserve water, turn off the faucet now by using two clean, dry crumpled paper towels and discard them in the trash. This will avoid the recontamination of your hands.
      f. Dry hands thoroughly with disposable paper towels.
         i. Using two paper towels per hand, begin drying each hand in a circular motion from the "clean" fingertips down to and including the wrist, then discard towels.
         ii. Repeat the process, drying the other hand by using the same technique.
   C. Surgical hand antisepsis (refer to Surgery Department procedures)
      1. Recommended before donning sterile gloves when performing surgical procedures.
      2. May be performed by using either an FDA-approved alcohol-based surgical hand rub or by washing hands with an antimicrobial soap and water.
         a. To minimize skin damage and to reduce the number of bacteria that may be released from the hands, a brush should not be used during the surgical scrub!!
   D. Skin Care
      1. The hands, including the nails and surrounding tissue, should be inflammation free.
      2. Water-based hand lotions/creams shall be available for all personnel; being aware that petroleum-based lotions/creams destroy the integrity of latex gloves.
      3. Personnel with cracked skin or dermatitis pose an infection risk and should contact Infection Control/Employee Health Department immediately for counseling, testing, and follow-up.
   E. Drying of Hands
      1. Paper towels shall be within easy reach of the sink, but beyond splash contamination.
      2. Cloth towels, hanging or roll type, shall not be permitted for use at St. Anthony Shawnee.
   F. Appropriate Glove Usage
      1. Gloves should be used as an adjunct to, not a substitute for, handwashing.
      2. Gloves should be worn when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, or non-intact skin will occur.
      3. Gloves should be removed after caring for a patient, when the integrity of the gloves is in doubt, and between patients.
      4. Gloves shall not be washed between patients.
G. Condition of Nails
1. Natural Nails:
   a. Natural nails are to be kept clean and short; they may be no longer than 1/4 (one-quarter) inch past the end of the tip of the finger.
   b. Natural nails should be free from snags or rough places that would potentially tear gloves.
2. Artificial Nail Enhancements
   a. Artificial nails, nail piercing, and nail art of any kind shall be prohibited in all staff who routinely provide patient care. Artificial nails (equal to or less than 1/4") may be worn by other personnel who rarely perform direct patient care, but these personnel must wear gloves while performing direct patient care.
   b. Personnel in the following departments listed below shall comply with VII.B.1 above:
      i. Department of Nursing (Emergency Department, Nursery, OBGYN, ICU, Medical/Surgical, Urgent Care Center
      ii. Medical Staff (physicians, physician assistants, etc.)
      iii. Surgical Services (Surgery, PACU, SDS, Central Sterile, Anesthesiology)
      iv. Laboratory
      v. Physical Therapy
      vi. Respiratory Care
      vii. Heart Cath Lab
      viii. Radiology
      ix. Nuclear Medicine/Radiation Therapy
      x. Nutritional Services
      xi. Infection Control/Employee Health
      xii. Additional departments may be included as defined by job duties
   c. New employees in the departments listed above shall comply immediately with VII.B.1 above.
   d. Department Directors and supervisors are responsible for monitoring and enforcing compliance.
   e. Nail polish is permitted, but it must be free of cracks or chips; nail jewelry is not permitted.
      i. Nail polish, if worn, should be either clear or a light traditional color because dark colors may obscure the space underneath the tip of the nail, reducing the likelihood of careful cleaning; no glitter or decorative applications shall be permitted.
      ii. Nail polish should be removed and applied fresh to natural nails every few (3-4) days.

H. Rings
1. Studies have found that rings appear to be a substantial risk factor for harboring gram-negative bacilli and Staphylococcus aureus, thus it is recommended that personnel performing direct patient care either remove rings or wash under them thoroughly when performing hand hygiene.
2. Rings that contain gemstones or designs that protrude outside of the ring band must always don gloves prior to performing patient care; this will promote good infection control and patient safety.

I. Storage and Dispensing of Hand Care Products
1. Liquid products shall be stored in closed containers.
2. Disposable containers shall be used.
3. In the event that the soap and paper towel dispensers do not function properly or are inadequately supplied, the Environmental Services Department should be contacted immediately to correct the problem.
J. DEFINITIONS.

1. Artificial Nail Enhancement: Application of a product to the nail to include, but not limited to 1. acrylics 2. appliqué 3. artificial Nails 4. gels 5. overlay tips or silk wraps or any additional items applied to the nail surface; does not refer to nail polish.
2. Decontaminate hands: Reducing bacterial counts on hands by performing antiseptic hand rub or antiseptic handwash.
3. Hand antisepsis: Refers to either antiseptic handwash or antiseptic hand rub.
4. Hand hygiene: A general term that applies to either handwashing, antiseptic handwash, antiseptic hand rub, or surgical hand antisepsis.
5. Nail Jewelry: Items applied to the nail for decoration to include, but not limited to items glued to or piercing the nail.
6. Natural Nails: Natural nails without an artificial covering.
7. Surgical hand antisepsis: Antiseptic handwash or antiseptic hand rub performed preoperatively by surgical personnel to eliminate transient and reduce resident hand flora. Antiseptic detergent preparations often have persistent antimicrobial activity.
8. Visibly soiled hands: Hands showing visible dirt or visibly contaminated with proteinaceous body substances (e.g., blood, fecal material, urine).
9. Waterless antiseptic agent: An antiseptic agent that does not require use of exogenous water. After applying such an agent, the individual rubs the hands together until the agent has dried.
   • The physical action of washing with soap and water and rinsing hands is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores.

K. PERFORMANCE INDICATORS

1. Periodically, hand-hygiene episodes (in clinical departments) shall be monitored versus the number of hand-hygiene opportunities; results shall be provided to the personnel/departments involved.
2. Adherence to the "Artificial Nail Enhancements" policy shall be monitored periodically by Infection Control personnel; any problem situation will be addressed with the department director who will be responsible for maintaining compliance with SASH's policy.
FACT SHEET FOR EMPLOYEES FOR FINGERNAIL ENHANCEMENTS

BACKGROUND: There has been evidence implicating artificial fingernails in the transmission of infections by healthcare workers. Several of these incidents that have been reported have resulted in the deaths of patients. These incidents were epidemiologically and microbiologically linked to healthcare workers who had persistent colonization of their artificial fingernails with the same strain of microorganisms that infected the patient.

SUBJECT: Artificial Nails Linked to Infections.

Q: Why are nail enhancements such as artificial nails, nail wraps, nail tips, acrylic lengtheners, appliqués, etc. no longer permitted for staff with patient contact?

A: Several scientific studies have shown that artificial nails and appliqués have been contaminated with germs (both bacteria and fungi) that have been passed to patients and caused serious infections. When artificial nails are contaminated (“colonized”), there is usually no change in the nails that you can see.

Q: Why doesn't handwashing prevent this contamination?

A: Although handwashing is ordinarily effective, the wearing of nail enhancements could hinder its effectiveness. Studies have shown that hospital personnel with nail enhancements had more bacteria both before and after handwashing than did personnel with natural nails.

Q: Can nail enhancements harm the person that is wearing them?

A: Yes, nail enhancements sometimes cause infections of the nail bed that are difficult to treat. Also, long-term artificial nail use causes natural nails to become thin, brittle, or damaged. If you are concerned about the state of your natural nails, please contact the Employee Health Office.

Q: Won't wearing gloves protect the patients?

A: NO. Gloves do not provide complete protection, especially when worn with long nails. Holes can develop and germs could pass between you and the patient.

Q: Can I wear nail polish?

A: Manicures and nail polish may be permitted, depending on your work location. Check with your department manager. Nail polish that is obviously chipped has a tendency to harbor greater numbers of bacteria. Chipped polish should be removed.

REFERENCES:
Dress Code Policy

We would like your assistance in following our dress code, since while you are here; you are considered a member of the team.

Hair:
In clinical areas, hair of shoulder length or longer that falls forward when the person bends forward should be tied back or up.

Personal Hygiene:
Avoid products that will result in an unpleasant or strong odor. If an odor is sufficiently strong enough to cause concern from other employees and/or patients, the person may be asked to change their clothing or take other appropriate action to eliminate the odor. Heavy make-up is unacceptable.

Jewelry:
Jewelry may be worn in moderation. Other than ears, no visible body piercing will be allowed. Tongue jewelry is NOT allowed.

Tattoos: All tattoos should be covered by clothing and SHOULD NOT be visible while in clinicals.

Finger Nails: Artificial fingernails, extenders or artificial nail products (e.g., tips, jewelry, overlays, wraps, gels, etc.) may not be worn by personnel having direct contact with patients, with food preparation, or with patient equipment/supplies. Natural nail tips must be kept less than ¼ inches long. Nail polish can be worn if well-manicured and not chipped.
HIPAA

HIPAA stands for the Health Insurance Portability and Accountability Act. It refers to the Health Insurance Portability and Accountability Act of 1996, which was signed into law on August 21, 1996.

HIPAA mandated the development of standards governing the privacy and security of certain protected health information, which applies to “covered entities”.

How does HIPAA define “covered entities”? Covered entities include health plans, healthcare providers that transmit health information in electronic format and healthcare clearinghouses.

HIPAA was designed to accomplish the following:

1. Ensure health insurance portability
2. Reduce health care fraud and abuse
3. Guarantee security and privacy of health information
4. Enforce standards for health information

The HIPAA Officer at St. Anthony Shawnee is:

1. Jana McQuain, HIPAA Privacy Officer

Who’s responsible for safeguarding patients’ protected health information?

YOU ARE!!!

Each and every one of us is responsible for adhering to established policies and procedures and taking appropriate measures to protect our patient’s health information.

What are your roles and responsibilities for ensuring the privacy and security of protected health information?

Not speaking in elevators or next to patient rooms, shredding patient information papers, not asking about patients unless you have a need to know, not gossiping. These are all things you can do. Can you think of any others?

As part of the American Recovery and Reinvestment Act (ARRA), which was signed into law by President Obama on February 17, 2009, changes have been made to privacy and security requirements applicable to protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
ARRA imposes new requirements on both covered entities and business associates

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<th>Covered Entities</th>
<th>Business Associates</th>
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<td>Accounting for Disclosures</td>
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<td>Prohibition on Sale of PHI</td>
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<td>Restrictions on Marketing</td>
<td>Restrictions on Marketing</td>
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<td>Satisfaction of “Minimum Necessary”</td>
<td>Satisfaction of “Minimum Necessary”</td>
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<tr>
<td>Individual Rights</td>
<td>HIPAA Security Requirements</td>
</tr>
<tr>
<td></td>
<td>Terminate Contract/Notification Requirements</td>
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</table>

We are required to notify each individual whose “unsecured” PHI is breached. We must make the notification without unreasonable delay and in any event within 60 days of discovery (or within 60 days of the date the breach should have been discovered). We can notify the person by first-class mail or by electronic mail “if specified as a preference” by the individual, and include the following information:

- Circumstances of the breach
- Date of the breach
- Date of the discovery
- Type of PHI involved
- Steps individuals should take to protect themselves
- Steps the covered entity is taking to mitigate harm and to protect future breaches
- How the individual can obtain additional information about the breach

St. Anthony Shawnee is required to maintain a log of breaches that affect fewer than 500 individuals and report such breaches annually to Health and Human Services (HHS).

- If a breach affects 500 or more individuals, notify HHS immediately.
- HHS will post information about breaches affecting more than 500 individuals.
- Notify “prominent media outlets” serving a state or jurisdiction if the breach affects more than 500 residents of that state or jurisdiction.
Restrictions

• We cannot sell PHI. Do NOT accept payment for PHI without the individual’s authorization (unless it is to recoup the costs of providing data to a public health official, to a researcher, or to the individual, or meets certain other exceptions).
• Do NOT send individual marketing materials and get paid for it, unless the patient authorizes it or the patient is taking medicine being marketed.
• Do NOT send an individual marketing materials for free, unless the patient authorizes it or the communication is made for certain purposes (e.g., to describe a product available in the health plan or to recommend alternative health care options.

Satisfaction of “Minimum Necessary”

• Whenever sufficient to carry out the purpose for which PHI is being used or disclosed, use or disclose PHI in the form of a “limited data set.”
  – Note: This requirement is satisfied by removing names, street addresses, social security numbers and other identifiers.

Individuals’ Rights

• If maintaining “electronic health records”, provide an individual (or designee) upon request with a copy of the information in such in electronic format.
• If using or maintaining, EHRs, provide an individual upon request with an accounting of disclosures of the information in his/her EHR during the last three years, including disclosures made for treatment, payment or healthcare operations.
• Honor the request of an individual not to disclose to his/her health plan the PHI related to a particular treatment if the individual is paying for the full cost of the treatment out-of-pocket.

Report ALL suspected HIPAA privacy or security breaches immediately to the HIPAA Privacy and Security Officer(s).

• Jana McQuain – ext. 8165
As a student or healthcare worker, you are not allowed to access any electronic medical records, including your own, without a legitimate excuse to do so. Curiosity about a certain disease is not a reason to explore any part of the record, unless you are caring for that individual and you need the information to care for that individual. If a family member or close friend asks you to look up a result for them or make a copy of their record, you must tell them no.

Medical records access is reviewed daily, and if you are in a record of a patient that is not yours, you will be asked to provide a reason for you being in that record. **If you do not have a legitimate reason for being in that record, you will be asked to leave clinicals and you will not continue them at this institution.**

It is never appropriate to post any pictures or information about our patients on social media. It is not appropriate to discuss what patients you cared for and what was wrong with them on social media, **even if** you do not mention their names or any other identifiers.

The HIPAA Privacy Rule requires that we protect the privacy of PHI and that we safely dispose of that information. **Records must be destroyed in a manner that ensures the confidentiality of the records and makes the information no longer recognizable.**

- Paper records containing PHI and confidential information should be placed in designated containers for shredding.

- Dispose of misprinted documentation in patient care areas immediately to avoid having one patient’s PHI inappropriately distributed to a different patient.

- Shred labels and/or arm bands with PHI.

- Place labeled medication bottles in a designated secure area for pick up by the contracted vendor for shredding or destroying.

- Use the appropriate method for destroying microfilm or microfiche.

- Contact the IHT Help Desk for assistance with removing PHI and other confidential data from computers, flash drives, CDs, etc.

- Ensure proper procedures are followed for removing PHI from printer/fax devices before exchange and/or disposal.
Pre-ARRA. Before ARRA, business associates were not directly regulated by HIPAA or subject to HIPAA’s penalties. They did have a contractual obligation to follow certain HIPAA privacy and security rules, which were required by law to be in their business associate agreements, but negative consequences rarely followed a breach.

Post-ARRA. With the passage of ARRA, effective February 17, 2010, the HIPAA security rules will apply directly to business associates for the first time. The HIPAA privacy rules will still, for the most part, apply only through operation of the business associate agreement. However, a breach of the privacy requirements contained in a business associate agreement will now be punishable under HIPAA.

Besides extending the penalties for HIPAA security and privacy violations to business associates effective February 17, 2010, ARRA has increased the amount of civil penalties currently applicable to covered entities.

<table>
<thead>
<tr>
<th>Criteria for Determining Penalty</th>
<th>Minimum Penalty (Per Violation/Cap)</th>
<th>Maximum Penalty (Per Violation/Cap)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violator did not know and could not have been expected to know about the violation</td>
<td>$100/$25,000</td>
<td>$50,000/$1,500,000</td>
</tr>
<tr>
<td>There was “reasonable cause” and no “willful neglect”</td>
<td>$1,000/$100,000</td>
<td>$50,000/$1,500,000</td>
</tr>
<tr>
<td>There was willful neglect and violation was corrected</td>
<td>$10,000/$250,000</td>
<td>$50,000/$1,500,000</td>
</tr>
<tr>
<td>There was willful neglect and violation was not corrected</td>
<td>$50,000/ $1,500,000</td>
<td>No specified maximum</td>
</tr>
</tbody>
</table>

Additionally, the law clarifies that criminal penalties can apply to employees and others who wrongfully obtain or disclose PHI held by a covered entity.

**Enforcement by State Attorneys General.** Effective immediately, state attorneys general are authorized to bring civil actions against violators in federal district court.

**Audits by HHS.** ARRA mandates that HHS conduct periodic audits to ensure that covered entities are in compliance with HIPAA Privacy and Security requirements.

**Mandatory Investigations and Penalties.** HHS is required to conduct formal investigation if a preliminary investigation of the facts of a complaint indicates willful neglect. It is also required to impose penalties anytime a HIPAA violation is accompanied by willful neglect.
Distribution of Penalties Collected. HHS is required to establish a process within the next three years whereby individuals affected by a HIPAA violation may receive a percentage of any penalty or settlement collected with respect to that violation.

Note: This enforcement mechanism in particular will provide a powerful financial incentive to plaintiffs and plaintiffs' counsel to monitor covered entities and business associates closely for HIPAA violations.

Breaking News Headline…

“Three Arkansas healthcare workers plead guilty to HIPAA violations”

Three Arkansas health care workers (a physician and two nurses) of St. Vincent Infirmary Medical Center as part of a criminal case plead guilty to misdemeanor violations of the privacy provisions of HIPAA on July 20, 2009 for “accessing patient records out of curiosity”.

The records that were illegally accessed related to Anne Pressly, a local TV personality who was brutally beaten by a home intruder on October 20, 2008 and had died at St. Vincent’s on Oct. 25th.

The Department of Justice releases a press release on sentencing of the former St. Vincent’s employees for violation of HIPAA on October 26, 2009.
Doctor and Two Former Hospital Employees Sentenced for HIPAA Violations

LITTLE ROCK—Jane W. Duke, United States Attorney for the Eastern District of Arkansas, along with Thomas J. Browne, Special-Agent-in-Charge of the Little Rock Division of the Federal Bureau of Investigation, announced today the sentencings of Dr. Jay Holland, of Little Rock, Arkansas; Sarah Elizabeth Miller, of England, Arkansas; and Candida Griffin, of Little Rock, Arkansas. United States Magistrate Judge Henry L. Jones, Jr. sentenced Holland to one year of probation, a $5,000 fine to be paid in 60 days, and 50 hours of community service educating professionals on HIPAA. Miller was sentenced to one year probation and a $2,500 fine payable in installments. Griffin was sentenced to one year probation and a $1,500 fine payable in installments.

Holland, Miller, and Griffin pleaded guilty on July 20, 2009 to misdemeanor violations of the health information privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) based on their accessing a patient’s records without any legitimate purpose.

“We hope that today’s sentencings send the message that the HIPAA protections apply to every person in the community, regardless of their position or stature. Likewise, the penalties for violating HIPAA apply equally to every person with access to protected health information,” stated Duke.

To report a HIPAA violation, follow the instructions at the US Department of Health and Human Services Office for Civil Rights website: www.hhs.gov/ocr/privacy/howtfile.htm or call 214-767-4056, the regional office with oversight over violations occurring in Arkansas.

This case was investigated by the Little Rock Division of the Federal Bureau of Investigation and was prosecuted by Assistant U.S. Attorney Laura G. Hoey.

For more information on this case, see attached prior News Release dated 7/20/09. The July news release is also available at www.usdoj.gov/usao/are/.

DON’T LET THIS HAPPEN TO YOU!
Follow-Up

You have now completed the orientation packet. Please complete the forms and test at the beginning of this packet and send back to the coordinator. If faxing packet – 405-878-3465.

Health information **ONLY** may be faxed to 405-878-3427. Do not fax the whole packet to this number.

Thank you for time and efforts to complete this orientation.