All About Skin

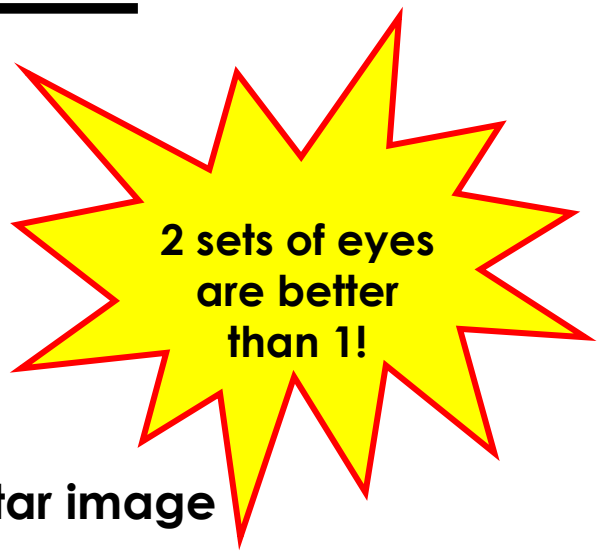
When to Place a Consult

- When you suspect a pressure injury- *new or present on admit*
- Severe incontinence related skin breakdown that is not improving with basic nursing care
- Lower leg ulcers
- New Ostomy
- New wound vac
- Full thickness wounds

If you are unsure CHECK WOUND CARE NOTE

Head to Toe Skin Assessment

- On admission w/in 8 hours
  - Gold standard is 4
- Upon transfer
- When off the unit for greater than 2 hour
- Upon discharge
- **Note: RN assessment to include photo and Avatar image**



Two (2) registered nurses (RN) are required to perform a head-to-toe skin assessment on admission, upon transfer, when off the floor for more than 2 hours and upon discharge. Cosign is required.

Implications for Practice:
The 2 RN skin assessment increases accountability, therefore, promotes quality patient care and makes the assessment of skin and prevention of injury a priority.

Documentation

All wounds and all devices placed on the patient are added to the Avatar:

-use wound LDA
-add location
-may include suspected etiology
-do not include assessment

Timely and accurate documentation

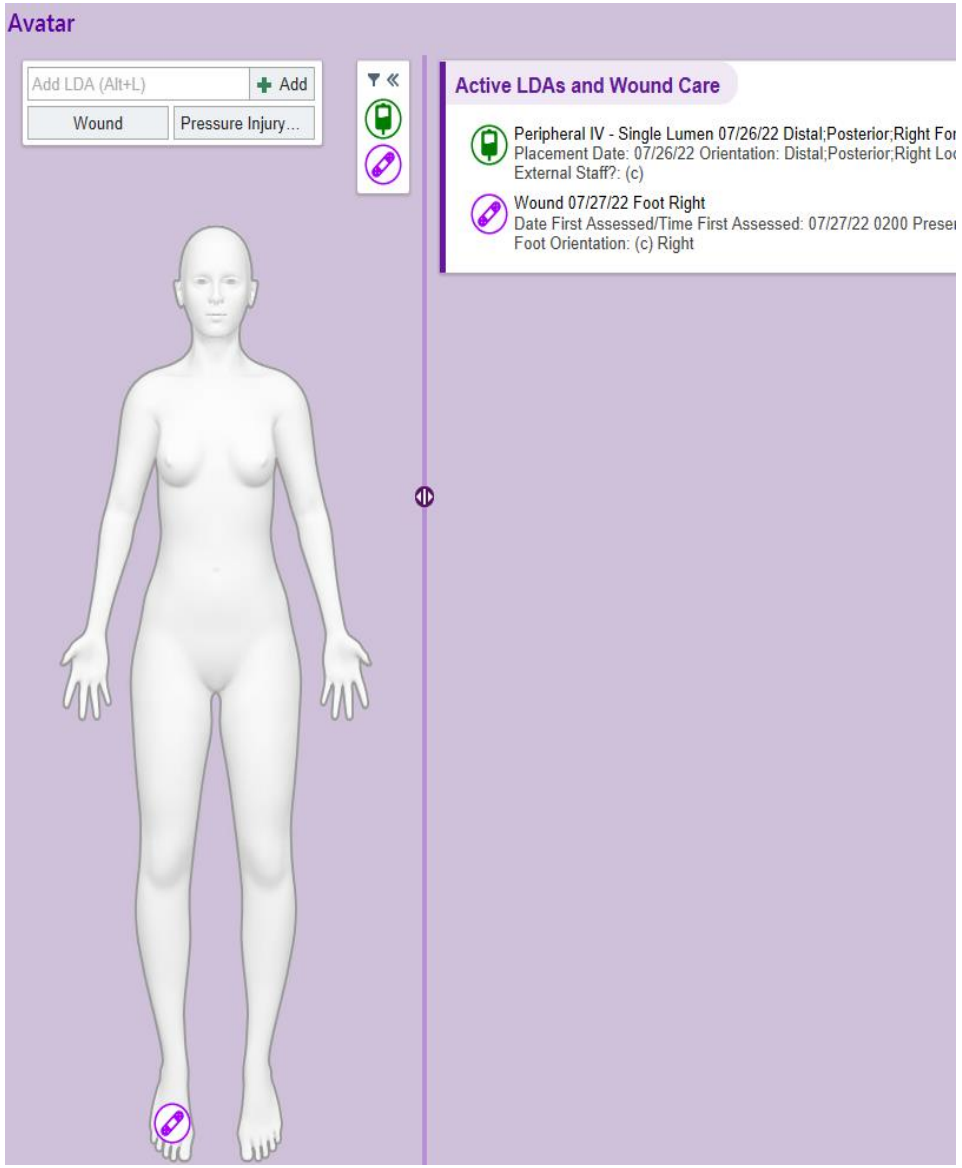


Photo Requirements:

- On admission
- New wound
- At discharge
- Consider privacy and dignity; hide eyes or distinguishing marks
- Use rules in photo as a scale reference
- Take a clear photo!
- Ensure the camera does not become an object for wound contamination
- Clean the wound and the area prior to taking a photo

Risk Assessment

To identify at-risk individuals needing prevention and the specific factors placing them at risk – the following risk assessments are used:

- "Braden Scale for Predicting Pressure Injury Risk" assessment tool will be used on all adult patients,
- "Braden QD" on all Pediatric patients
- "Neo-Natal Skin Condition Score" on all NICU patients

Consult Guideline

When to Consult	• Pressure Injuries- present on admit • Hospital Acquired Pressure Injuries (HAPI) • Complex wound management • Vascular wounds and ulcers • Diabetic neuropathic wounds • New ostomy out of surgery • Complex stomas/fistulas • Ostomy site marking • Negative Pressure Wound Therapy
How to Order	• Enter a "Wound Evaluation and Treatment" order in HealthLink/Epic • Please provide anatomical location and description of wound in consult • If wound deteriorates or needs new dressing change recommendations, please consult

Available Creams

Ointment	Indication
Clear Aid Ointment	• Helps seal out wetness and relieve chapped or cracked skin, minor cuts, scrapes and burns
Hydragaurd	• Appropriate for perineal care since it forms a water-resistant film over skin • Silicone-rich formulation creates a breathable, water-resistant film over skin as it moisturizes and nourishes
Zinc Paste	• Indicated for the relief of discomfort associated with diaper rash caused by wetness, urine and/or stool and other macerated skin conditions • Temporarily protects chapped or cracked skin, minor cuts, scrapes and burns
Moisturizer and Lip Balm	• Absorbs readily into the skin upon application with no greasy residue • Helps restore skin's natural moisture balance and barrier properties

Skin Health

Skin Care Guidelines

O'CONNOR HOSPITAL
A COMMUNITY HOSPITAL

Bathing / Cleansing

- For overall body bathing, use the **Remedy Cleansing Foam**
- For incontinence cleansing, use the **Remedy Foaming Cleanser or the Remedy Cleansing Lotion**
- Apply **Remedy Foaming Cleanser** to wet or dry cloth, or directly on the skin. For full body washing, including the head for washing the hair, use the **Remedy Foaming Cleanser or Shampoo Cap**
- Gently dry the skin when applicable. Avoid vigorous rubbing or scrubbing

Moisturization

- Apply **Remedy Skin Repair Cream** only to point where it disappears
- Avoid massaging red, bruised, or discolored skin, or over a bony prominence
- Inspect skin for signs of breakdown especially over bony prominences, and under breasts, abdominal folds, axilla areas, heels, ankles
- Remove socks or support hose daily to inspect feet for signs of pressure or skin breakdown
- Apply **Remedy Phytoplex Lip Balm** to lips as needed for dryness
    - Safe to use in oxygen-rich environments

Preventative Barrier

- Cleanse skin. Dry thoroughly
- Apply **Remedy Hydraguard** to intact skin
- Apply only until the point where it disappears
- Inspect skin with each incontinent episode to identify early breakdown

Preventative/Protectant

- **Marathon** to be applied by wound care dept.
- Where **Marathon** is used, skin will take on a purple hue.
- Leave clean, dry and intact.

Barrier Protectant

- Remove excessive stool with cleanser

If skin is weepy;

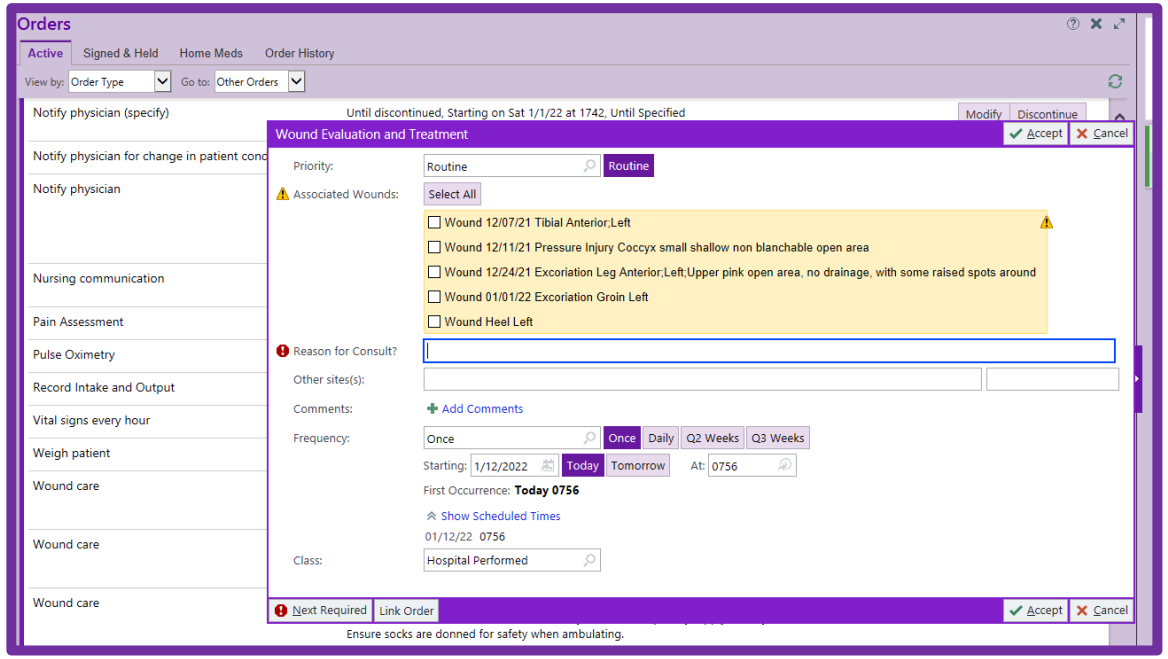
- Apply a thin layer of **Remedy Z-Guard** It is not necessary to remove all of the **Remedy Z-Guard**, only the soiled portion
- Remove soiled paste gently. Avoid vigorous rubbing or scrubbing.
- Avoid applying excessive **Remedy Z-Guard** as it may clog the under pad or brief

If skin is intact;

- Apply **Clear-Aid**

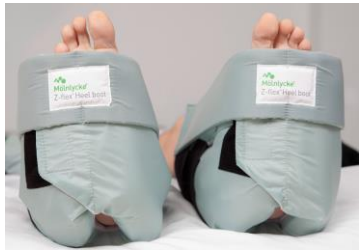
Basic Wound Care Expectation

- Clean
- Cover
- Consult



Pressure Injury Prevention

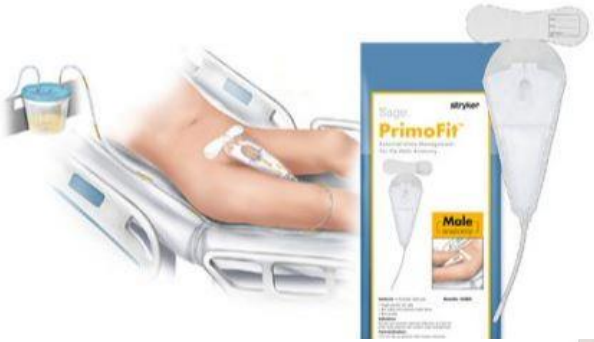
- Turn and offload q 2 hours or more often as needed to prevent skin breakdown
- Heelzup
- Wedges
- Comfort glide pad
- Soft offloading boots
- zFlo positioner



Incontinence Management and Skin Care

- Purewick
- Primofit
- Condom catheters- S/M/I
- Extrasorb pads
- Versette
- Clear aid Ointment
- Hydragaurd
- Z-Guard Paste (Zinc Paste)
- Moisturizer Nourishing Skin Cream
- Lip Balm

Wall suction is 40-60; change q shift



MALE EXTERNAL CATHETER DEVICES

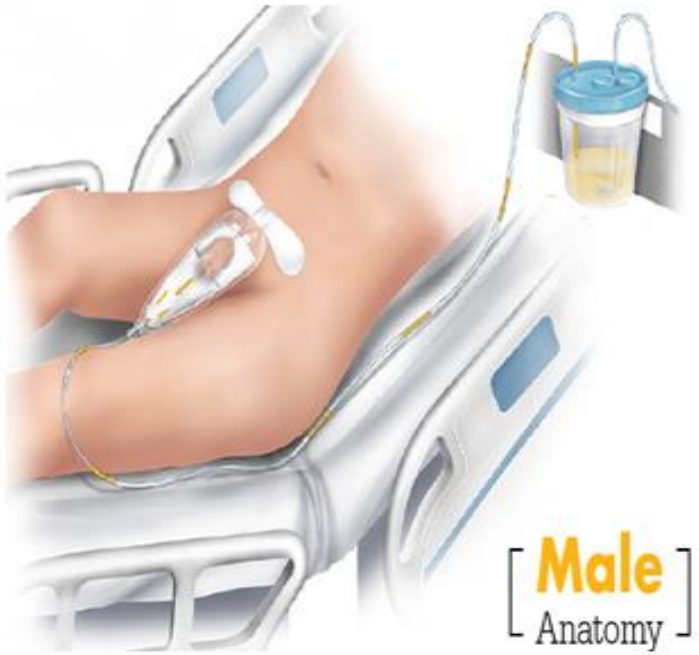
*** Only use on Male Patients *** Do Not use multiple devices on patient *** Do Not Create a Device

No Suction.

Should only be connected to a Foley Catheter

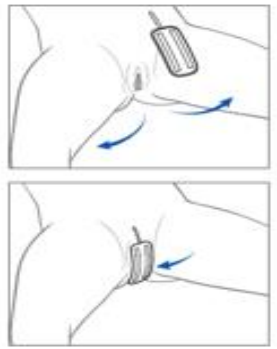
Bag or Leg Bag.

CONDOM CATHETER

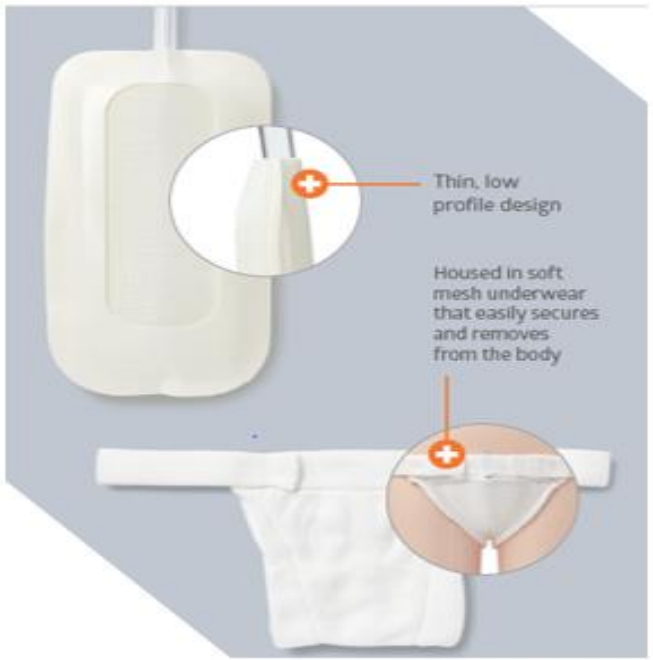


Attaches to continuous wall suction 40-60mmHG.

SAGE PRIMOFIT



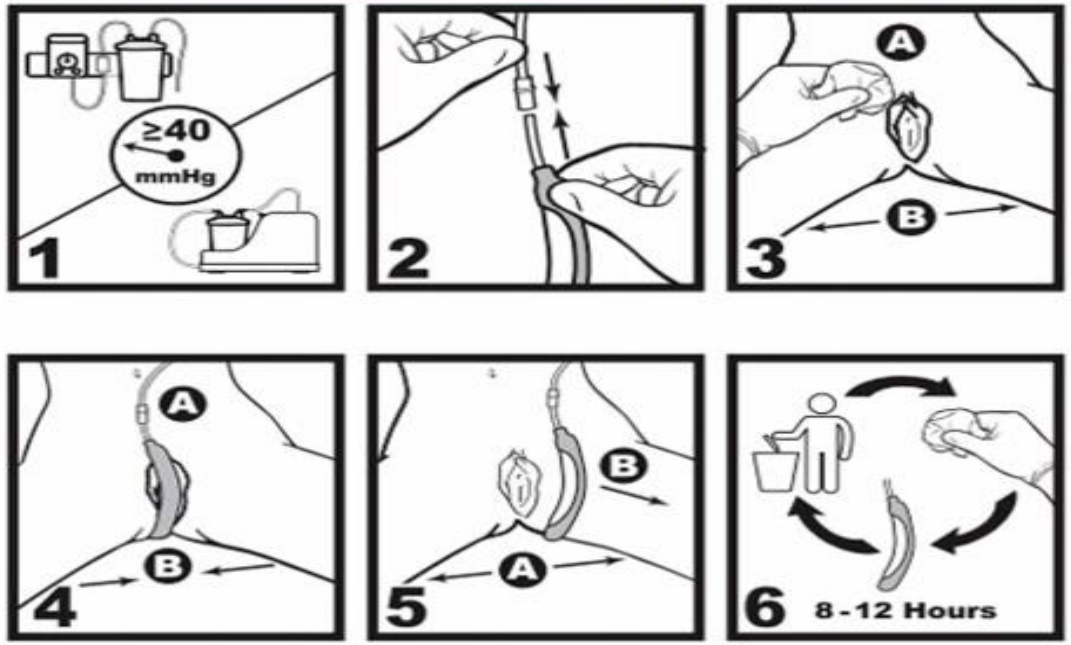
Can be used on males with retracted anatomy. Attaches to continuous wall suction 40-60mmHG.



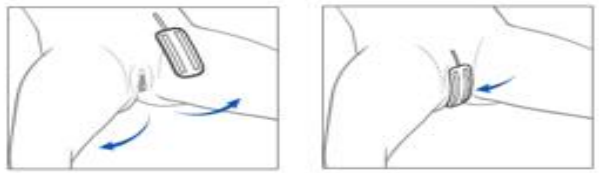
VERSETTE

Female External Catheter Devices

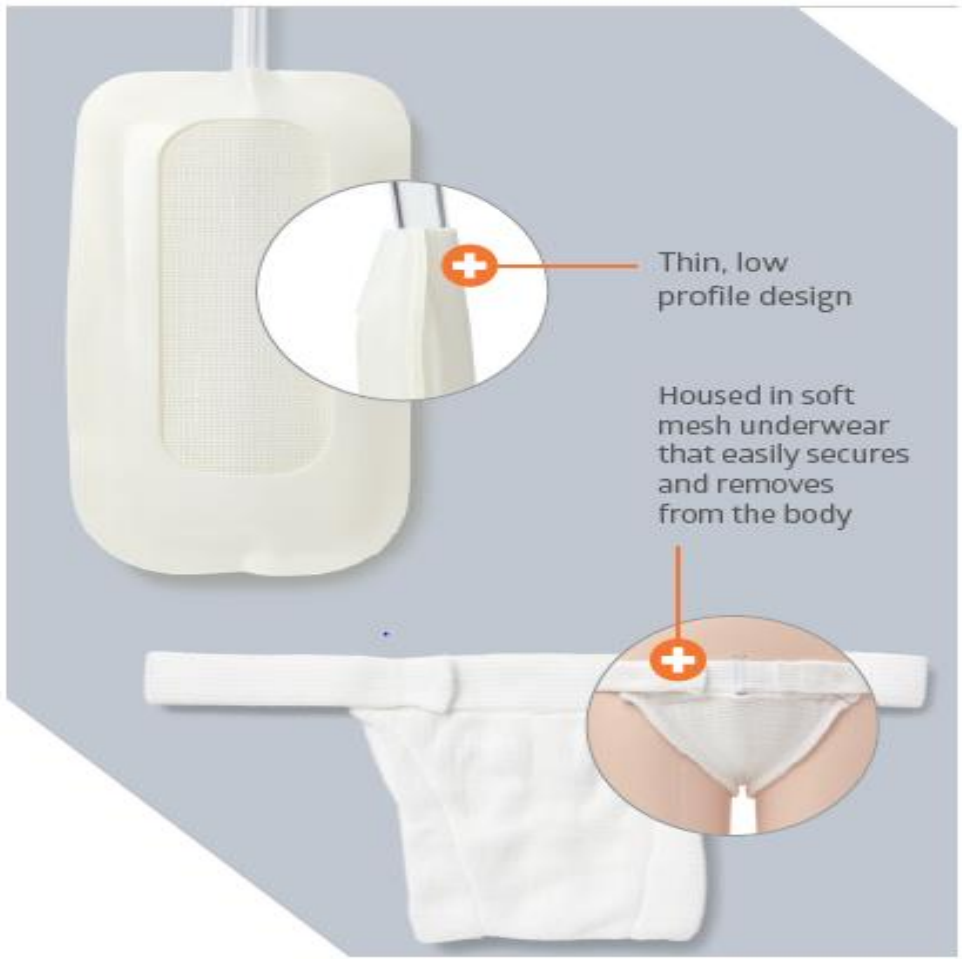
***Both should be connected to continuous wall suction 40-60mmHG ***Change device every 8-12 hours or prn



Pure Wick



Versette



References/Polices

- O'Connor Hospital Skin and Wound Care Addendum Policy #7212570
- Skin and Wound Care – Enterprise # 0063

Blood Bank Presentation

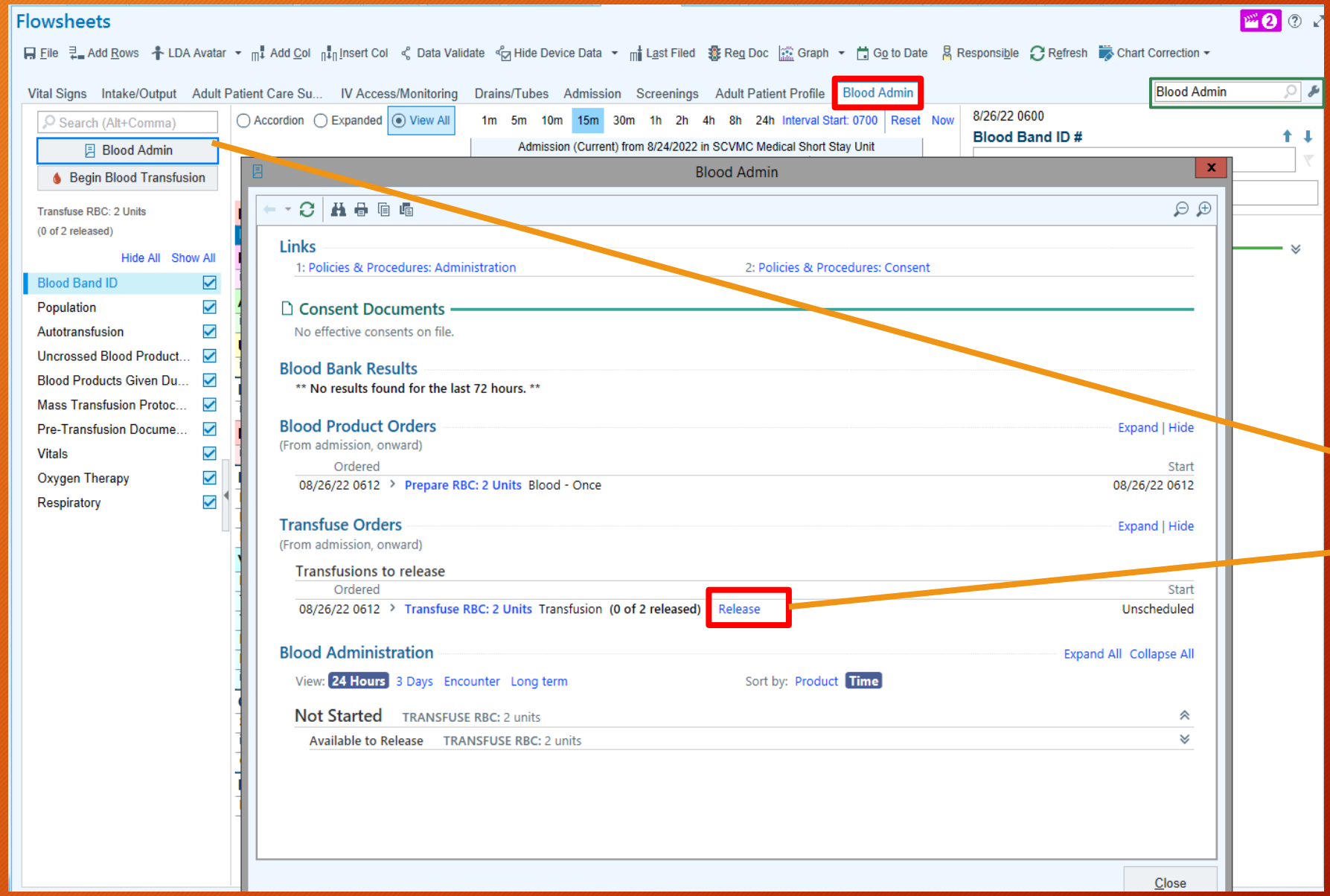
Fenwal Bands

- **Fenwal Bands** only used for: ED patients, Pre-Op, Patient in surgery, Unidentified patient (Jane/John Doe), during downtime.

- If there is a need to move the band to another limb, call the lab and the lab assistant will do it for you.
- When Fenwal is used, ensure band number matches blood unit and release form

- Do not cut off Fenwal band unless it has expired

How to Release Blood



- Go to Flowsheet
- Wrench in Blood Admin
- Open Blood Admin on the right corner
- Select Release

Blood Release Form

John Doe
MRN: 012357
DOB: 01/02/1950

BLOOD RELEASE

Please issue one (1) unit of:

- ☐ Packed Red Blood Cells, Crossmatched
- ☐ Neonate Packed Red Blood Cells, Crossmatched: CMV Negative & Irradiated
- ☐ Plasma (FFP - Thawed)
- ☐ Plateletpheresis
- ☐ Cryoprecipitate
- ☐ RhoGam Immune Globulin
- ☐ Autologous Packed Red Blood Cells (crossmatched)
- ☐ Direct Donor Unit Packed Red Blood Cells (crossmatched)
- ☐ Other Special Request: _____

Fenwal
5687

Required Information

Operating Room: ☐ COOLER Time Needed _____ Room _____ Ext _____

Ordered by: _____ R.N. (Initials)

Date: _____ Time: _____ of release

This unit of blood released from the Blood Bank for more than **30** minutes cannot be reissued for transfusion.

LAB-881 (1/15)

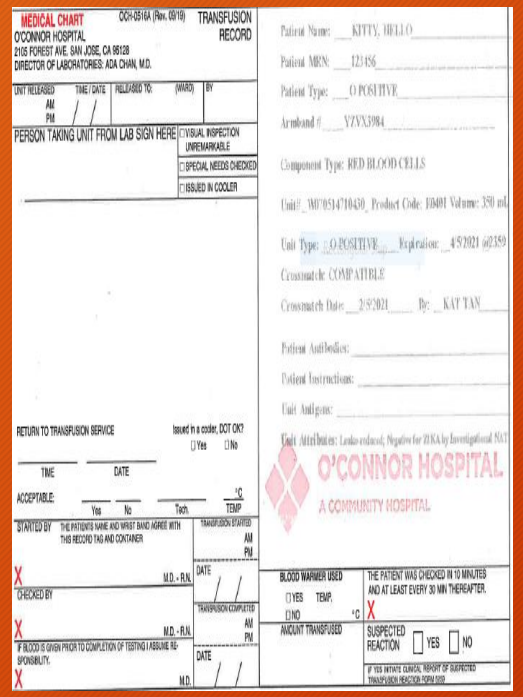
Picking Up Units in the Blood Bank

- Verify & release transfusion order. If Fenwal Band in use, write this number on the Blood Release form
- Verify that the consent form has been signed. If not, get the form signed before picking up the unit.
- Verify that the IV line is prepped and ready
- Take the vital signs
- Bring the Blood Release Form to the Blood Bank for pick up with date and initials of requesting personnel. Include FENWAL # if applicable.
- Unit will be verified by you and the Blood Bank personnel, and unit will be issued
- Blood should be infused within 15 minutes
  - Countdown begins from the time it leaves Blood Bank to infusion
- If you are unable to transfuse right away, you may return un-spiked blood product to Blood Bank within 15 minutes of issue

Verify Blood with The Blood Bank Personnel

The person who pick up blood will read the transfusion record to the Blood Bank Personnel

- Patient Name
- MRN
- Patient ABO/Rh
- Blood Band #
- Unit #
- Unit ABO/Rh
- Unit Expiration Date


MEDICAL CHART — TRANSFUSION RECORD

O'CONNOR HOSPITAL
2105 FOREST AVE, SAN JOSE, CA 95128
DIRECTOR OF LABORATORIES: ADA CHAN, M.D.

Patient Name: KITTY, HELLO
Patient MRN: 12456
Patient Type: O POSITIVE
Armband #: YZVX3984
Component Type: RED BLOOD CELLS
Unit #: W0705147104302 Product Code: E0401 Volume: 350 mL
Unit Type: O POSITIVE Expiration: 4/5/2021 @2359
Crossmatch: COMPATIBLE
Crossmatch Date: 2/5/2021 By: KAT TAN
Patient Antibodies:
Patient Instructions:
Unit Antigens:
Unit Attributes: Leuko-reduced; Negative for HBSAg by Investigational NAT

PERSON TAKING UNIT FROM LAB SIGN HERE
VISUAL INSPECTION UNREMARKABLE
SPECIAL NEEDS CHECKED
ISSUED IN COOLER
RETURN TO TRANSFUSION SERVICE
Issued in a cooler, DOT OK? Yes No
TIME DATE
ACCEPTABLE: Yes No Tech. °C TEMP
STARTED BY — THE PATIENT'S NAME AND WRIST BAND AGREE WITH THIS RECORD TAG AND CONTAINER — TRANSFUSION STARTED AM PM
CHECKED BY — DATE
TRANSFUSION COMPLETED AM PM
IF BLOOD IS GIVEN PRIOR TO COMPLETION OF TESTING I ASSUME RESPONSIBILITY. — DATE
BLOOD WARMER USED YES TEMP. °C NO
THE PATIENT WAS CHECKED IN 10 MINUTES AND AT LEAST EVERY 30 MIN THEREAFTER.
AMOUNT TRANSFUSED
SUSPECTED REACTION YES NO
IF YES WITHIN CLINICAL REPORT OF SUSPECTED TRANSFUSION REACTION FORM 559

O'CONNOR HOSPITAL
A COMMUNITY HOSPITAL

Lab will read the front as you confirm

- Unit #
- Unit ABO/Rh
- Unit Expiration Date
- Blood Band #

Ready to Transfuse

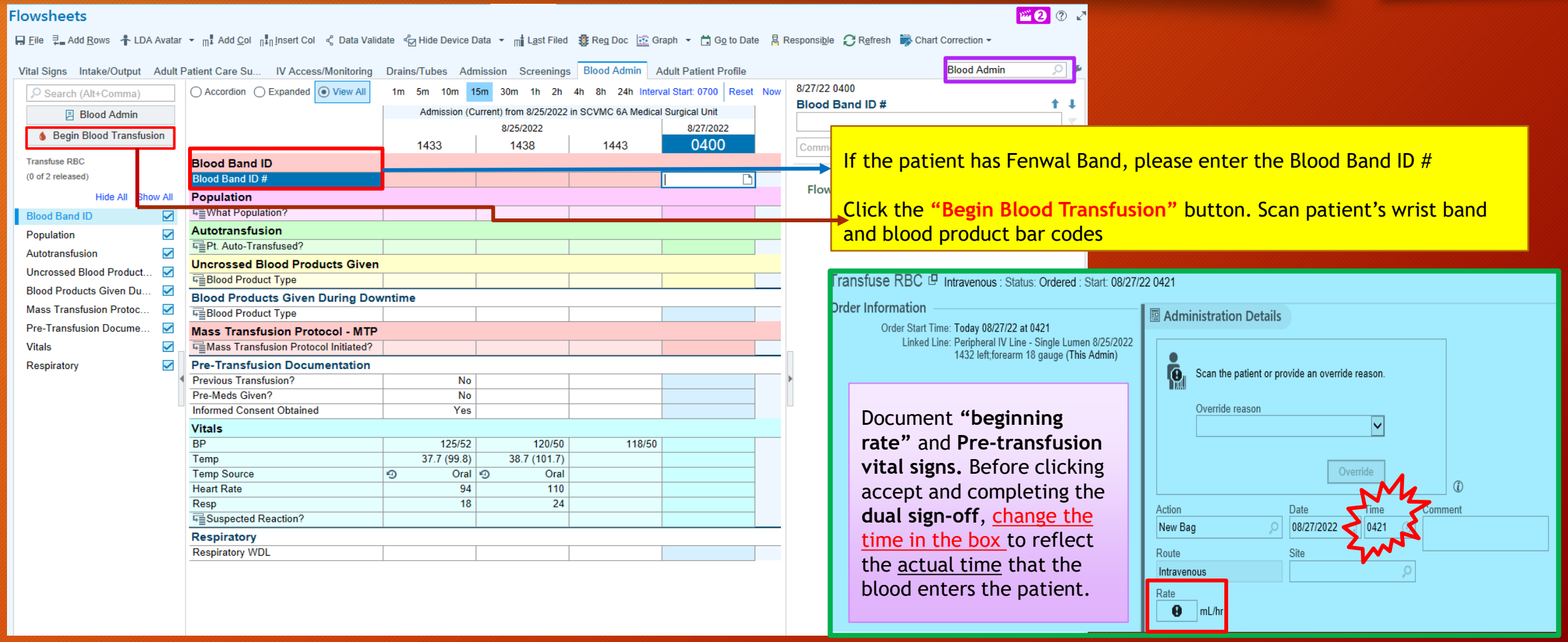
- Before transfusion, verify the intended recipient by “read backs” between 2 RNs or 1 RN and 1 LVN at the bedside
- Ensure that blood product barcodes and patient are both scanned

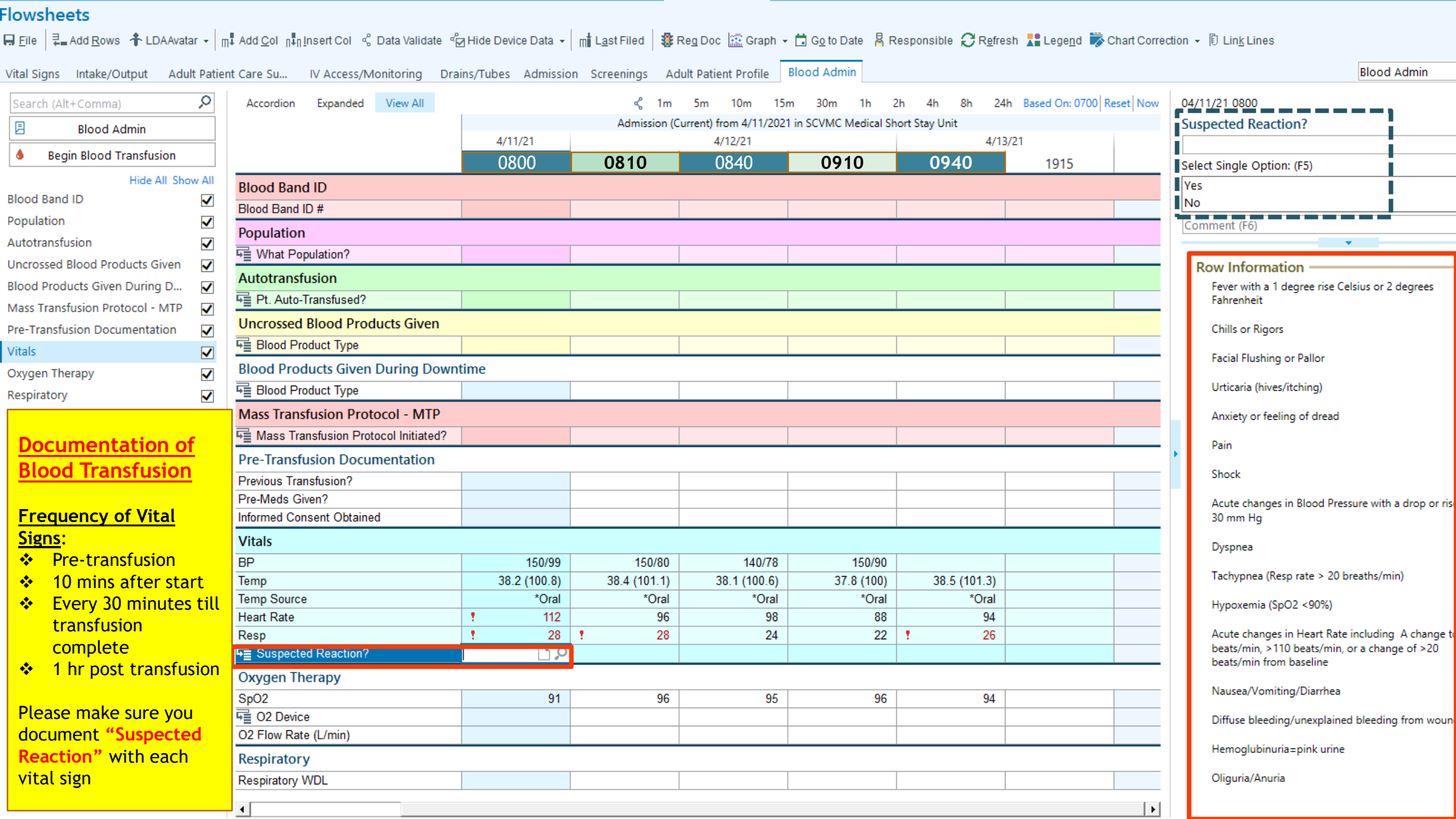
- Information on the transfusion slip must match patient’s hospital armband
  - **Notify Blood Bank of any discrepancy**

- Fenwal Blood band must be on patient’s wrist if applicable

- Fenwal information on the blood and transfusion slip must be identical
  - **Mismatch = DO NOT TRANSFUSE**

Blood Transfusion

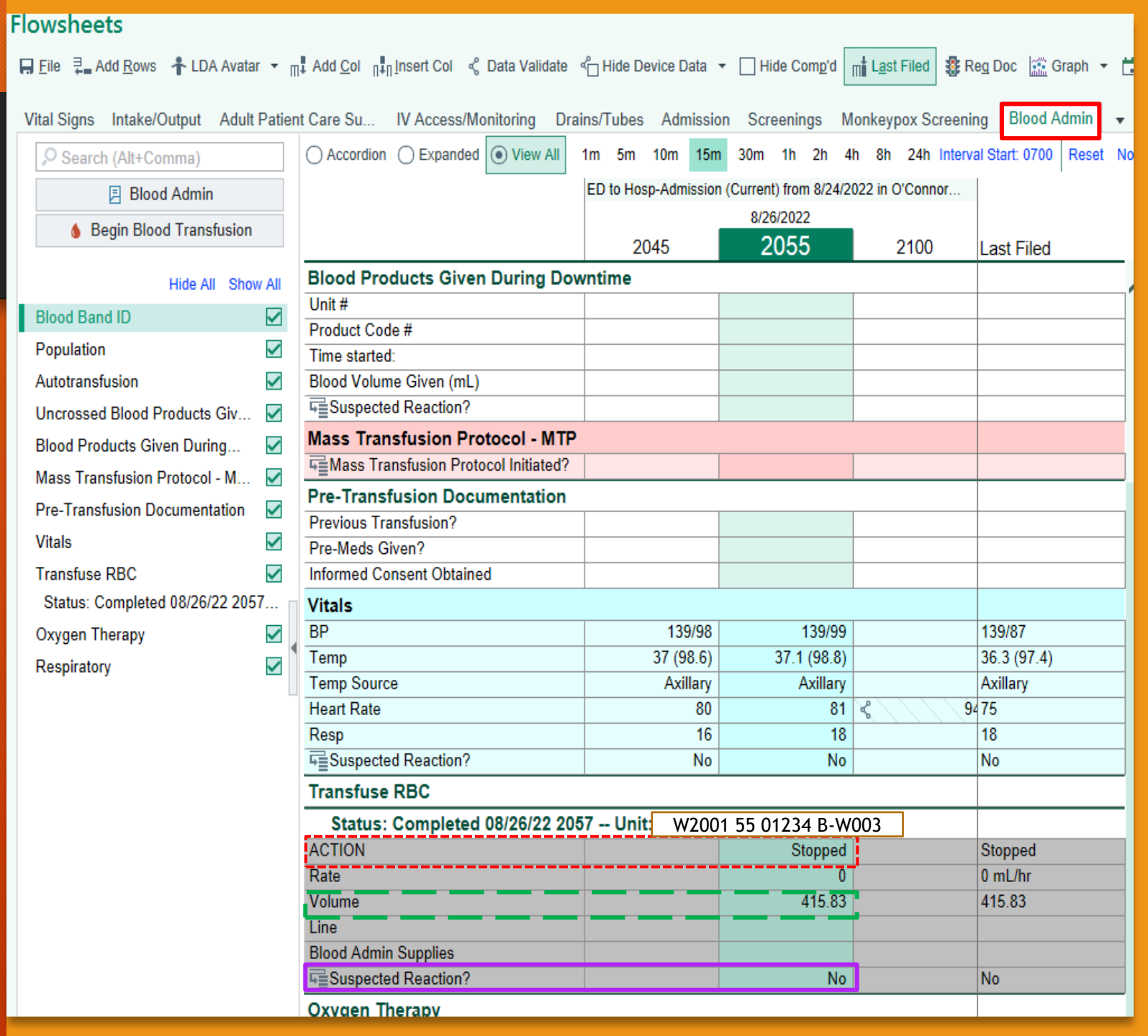



Flowsheets
File
Add Rows
LDAAvatar
Add Col
Insert Col
Data Validate
Hide Device Data
Last Filed
Reg Doc
Graph
Go to Date
Responsible
Refresh
Legend
Chart Correction
Link Lines
Vital Signs
Intake/Output
Adult Patient Care Su...
IV Access/Monitoring
Drains/Tubes
Admission
Screenings
Adult Patient Profile
Blood Admin
Blood Admin
Search (Alt+Comma)
Blood Admin
Begin Blood Transfusion
Hide All Show All
Blood Band ID
Population
Autotransfusion
Uncrossed Blood Products Given
Blood Products Given During D...
Mass Transfusion Protocol - MTP
Pre-Transfusion Documentation
Vitals
Oxygen Therapy
Respiratory
Accordion
Expanded
View All
1m
5m
10m
15m
30m
1h
2h
4h
8h
24h
Based On: 0700
Reset
Now
Admission (Current) from 4/11/2021 in SCVMC Medical Short Stay Unit
4/11/21
4/12/21
4/13/21
0800
0810
0840
0910
0940
1915
Blood Band ID
Blood Band ID #
Population
What Population?
Autotransfusion
Pt. Auto-Transfused?
Uncrossed Blood Products Given
Blood Product Type
Blood Products Given During Downtime
Blood Product Type
Mass Transfusion Protocol - MTP
Mass Transfusion Protocol Initiated?
Pre-Transfusion Documentation
Previous Transfusion?
Pre-Meds Given?
Informed Consent Obtained
Vitals
BP 150/99 150/80 140/78 150/90
Temp 38.2 (100.8) 38.4 (101.1) 38.1 (100.6) 37.8 (100) 38.5 (101.3)
Temp Source *Oral *Oral *Oral *Oral *Oral
Heart Rate 112 96 98 88 94
Resp 28 28 24 22 26
Suspected Reaction?
Oxygen Therapy
SpO2 91 96 95 96 94
O2 Device
O2 Flow Rate (L/min)
Respiratory
Respiratory WDL
04/11/21 0800
Suspected Reaction?
Select Single Option: (F5)
Yes
No
Comment (F6)
Row Information
Fever with a 1 degree rise Celsius or 2 degrees Fahrenheit
Chills or Rigors
Facial Flushing or Pallor
Urticaria (hives/itching)
Anxiety or feeling of dread
Pain
Shock
Acute changes in Blood Pressure with a drop or ris 30 mm Hg
Dyspnea
Tachypnea (Resp rate > 20 breaths/min)
Hypoxemia (SpO2 <90%)
Acute changes in Heart Rate including A change t beats/min, >110 beats/min, or a change of >20 beats/min from baseline
Nausea/Vomiting/Diarrhea
Diffuse bleeding/unexplained bleeding from woun
Hemoglubinuria=pink urine
Oliguria/Anuria
Documentation of Blood Transfusion
Frequency of Vital Signs:
Pre-transfusion
10 mins after start
Every 30 minutes till transfusion complete
1 hr post transfusion
Please make sure you document "Suspected Reaction" with each vital sign

How to Complete Blood Transfusion

- Upon completion, document action as **“stopped”** as well as the suspected transfusion reaction (yes or no). Click on the little calculator in the **“volume”** field to accept or change the calculated volume

- Right click on the blood unit number W0001233, then select **“complete transfuse RBC”**



Transfusion Reaction—What to Do?

- **Stop the transfusion, but keep IV fluids running**
  - **Call the MD**
  - **Obtain Vital Signs every 15 mins x 4 and record in the EHR.**
  - **Order Transfusion Reaction Work-Up Panel in Epic/HealthLink**
  - **Escalate to Leadership**
  - **Call the Blood Bank**
    - To notify Blood Bank about transfusion reaction
    - Blood Bank will send phlebotomist.
    - Phlebotomist will:
      - Draw post-transfusion specimens
      - Take back post-transfusion urine sample
      - Take back what is left of the unit, IV bag and tubing
  - **Order and Obtain post-transfusion urine sample**
  - **Send what is left of the unit, blood tubing and the IV bag to Lab**

Massive Transfusion Protocol

- Can be initiated by any Physician
- Designate **ONE person** with dedicated phone to communicate with Blood Bank
- Call Blood Bank to initiate ‘Massive Transfusion Protocol’ & place order in Health Link
    - **4 units O neg – Emergency Release and uncross matched – can be issued if needed based on patients' gender or age**

Massive Transfusion Protocol

- Blood Bank will fill start filling coolers with **Massive Transfusion Packs – each pack includes:**
- 4 units O neg RBCs for females of childbearing age < 55 years old & unknown gender
- 4 units of O positive RBCs for male & females >55 years old.

The first pack will have:

- 4 RBC's/4 Plasma/1 Platelet

(plasma takes approx. 30 min to thaw, so first pack will be RBCs and platelets with FFP sent as soon as it is thawed)

The second pack will have:

- 4 RBC's/4 Plasma

***Platelets will be given every other pick up

- Cryoprecipitate (only if requested)

- Have designated person pick up cooler when ready
- Don't Forget to 'Deactivate' once patient stabilizes or Notify the Laboratory if the patient changes locations

References

- Enterprise policy #0023:
"Administration of Blood & Blood Components"

Fall Prevention

Lindsay Kehl, RN QI Coordinator
Santa Clara Valley Medical Center

Fall Prevention Program

Universal Fall Precautions – All Patients

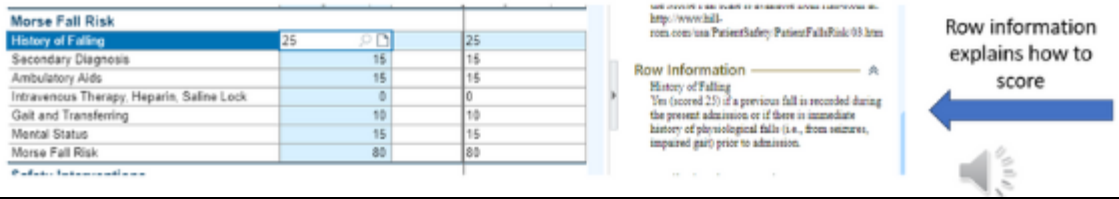
- Keep 2 or 3 siderails up (4 is considered a restraint)
- Keep pathways clear to bathroom
- Non-skid footwear
- Clean up or contains spills
- Adequate lighting (in bathroom or patient room)
- Keep call light within reach
- Advise patients to call for assistance out of bed
- Keep bedpan, urinal, and personal items within patient reach
- Bed locked & in lowest position

Fall Prevention

Fall Risk Assessments

Required assessments and documentation

- Fall risk assessments are required on all patients q shift and on admit
- **Morse** for Adults and **Humpty-Dumpty** for Pediatrics (17 and under)
- Clarification on assessments can be found in the sidebar when you click the assessment cell



Fall Risk Assessments

Required assessments and documentation

- Best Practice Advisory reminders will populate to add care plan if a patient scores as being a fall risk (the first time they score as a fall risk)
  - Fall Risk care plan is required for all fall risk patients
  - Please "Accept" the reminders to add a Fall Risk care plan for the patient

Fall Prevention Program – Risk Signs

Visual Indicators Identify Patients at Risk for Falls (Morse ≥45)

OCH

VMC Rehab (Circle for alarm)

VMC Bed Alarm and High Risk

VMC

1 Star = Moderate Risk

2 Stars = High Risk (Morse ≥75)

SLRH Magnets from bundle

Pedi Only

Fall Program Risk Signs & Visual Indicators

Fall Prevention Program - Interventions

Consider optional interventions for patients at high for falls

- Bed alarm (most beds have built-in alarm to activate)
- Sitter
- Telesitter (VMC only)
- Restraints (last resort)
- Schedule purposeful, Q1H rounds on the 4 "Ps" (Pain, "Potty", Personal Items, Positioning"
- Move closer to nurse's station
- Extra low bed

Immediate Fall Recovery for Falls with Injury

VMC

- Call Transport at x57995 for HoverJack or use portable hover to assist patient back to bed
- Notify MD of any fall (Secure Chat), call RRT if significant injury suspected

OCH

- Call 5-5-5 and ask for overhead page for code Falling Star with location
- Team will respond for fall recovery, including Hoverjack
- Notify MD

SLRH

- Hoverjack located on Med-Surg Rm 127, other departments to borrow as needed
- Notify MD of any fall, call RRT if significant injury suspected

Fall Prevention Program – Visual Indicators

Visual Indicators Identify Patients at Risk for Falls (Morse ≥45)

OCH/SLRH

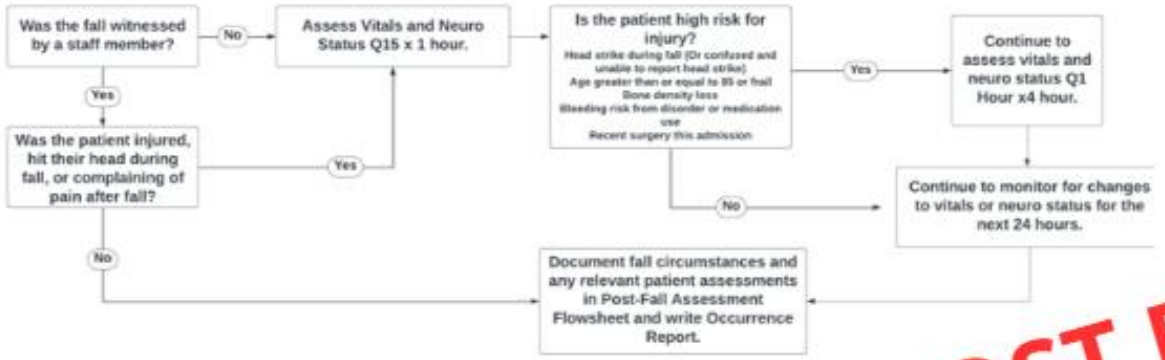
Uses fall bundle with wrist band, blanket, yellow non-skid socks, and yellow magnets

VMC

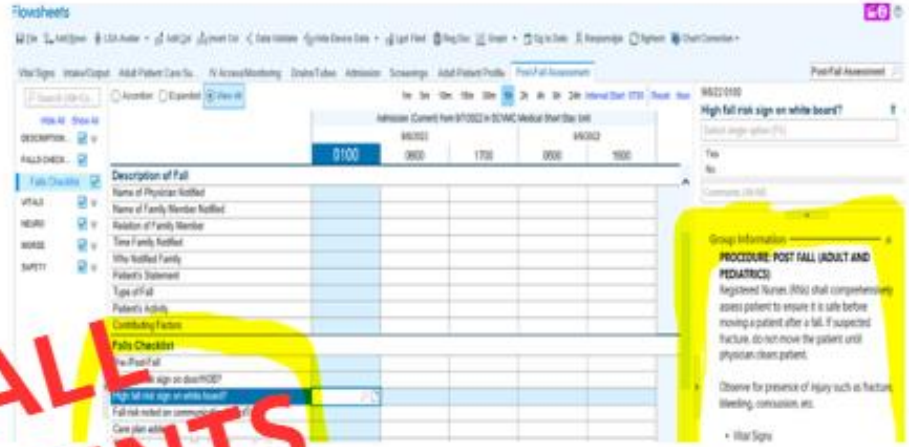
Yellow non-skid socks, wrist bands in select care areas

Post-Fall Assessment

If a patient falls, monitoring is required after a fall



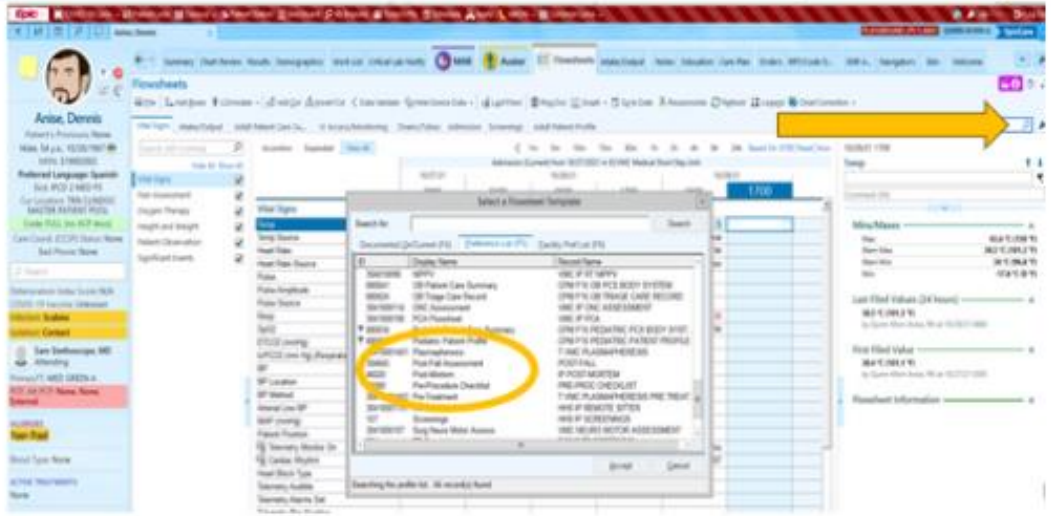
Post-Fall Assessment: Document



Flowsheet contains required assessment pieces. The sidebar of flowsheet will show required assessment pieces when the falls checklist is clicked.

POST FALL REQUIREMENTS

Post-Fall Assessment: Wrench In



Occurrence Reporting

- Find desktop icon for Occurrence Reports
- Select Fall from the list of icons and fill out to the best of your ability
- At minimum include patient name/MRN, date of fall, department of fall, and any injuries sustained

Infection Prevention

It’s in your hands…

HAND HYGIENE

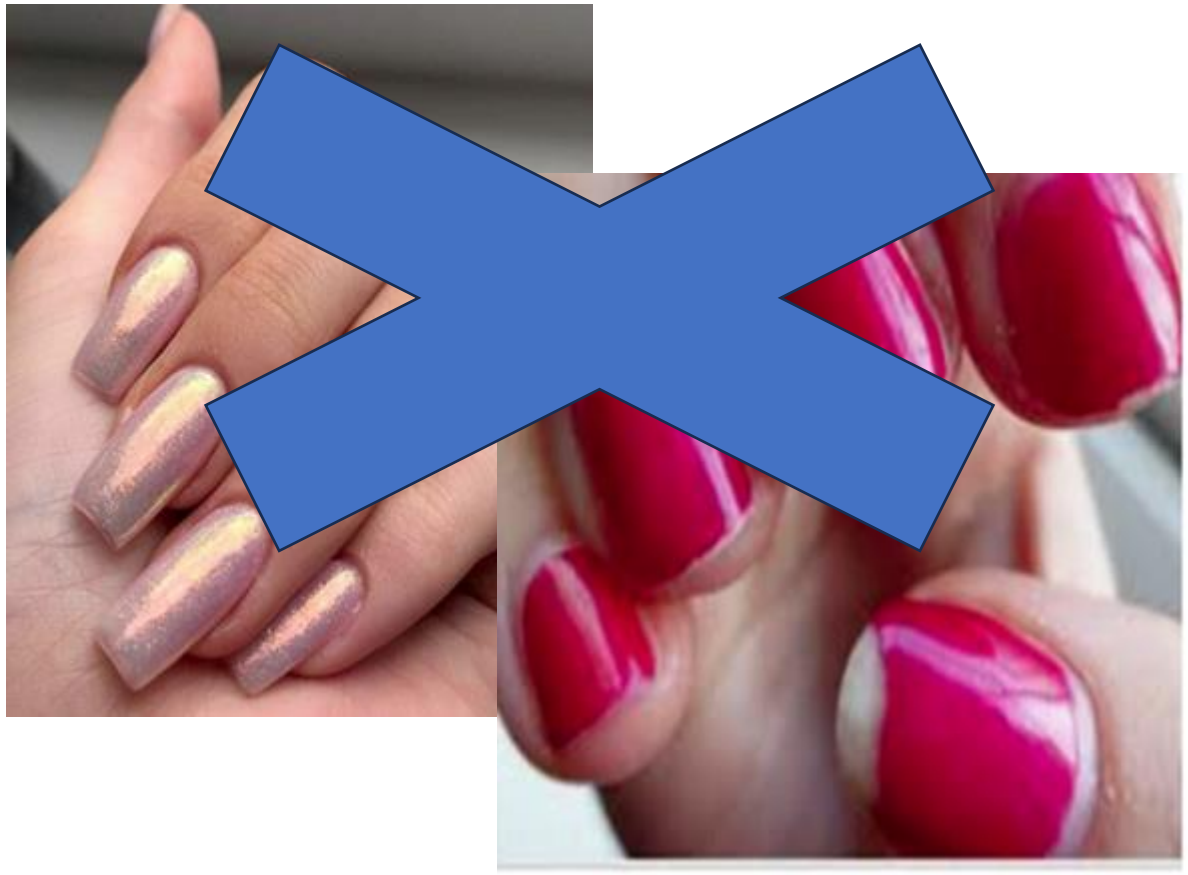
STANDARD WASHING

- ***Using anti-microbial soap***
- ***20 seconds minimum***
- ***Scrub all surfaces, wrist to tip***
  - When hands are soiled
  - After providing care for patients with C-difficile
  - After sneezing, coughing, wiping nose
  - Upon build-up of hand rub

HAND DISINFECTION

- ***Alcohol-based rub***
- ***Apply to palm, cover all surfaces***
- ***Rub until hands are dry***
  - *Prior to patient care*
  - *After patient care*
  - *After contact with patient's environment or equipment*
  - *After removing gloves*
  - *Prior to invasive procedure*

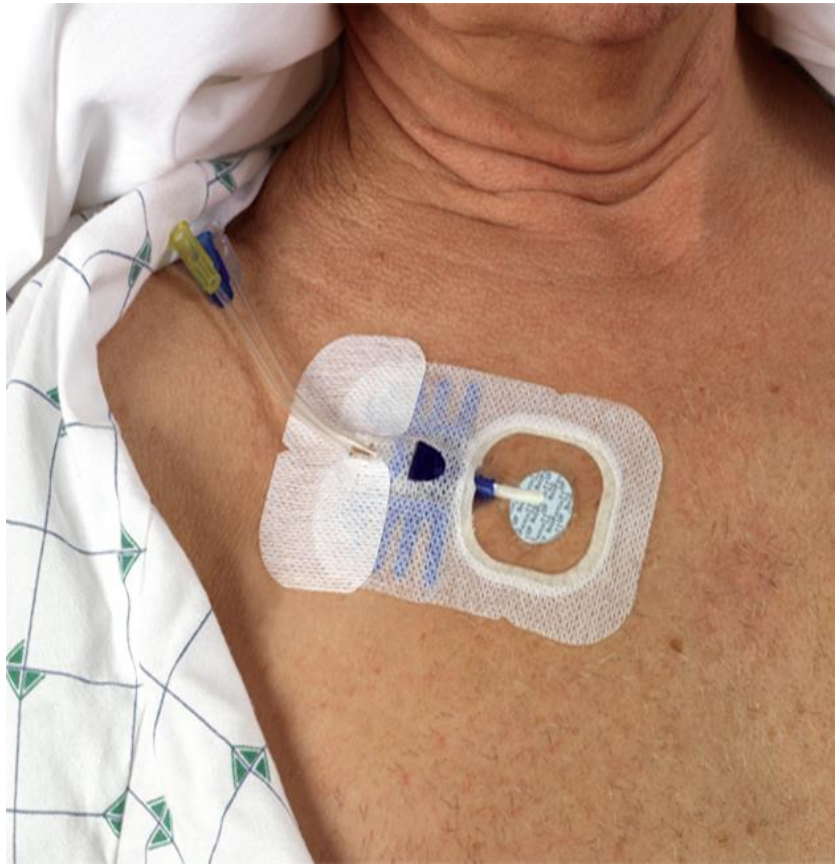
Hand & Fingernail



- Natural fingernails
- No longer than ¼” from end of finger
- No artificial nails, no gel or shellac
- Nails must be kept clean
- Polish, if worn, without cracks or chips

Prevention of CLABSI

- Hand hygiene for insertion and line care
- Maximal barrier precautions upon insertion
- Sterile gown & gloves
  - Hair cover & mask
- Daily Skin antisepsis, Theraworx or CHG
- Daily Review of Line necessity
- Prompt removal of unnecessary lines
- Optimal catheter site selection, subclavian vs femoral



CENTRAL LINE MANAGEMENT

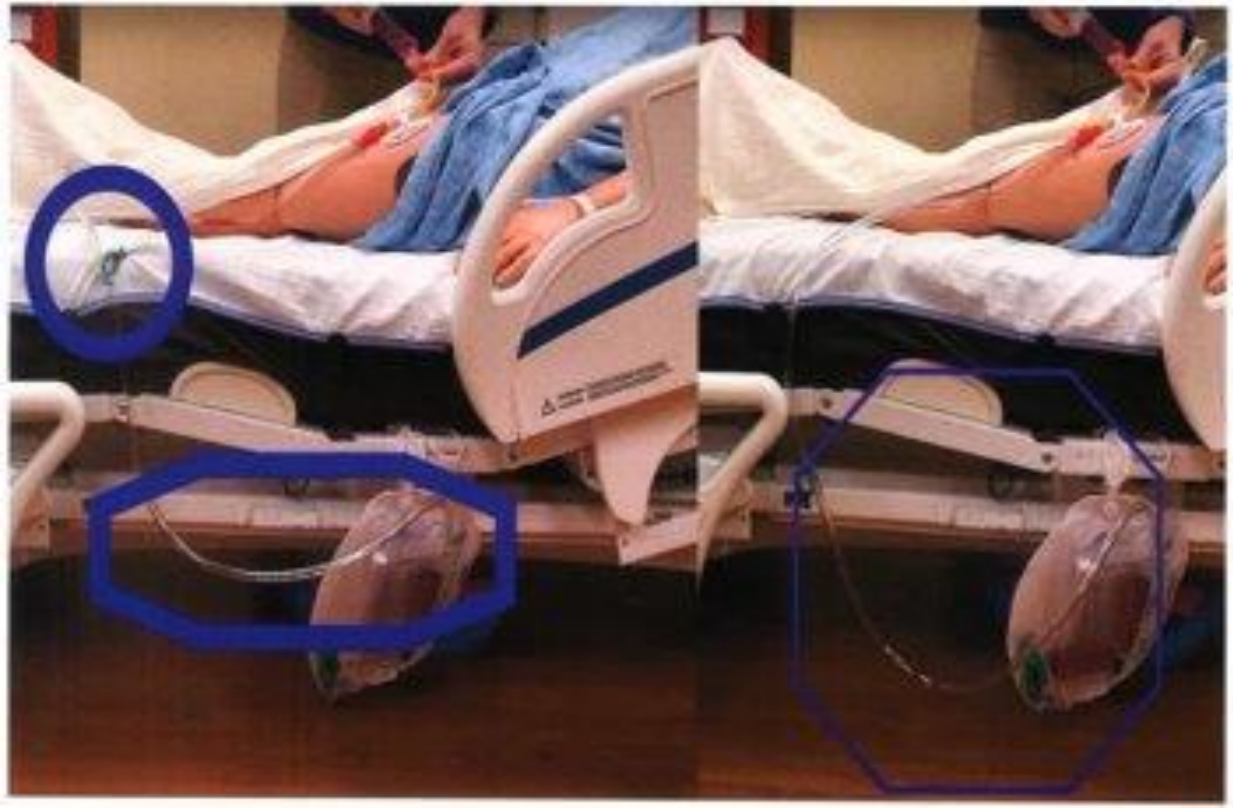
ADULT CENTRAL VENOUS CATHETER MANAGEMENT GUIDELINES

FLUSHING PROTOCOL
Using pulsating, push-pause technique; leave 1mL NS in flush syringe
Never use syringes smaller than 10 mLs until patency is determined
Volumes may be adjusted for patients with a fluid restriction
Flush before and after meds & anytime blood is visible.
Verify blood return any time the line is accessed.

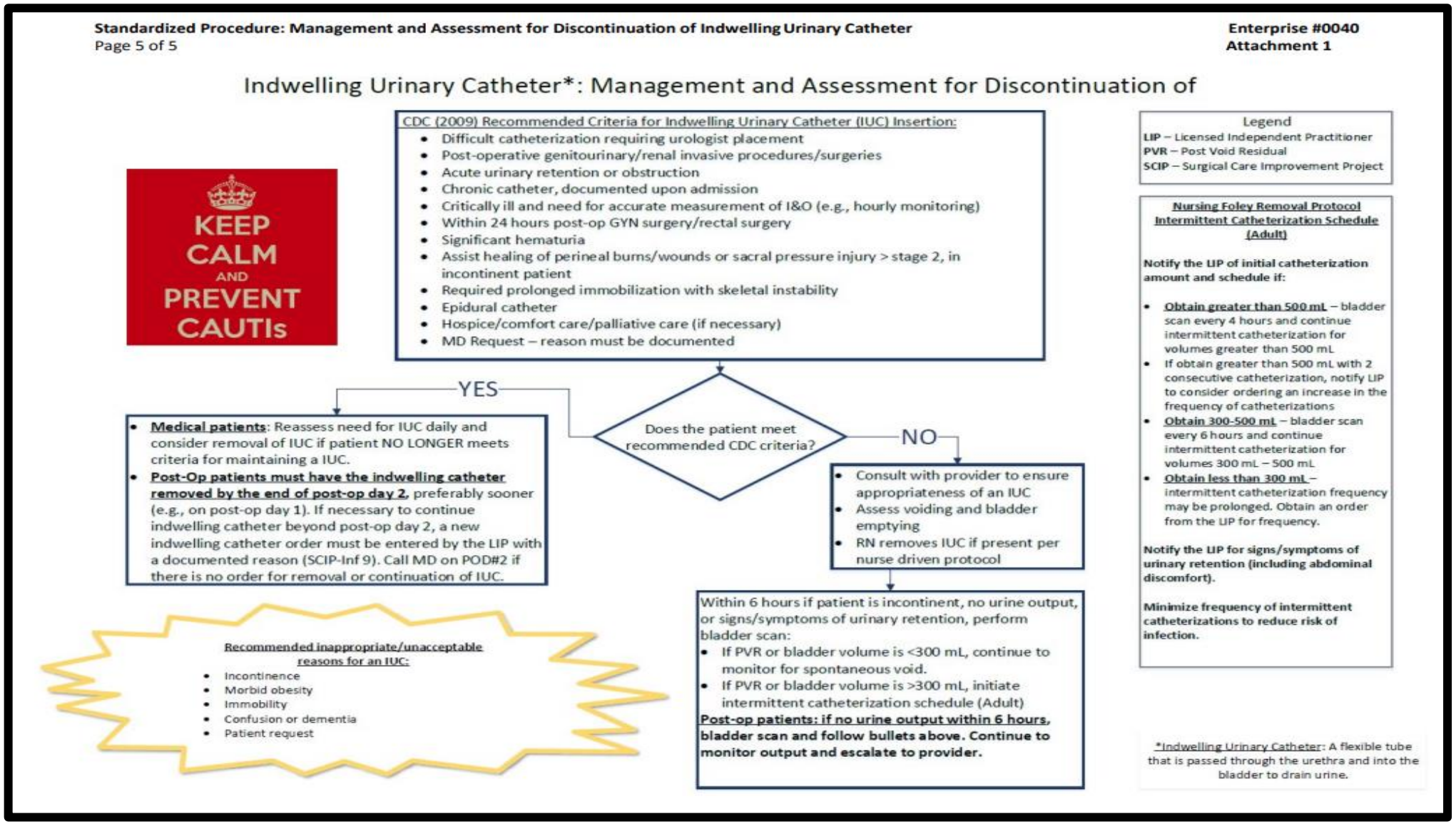
CATHETER		FLUSHING	LOCKING	BLOOD SAMPLING*	POST BLOOD ADMINISTRATION	DRESSING	ADMINISTRATION SET INJECTION CAP ADD-ON DEVICES
NONTUNNELED	**Subclavian, Internal jugular, Femoral CVCs**	10 mL NS	10 mL NS every 8 hours	Keep a closed system, draw blood samples through injection cap **Pre-draw** • Stop all infusions • Verify blood return then flush 10mL NS • Wait to allow hemodilution • Discard 5 mL Do not return to the patient **Post-draw** • Minimum 20 mL NS to clear injection cap and catheter **Blood culture:** Replace injection cap prior to sampling ***Must** stop all infusions, flush the port to be used for blood sampling with 10ml NS and wait for at least 3 minutes before drawing blood	Minimum 20 mL NS to clear catheter and injection cap	**Transparent** dressing: Change every 7 days and PRN **Gauze**, including gauze under transparent dressing: Change every 48 hours and PRN **Outpatient gauze dressing**, change at least twice a week **Intact, irritated skin:** • Use povidone-iodine in lieu of alcohol and CHG solutions • Apply breathable transparent dressing (eg. Sorbaview™) • If unable to tolerate adhesives, use sterile gauze, gauze wrap, and elastic netting	**Continuous** IV tubing and add-on devices: Every 96 hours **Intermittent, Parenteral Nutrition, Lipids** IV tubing and add-on devices: Every 24 hours Replace **injection cap**: • If removed for any reason • Every 96 hours, with IV tubing change • With each dressing change • When visibly soiled • When unable to clear with a flush • When admitting a patient with a central line • Prior to blood culture sampling via CVC **Dead-end cap & port protector**: Replace when removed One-time use, never reuse **Implanted port** Non-coring needle change every 7 days with dressing change
	PICC with clamp	10 mL NS	**Inpatient:** 10 mL NS for intermittent locking **Outpatient:** Weekly 10 mL NS followed by 2mL Heparin 100 units/mL unless heparin is contraindicated				
	PICC valved	10 mL NS	**Inpatient:** 10 mL NS for intermittent locking **Outpatient:** 10 mL NS weekly				
TUNNELED	**Cuffed CVC ex. Hickman, Broviac**	10 mL NS	**Inpatient:** 10 mL NS for intermittent locking **Outpatient:** Weekly 10 mL NS followed by 3mL Heparin 100 units/mL unless heparin is contraindicated				
	Implanted port**	10-20mL NS ** Consider topical analgesia prior to access: Obtain provider order for EMLA cream to port site PRN port access	**Inpatient:** 10 mL NS for intermittent locking **Deaccess:** 20 mL NS followed by 5mL of Heparin 100 units/mL **Outpatient / Maintenance flushing and locking:** Up to every 12 weeks, 20 mL NS followed by 5mL of Heparin 100 units/mL				

Prevention of CAUTI

- Hand hygiene before and after
- Insert using sterile technique
- Use securement device
- Keep catheter below bladder level
- Maintain a closed-loop system
- Peri-care, daily and when soiled
- No dependent loops
- Daily evaluation of need for foley



Management and Assessment of Indwelling Urinary Catheter Enterprise policy #0040



Standardized Procedure: Management and Assessment for Discontinuation of Indwelling Urinary Catheter
Page 5 of 5

Enterprise #0040
Attachment 1

Indwelling Urinary Catheter*: Management and Assessment for Discontinuation of

CDC (2009) Recommended Criteria for Indwelling Urinary Catheter (IUC) Insertion:

- Difficult catheterization requiring urologist placement
- Post-operative genitourinary/renal invasive procedures/surgeries
- Acute urinary retention or obstruction
- Chronic catheter, documented upon admission
- Critically ill and need for accurate measurement of I&O (e.g., hourly monitoring)
- Within 24 hours post-op GYN surgery/rectal surgery
- Significant hematuria
- Assist healing of perineal burns/wounds or sacral pressure injury > stage 2, in incontinent patient
- Required prolonged immobilization with skeletal instability
- Epidural catheter
- Hospice/comfort care/palliative care (if necessary)
- MD Request – reason must be documented

Does the patient meet recommended CDC criteria?

YES

- **Medical patients**: Reassess need for IUC daily and consider removal of IUC if patient NO LONGER meets criteria for maintaining a IUC.
- **Post-Op patients must have the indwelling catheter removed by the end of post-op day 2,** preferably sooner (e.g., on post-op day 1). If necessary to continue indwelling catheter beyond post-op day 2, a new indwelling catheter order must be entered by the LIP with a documented reason (SCIP-Inf 9). Call MD on POD#2 if there is no order for removal or continuation of IUC.

NO

- Consult with provider to ensure appropriateness of an IUC
- Assess voiding and bladder emptying
- RN removes IUC if present per nurse driven protocol

Within 6 hours if patient is incontinent, no urine output, or signs/symptoms of urinary retention, perform bladder scan:

- If PVR or bladder volume is <300 mL, continue to monitor for spontaneous void.
- If PVR or bladder volume is >300 mL, initiate intermittent catheterization schedule (Adult)

Post-op patients: if no urine output within 6 hours, bladder scan and follow bullets above. Continue to monitor output and escalate to provider.

Recommended inappropriate/unacceptable reasons for an IUC:

- Incontinence
- Morbid obesity
- Immobility
- Confusion or dementia
- Patient request

Legend
LIP – Licensed Independent Practitioner
PVR – Post Void Residual
SCIP – Surgical Care Improvement Project

Nursing Foley Removal Protocol Intermittent Catheterization Schedule (Adult)

Notify the LIP of initial catheterization amount and schedule if:

- **Obtain greater than 500 mL** – bladder scan every 4 hours and continue intermittent catheterization for volumes greater than 500 mL
- If obtain greater than 500 mL with 2 consecutive catheterization, notify LIP to consider ordering an increase in the frequency of catheterizations
- **Obtain 300-500 mL** – bladder scan every 6 hours and continue intermittent catheterization for volumes 300 mL – 500 mL
- **Obtain less than 300 mL** – intermittent catheterization frequency may be prolonged. Obtain an order from the LIP for frequency.

Notify the LIP for signs/symptoms of urinary retention (including abdominal discomfort).

Minimize frequency of intermittent catheterizations to reduce risk of infection.

*Indwelling Urinary Catheter: A flexible tube that is passed through the urethra and into the bladder to drain urine.

Nurse driven protocol still requires a physician order

C DIFF

If patient admitted with diarrhea

- Isolate patient
- RN can isolate patient without MD order

Hospital Day 1-3, Cdiff is Community Acquired

After Hospital Day 3, Cdiff is Hospital Acquired

Consider the clinical picture – elevated temp, pain, elevated WBC?

- Is the patient on laxatives
- Is patient on tube feeds, oral contrast
- Is stool liquid, does it have an odor?

FOLLOW FACILITY PROTOCOL

O'CONNOR HOSPITAL
A COMMUNITY HOSPITAL

Management of Clostridioides difficile

New Admission
Day 1 to Day 3
First loose/ liquid stool

YES

Place patient in Contact + Isolation and send first stool specimen with the **checklist form**
Verify with Charge RN
No IC approval needed
Obtain C-diff order from Provider

If stool is negative, call Provider to DC Isolation.

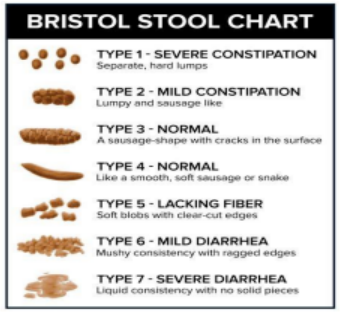
If stool is (+) maintain isolation until DC. Any (+) test from day 1-3 is a community onset. Day 4 and onwards is a hospital acquired.

NO

Standard Precaution

[How To Calculate Hospital days]

Day 1 = Admission to Inpatient bed



Current Admission
After Day 3
Loose/Liquid stools (3 or more) within 24 hours

YES

Has patient had a colon/ bowel surgery or is pt. on bowel prep, laxative, enema, tube feeding formula changed or started in last 24 hours?

YES

Do not collect.
Hold above treatment/s and wait for 24 hours

Is liquid stool present after 24 hours?

YES

Place patient in Contact Plus Isolation.
Send 3rd liquid stool specimen within 24 hours.
Fill out C. diff Checklist form.
Verify with Charge RN.
Call IC for approval.
Obtain C. diff order.

NO

Do not send stool.
Soft stool does not meet criteria.

NO

Place patient in Contact Plus Isolation.
Collect the 3rd liquid stool within 24 hours.
Complete C. diff Checklist form.
Verify with Charge RN.
Call IC for approval.
Obtain Provider's order.

NO

Do not send stool.
Soft stool does not meet criteria.

Educate patient, family & Visitors about C. diff and Contact + Isolation. Document on EHR.

Handwashing is required hand hygiene method in caring for the patient.
NO ALCOHOL SANITIZER

Discharge: Room requires Tru-D \UV light
Do not remove isolation sign.
EVS will take down sign.

Documentation of liquid stools should reflect on EHR.
See back for stool collection.

Update Care Plan

Weekdays: Call IC 408-947-2540
After 4PM: Put specimen on ice and call IC at 7:30 next day for approval.
On weekends: Check AMION for on-call IC Team member.

BRISTOL STOOL CHART

TYPE 1 - SEVERE CONSTIPATION
Separate, hard lumps

TYPE 2 - MILD CONSTIPATION
Lumpy and sausage like

TYPE 3 - NORMAL
A sausage-shape with cracks in the surface

TYPE 4 - NORMAL
Like a smooth, soft sausage or snake

TYPE 5 - LACKING FIBER
Soft blobs with clear-cut edges

TYPE 6 - MILD DIARRHEA
Mushy consistency with ragged edges

TYPE 7 - SEVERE DIARRHEA
Liquid consistency with no solid pieces

ISOLATION CARTS

Personal Protective Equipment (PPE)

Donning PPE

- Hand hygiene
- Put on & fasten gown
- Mask
- Eyewear
- Gloves

Doffing PPE

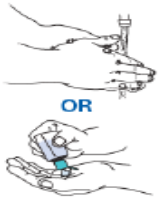
REMOVE:

- Gloves
- Gown
- Mask
- Eyewear
- Hand hygiene

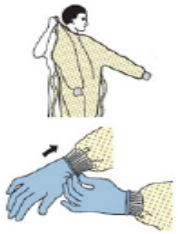
CONTACT PRECAUTIONS

Visitors: Report to nurses' station before entering
Por favor hable con un/una enfermero/a antes de entrar
Xin đến báo với y tá trước khi vào phòng

Patient placement
Private room
Door may be open



Perform hand hygiene
Entry and Exit = Clean hands with hand sanitizer or soap and water



Personal Protective Equipment (PPE)
All employees and visitors must wear gown and gloves before entering the room.
Note: Additional PPE if indicated as per Standard Precautions (e.g., face shield or safety goggles)

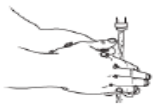
Patient Care Equipment
Dedicate non-critical patient care equipment to a single patient. If non-dedicated equipment is used, thoroughly disinfect with healthcare-approved disinfectant. Remove disinfectant residue with clean damp paper towel once contact/wet time completed.

Patient Transport
Only transport patients for essential therapeutic or diagnostic exams.

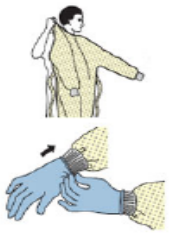
CONTACT PLUS PRECAUTIONS

Visitors: Report to nurses' station before entering
Por favor hable con un/una enfermero/a antes de entrar
Xin đến báo với y tá trước khi vào phòng

Patient placement
Private room
Door may be open



Perform hand hygiene
Entry = Clean hands with hand sanitizer or soap and water
Exit = Clean hands with soap and water only



Personal Protective Equipment (PPE)
All employees and visitors must wear gown and gloves before entering the room.
Note: Additional PPE if indicated as per Standard Precautions (e.g., face shield or safety goggles)

Patient Care Equipment
Dedicate non-critical patient care equipment to a single patient. If non-dedicated equipment is used, thoroughly disinfect with healthcare-approved disinfectant. Remove disinfectant residue with clean damp paper towel once contact/wet time completed.

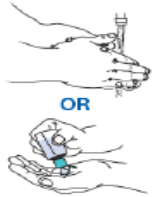
Patient Transport
Only transport patients for essential therapeutic or diagnostic exams.

UV Disinfection Robot to be Used on Discharge

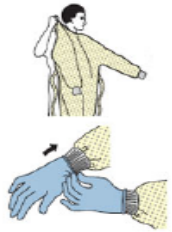
ENHANCED CONTACT PRECAUTIONS

Visitors: **Report to nurses' station before entering**
Por favor hable con un/una enfermero/a antes de entrar
Xin đến báo với y tá trước khi vào phòng

Patient placement
1:1 RN
Private room
Door may be open
Limit persons entering room



Perform hand hygiene
Entry and Exit = Clean hands with hand sanitizer or soap and water



Personal Protective Equipment (PPE)
All employees and visitors must wear gown and gloves before entering the room.
Note: Additional PPE if indicated as per Standard Precautions (e.g., face shield or safety goggles)

Patient Care Equipment
Dedicate non-critical patient care equipment to a single patient. If non-dedicated equipment is used, thoroughly disinfect with healthcare-approved disinfectant. Remove disinfectant residue with clean damp paper towel once contact/wet time completed.

Patient Transport
Only transport patients for essential therapeutic or diagnostic exams.

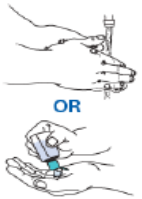
UV Disinfection Robot to be Used on Discharge

AIRBORNE PRECAUTIONS

STOP

Visitors: Report to nurses' station before entering
Por favor hable con un/una enfermero/a antes de entrar
Xin đến báo với y tá trước khi vào phòng

Patient placement
Negative pressure room with door closed



Perform hand hygiene
Entry and Exit = Clean hands with hand sanitizer or soap and water

Personal Protective Equipment (PPE)
All visitors must wear surgical mask and gloves before entering the room.
Employees must wear N95 or Controlled Air-Purifying Respirator (CAPR)
Note: Additional PPE if indicated as per Standard Precautions (e.g., face shield or safety goggles)

Patient Care Equipment
Dedicate non-critical patient care equipment to a single patient. If non-dedicated equipment is used, thoroughly disinfect with healthcare-approved disinfectant. Remove disinfectant residue with clean damp paper towel once contact/wet time completed.

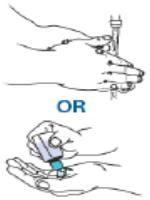
Patient Transport
Only transport patients for essential therapeutic or diagnostic exams.
Place surgical mask on patient during transport.

Place Surgical Mask on Patient During Transport

DROPLET PRECAUTIONS

Visitors: Report to nurses' station before entering
Por favor hable con un/una enfermero/a antes de entrar
Xin đến báo với y tá trước khi vào phòng

Patient placement
Private room
Door may be open



Perform hand hygiene
Entry and Exit = Clean hands with hand sanitizer or soap and water

Personal Protective Equipment (PPE)
All employees and visitors must wear surgical mask and gloves before entering the room.
Note: Additional PPE if indicated as per Standard Precautions (e.g., face shield or safety goggles)

Patient Care Equipment
Dedicate non-critical patient care equipment to a single patient. If non-dedicated equipment is used, thoroughly disinfect with healthcare-approved disinfectant. Remove disinfectant residue with clean damp paper towel once contact/wet time completed.

Patient Transport
Only transport patients for essential therapeutic or diagnostic exams.
Place surgical mask on patient during transport.

Place Surgical Mask on Patient During Transport

*Consult with Infection Prevent and Control (IPC) for cohorting	CONTACT	CONTACT PLUS UV LIGHT USE ON DISCHARGE/TRANSFER	DROPLET	AIRBORNE	ENHANCED CONTACT UV LIGHT USE ON DISCHARGE/TRANSFER
Sign Color	Dark Green	Tan	Gray	Red	Light Green
Common Diseases	• MRSA (Excludes MRSA NT) • MDRO-CRO • Hx of CPO • VRE • ESBL • Other MDROs • Lice/Scabies • RSV (immunocompromised or pediatrics) CPO (Rule Out): • Carbapenem-Producing Organisms (CPO)	Positive or Rule Out: • Clostridioides difficile • Norovirus • Other spore forming microrganisms	Positive or Rule Out: • Meningitis or Meningococcemia • Influenza • Pertussis/ Parapertussis • Rubella • Mumps • Haemophilus influenzae in children	Positive or Rule Out: • Tuberculosis (TB) • Varicella (chickenpox) • Disseminated Shingles (Herpes zoster) or localized Shingles in immunocompromised • Measles • Novel Airborne Disease (SARS, MERS, etc.)	• Carbapenem-Producing Organisms (CPO)
PPE - *in addition to Standard Precautions*	GOWN and GLOVES	GOWN and GLOVES	SURGICAL MASK and GLOVES	CAPR/N95	GOWN and GLOVES
Alcohol Hand Gel or Hand Washing	BEFORE and AFTER patient contact	GEL IN and HAND WASH OUT	BEFORE and AFTER patient contact	BEFORE and AFTER patient contact	BEFORE and AFTER patient contact
Private Room	Yes	Yes	Yes	Yes	Yes
Negative Pressure	No	No	No	Yes	No
Closed Door	No	No	No	Yes, at all times, except to enter/exit	No
Dedicated Staff (1:1)	No	No	No	No	Yes

For a more complete list of infections/diseases and their appropriate isolation,
please see Enterprise Policy #850 "Standard/Transmission-Based Precautions Index of Diseases".

Consult with IPC for any questions at 408-947-2540 or via email OCHInfectionTM@hhs.sccgov.org, Monday to Friday (7:30AM-4:00PM).
Saturday and Sunday (7:30AM-4:00PM), please see AMION for on-call IPC contact information.

UPDATED 11.2023

INPATIENT MULTI-DRUG RESISTANT ORGANISM (MDRO) GRID

MDRO INFECTION BANNER	TYPE OF ISOLATION	# NEGATIVE CULTURES	MINIMUM INTERVAL TO TEST	SITE TO BE TESTED	OFF EFFECTIVE ANTIBIOTIC TREATMENT FOR MINIMUM 72 HOURS
Clostridioides difficile (C. diff)	Contact Plus	N/A	No test of cure	Retesting not applicable isolation to remain for duration of hospital stay.	N/A
CPO	Enhanced Contact	3	7 days	Original site as applicable and additional sites if requested by Infection Prevention and Control (IPC). If original site is closed consult with IPC. (use CARBA-R Panel for same day turnaround time) *Note: Enhanced Contact isolation maybe downgraded to Contact isolation once IPC reviews to confirm discontinuation criteria met.*	Yes
ESBL	Contact	3	5 days	Original site as applicable. If original site is closed, consult with IPC.	Yes
MDRO	Contact	3	5 days	Original site as applicable. If original site is closed, consult with IPC.	Yes
MRSA	Contact	2	24 hours	Original site as applicable. If original site is closed, consult with IPC.	Yes
TB	Airborne	3 AFB 2 MTB	AFB 8 hours apart with at least 1 early morning specimen	3 sputum negative AFB and 2 negative MTB PCR needed to consider isolation discontinuation	N/A
VRE	Contact	3	5 days	Original site as applicable and additional sites if requested by IPC. If original site is closed, consult with IPC.	Yes

Consult with IPC for any questions at 408-947-2540 or via email OCHInfectionTM@hhs.sccgov.org, Monday to Friday (7:30AM-4:00PM). Saturday and Sunday (7:30AM-4:00PM), please see AMION for on-call IPC contact information.

UPDATED 11.2023

Guidance for Patients Transferring to a New Room

Continue to wear appropriate PPE per isolation signage until patient is ready for transport

Prior to transport:
- ✓ Bathe patient
- ✓ Place patient in a new hospital gown
- ✓ Discard all disposable items
- ✓ Clean and disinfect all essential items with healthcare-approved disinfectant wipes before transferring
- ✓ Double bag personal items with clean bags if items are not able to be cleaned and disinfected

Please ensure for transport:

PPE
- If indicated on the isolation signage (e.g. Droplet, Airborne), provide patient with a mask.
- No gloves and isolation gown are needed unless staff is providing direct patient care during transport.
- Follow current masking guidelines.

Mode of Transportation
- Patient should be transported via gurney, wheelchair, or other mode of transportation as current bed and all other equipment are to be left in the room.
- Ensure mode of transportation is cleaned before and after patient transport.

Leave the isolation signage and cart in place to ensure EVS appropriately cleans the environment.

Patient Ambulation Guidelines

Is the patient on isolation?

NO

If the patient has any of the following listed below, perform the required task(s) before ambulating:
- Draining wound – Ensure drainage is contained and wound is covered
- Urinary incontinence – Ensure use of diaper to contain urine
- Colostomy bag – Ensure bag is emptied
- Bowel incontinence – Consult with Infection Prevention and Control (IPC)

Before ambulation, please ensure:
- The patient is given a new clean gown/clothing.
- The patient performs hand hygiene before leaving the room.
- If the patient is on Contact Plus Isolation, all staff, patients, and visitor(s) must wash their hands with soap and water for a minimum of 20 seconds.

NOTE: The patient should not wear PPE except if on Droplet and Airborne Isolation, then the patient should wear a surgical mask.

YES

While inside the patient's room, staff must wear the appropriate PPE per isolation signage until patient is ready for ambulation.

Introduction to the County of Santa Clara Sepsis Program

Kathy Madlem, BSN, RN

SLRH Quality Manager (interim), SCVMC Sepsis QI Coordinator
Sepsis Alliance Advisory Board Member, Santa Clara County Sepsis Collaborative Chair

KNOW SEPSIS
Save a life today!

THE COUNTY OF SANTA CLARA 1850

O'CONNOR HOSPITAL
A COMMUNITY HOSPITAL

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

ST. LOUISE REGIONAL HOSPITAL
A COMMUNITY HOSPITAL

Recorded in July 2021 and updated: Jan 2022, Nov 2023, March 2024

Best Practices To Improve Outcomes

- Follow the Surviving Sepsis Campaign Guidelines
- ED can receive advanced notification by EMS if potential septic case incoming (EMS sepsis protocol effective 2017)
- Routine screening and monitoring
- Single call activation system on inpatient side using RRT Sepsis Alert once severe sepsis present
- Rapid initiation of sepsis order set(s)
- Team based, coordinated, structured approach with awareness of sepsis bundles, performance data shared with staff
- Patients and family/support person receive sepsis education while in hospital and with discharge instructions (AVS)

Timeliness of Care and Optimize Flow

Multidisciplinary commitment to sepsis care

- Express Care Clinic, Sobrato Cancer Center, Custody Health
- Ambulatory Charge Nurses
- Emergency Department
- Inpatient: All adult units, L&D, FBU, Pedi/PICU

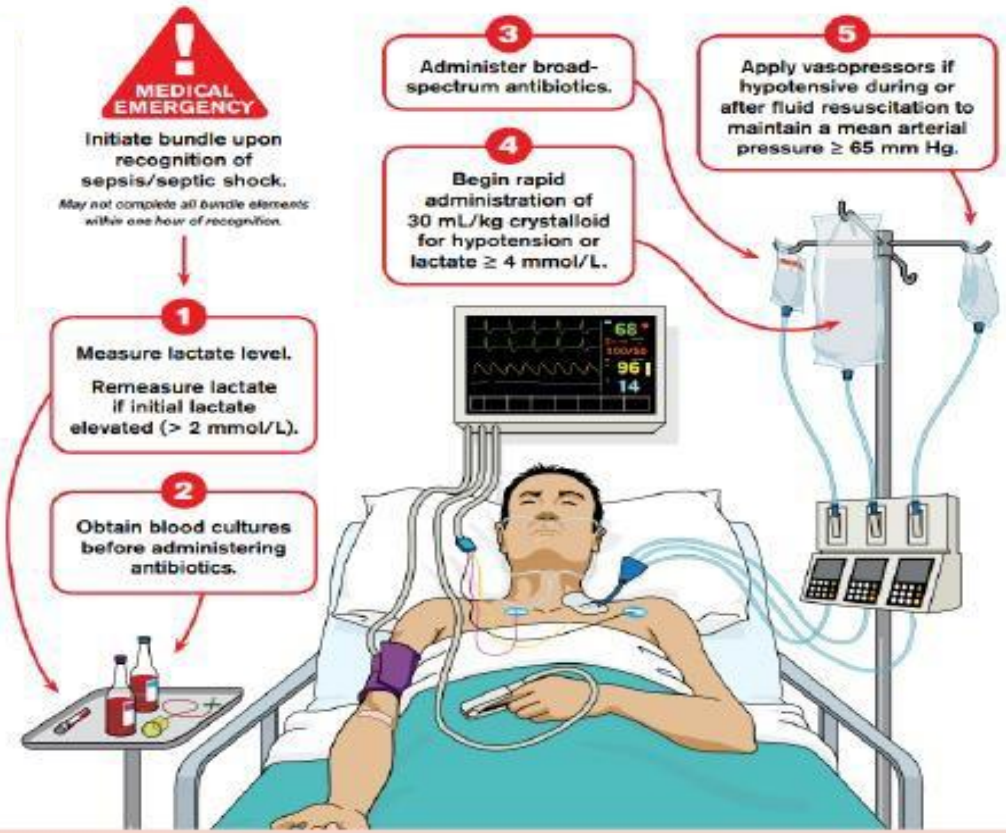
Sepsis team support 24/7

- SCVMC Sepsis leadership team or clinical nurses available on Amion for consult
- SVCMC with Unit-based RN Sepsis Champions on all shifts in 15 adult inpatient units and the ED, the RRT nursing staff, and cross coverage for sepsis by the stroke clinical nurses
- OCH has dedicated RRT nursing staff
- SLRH assigns unit nurses to respond to RRT calls

Hour-1 Bundle

Initial Resuscitation for Sepsis and Septic Shock

Surviving Sepsis Campaign



Lactate w Reflex	Blood Culture(s)	ABX	IVF w/ exam	Vasopressor

KNOW SEPSIS. Save a life today!

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

GO PUBLIC!
County of Santa Clara

Sepsis Syndrome Definitions

Sepsis

Suspicion of infection or confirmed infection and 2 SIRS (systemic inflammatory response syndrome) criteria present

Severe Sepsis

Life-threatening organ dysfunction caused by a dysregulated host response to infection (sepsis + new organ dysfunction)

Septic Shock

Subset of sepsis with circulatory and cellular/metabolic dysfunction associated with a higher risk of mortality (persistent hypotension despite IV fluid resuscitation or lactate ≥ 4 mmol/L)

How do we put the puzzle together? How do we identify patients in severe sepsis or shock?

RN ASSESSMENT

INFECTION + SIRS +

1st sign of new ORGAN DYSFUNCTION OR FAILURE

Infection can be suspected or confirmed

SIRS may or may not be present

When and how do I screen for sepsis?

- Completed on all patients: Adult tool for 18 years of age and older, Pedi tool for 17 years of age and younger (exceptions apply depending on the unit), and any age for OB population (must meet OB criteria):
  - ED – routine screening at triage, when pt roomed, and PRN (until pt discharged or admitted)
  - Inpatient units – routine screening every 8hr and PRN, upon admission/and within 3 hours prior to discharge from hospital

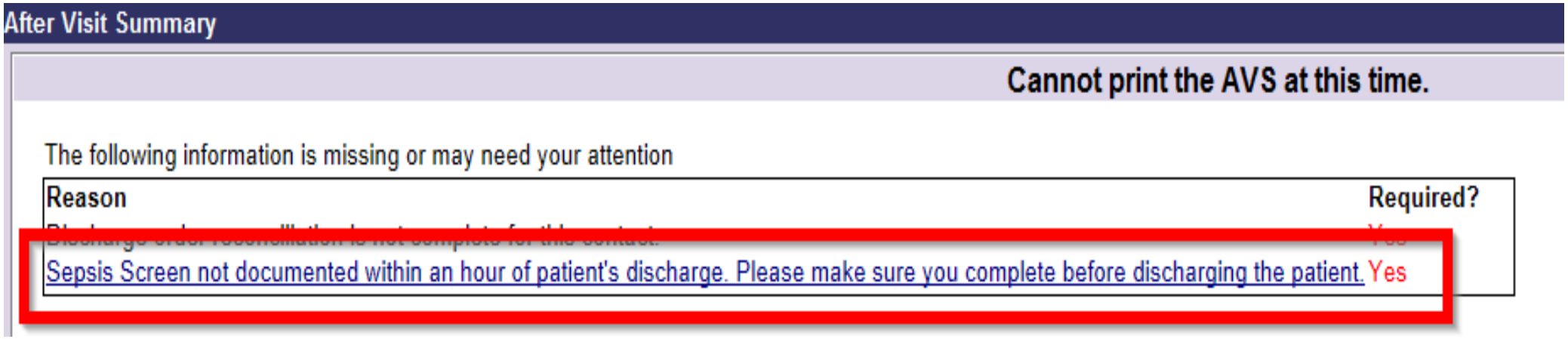
- Sepsis surveillance is part of the routine nursing assessment
  - Goal to conduct sepsis surveillance with each interaction, just like MI and Stroke
  - At least once per shift document in the sepsis screening tool located in HealthLink. Document within 1-120 minutes of most recent vital signs and no more than 6 hours after physical assessment
  - Please launch sepsis screening tool again if you get abnormal lab/vital sign or think the patient is deteriorating

Routine Workflow
sepsis assessment aka sepsis screen

1. Perform physical assessment and record in proper flowsheet rows
2. All vital signs must be recorded (within 1-120 minutes before documenting sepsis screen)
3. Begin Sepsis Screen documentation – only document in real time, do not back chart to earlier time!
4. System will perform data search in real time and autofill SIRS and organ dysfunction fields from physical assessment, vitals, and lab data
5. Analyze the screening tool results!!
6. If infection is possible or confirmed and/or 0-1 SIRS present, notify provider as sepsis order set should be initiated to rule in/out Sepsis Syndrome
7. If patient is positive for Severe Sepsis or Shock take immediate action – MEDICAL EMERGENCY!

Required for nurses to screen all adult inpatients within three hours of discharge

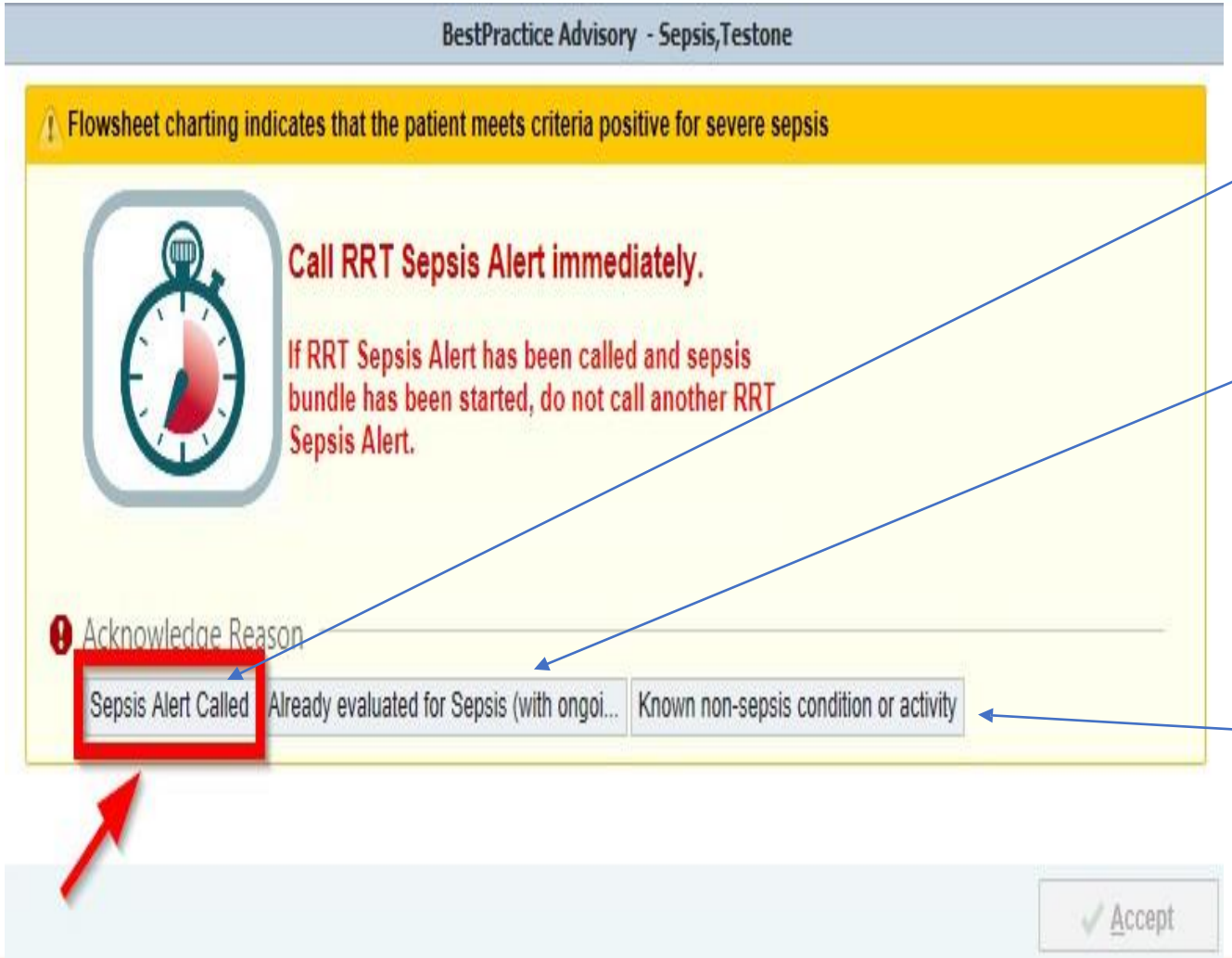
When anyone tries to print the AVS and the last Sepsis Screen was not documented within 3 hours of patient's discharge, they will get this hard stop:



Why do I have to perform another screen???

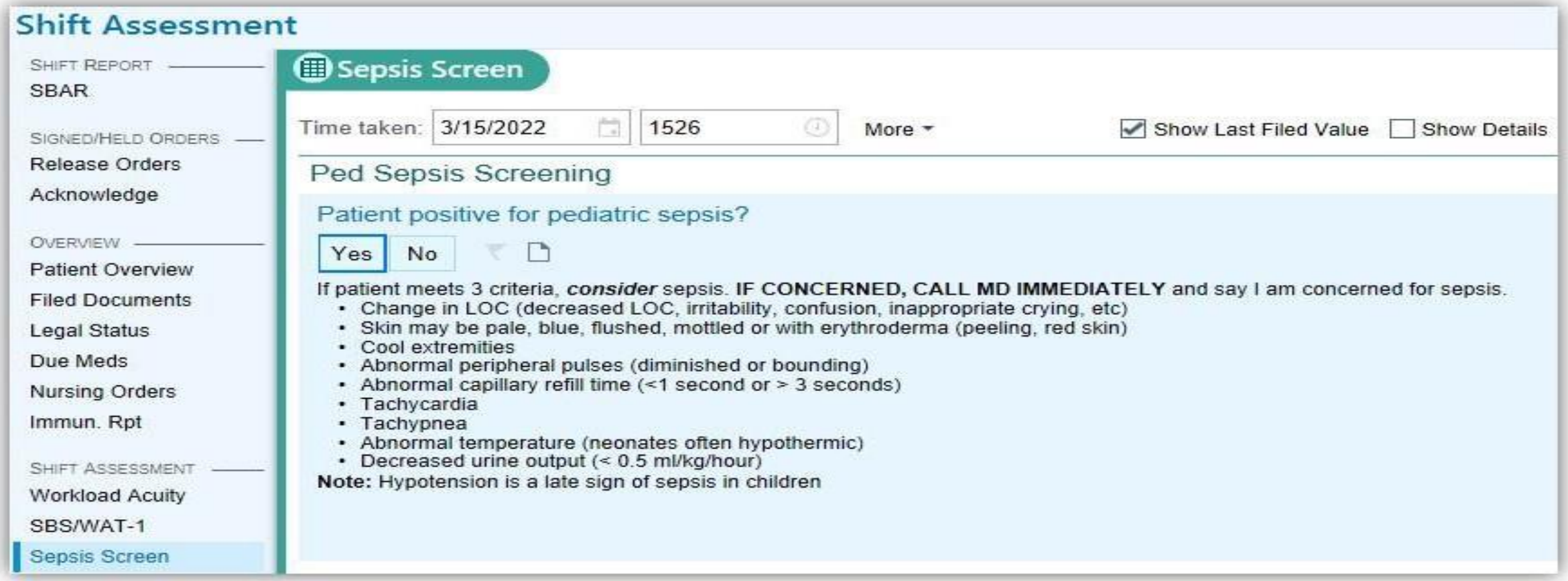
- Sepsis responsible for more than 314,600 readmissions each year
- Sepsis is the most expensive readmission costing more than $6.2 billion per year

PCU, Med-Surg, Rehab, L&D, and maternal areas get action or alert box reminder to call RRT - Sepsis Alert. Select the appropriate response:

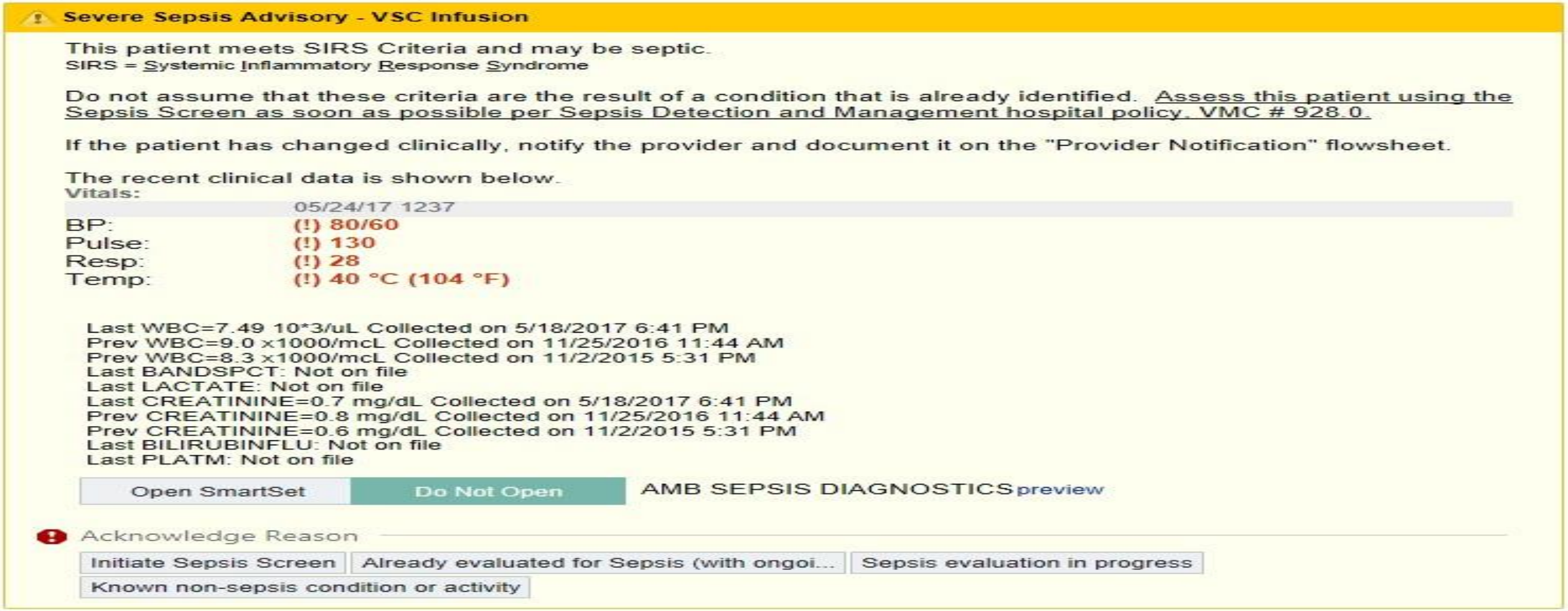


- If you determine the screening tool result is accurate and there is new organ involvement or worsening organ dysfunction(s), select “sepsis alert called” for the response and call the RRT sepsis alert per policy.
- If the patient has already screened positive in the ED or previous unit/shift and the organ involvement is stable or improving and the full bundle was administered, select the second option “already evaluated for sepsis with ongoing treatment” as the response. DO NOT CALL ANOTHER RRT!
- If the only organ dysfunction that was flagged by the screening tool is part of a chronic condition, select the third option “known non-sepsis condition or activity” as the response.

Pediatric Screening Tool

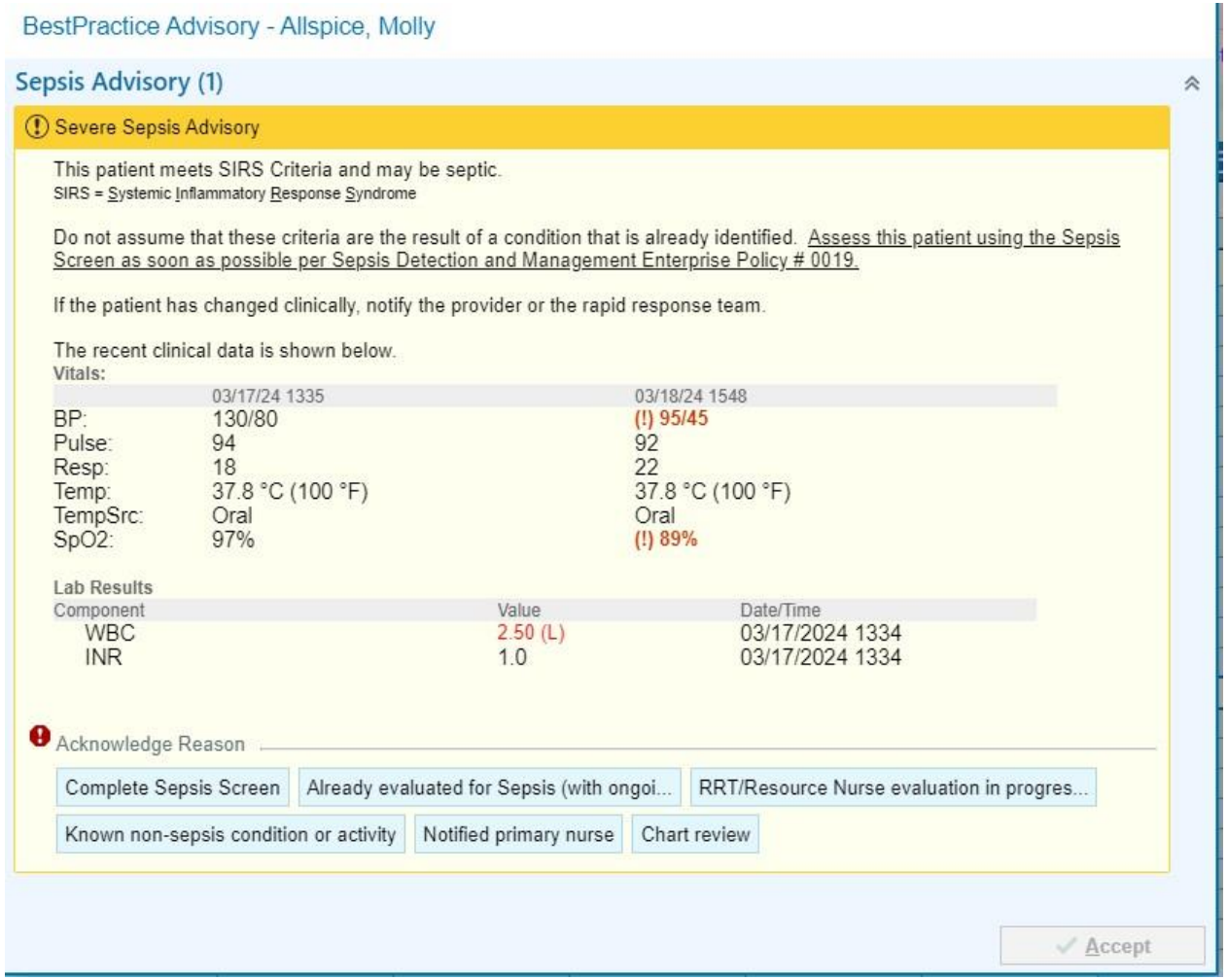


Oncology Clinic Sepsis Screening BPA Tool



Adult patient BPA for Nurses – Hospital Inpatient units (excluding ICU) and ED

The BPA or best practice advisory alert will fire if the system detects the patient has 2 SIRS criteria AND organ dysfunction present. This alert can help staff identify patients who are suffering a medical emergency but still "look good". The alert cannot detect suspected or confirmed infection, the RN completes that part in order to distinguish severe sepsis or shock is present or another reason patient has organ dysfunction present.



How to select the proper acknowledge reason:

- If you determine the BPA is accurate and there is new organ involvement or worsening organ dysfunction(s) or you aren't sure what the organ involvement is or if patient has an infection, select "complete sepsis screen" for the response. Then immediately assess the patient and complete the sepsis screening tool documentation. If the patient screens positive for severe sepsis or shock and all info verified as accurate, call the RRT sepsis alert per policy if in PCU, med-surg, rehab, L&D, and Maternal units and alert provider emergently if ED or ICU.
- If the patient has already screened positive in the ED or previous unit/shift and the organ involvement is stable or improving and the full bundle was administered, select the second option "already evaluated for sepsis with ongoing treatment" as the response. DO NOT CALL ANOTHER RRT!
- If the only organ dysfunction that was flagged by the BPA is part of a chronic condition, select the option "known non-sepsis condition or activity" as the response.
- If you are not the patient's assigned nurse at the time of opening the chart and the BPA fires, you should select the option "notified primary nurse" as the response and immediately notify the assigned nurse so they can assess the patient for possible medical emergency.
- If you are accepting the patient from another unit, in an administrative role, or charge nurse and the BPA fires on you, you should select the option "chart review" as the response.
- If you already called the RRT nurse to the bedside or you are the RRT nurse and it fires, you should select "resource nurse eval in progress" as the response.

WHAT CAN YOU DO OUTSIDE THE HOSPITAL?

THINK SEPSIS!

For clinic or custody nurses: If patient presents with s/sx of infection or new organ dysfunction - THINK SEPSIS

For psych nurses: Same as above☺ For example, if patient's mental status deteriorates/changes unexpectedly - THINK SEPSIS

If severe sepsis possible, **medical emergency** alert provider

Screen is Positive for New Severe Sepsis or Septic Shock - Now What?

RRT - SEPSIS ALERT

- Seek advice of colleagues as needed but don't delay contacting provider (or at SCVMC an RN sepsis champion authorized for protocol)
- Communication is vital!
- Formulize your change of condition SBAR report to provider
- Medical emergency – use rapid form of contact
- Think and say you suspect sepsis
- Use the resource materials and follow hospital policies Enterprise #0019 (and if SCVMC #423.0)
- Recommend the provider initiate the Sepsis Order Set (or if SCVMC an authorized RN initiate Sepsis Standardized Procedure)
- If needed, remind provider how important timely care is (one hour treatment goal)

References/Additional Information

- Surviving Sepsis Campaign Website www.survivingsepsis.org
- The Sepsis Alliance http://www.sepsis.org
- The Sepsis Institute https://www.sepsisinstitute.org/
- The Sepsis Clinical Network https://www.sepsiscoordinatornetwork.org/
- Centers for Disease Control and Prevention http://www.cdc.gov/sepsis
- End Sepsis, The Legacy of Rory Staunton https://www.endsepsis.org/
- California Maternal Quality Care Collaborative (CMQCC) https://www.cmqcc.org
- The Joint Commission https://www.jointcommission.org
- World Sepsis Day Day World Sepsis Day - September 13

Care for the Suicidal Patient
Constant Observation
Code Green—Elopement/AMA
Restraints

SANTA CLARA VALLEY HEALTHCARE

Nursing Assessment and Care of the Suicidal Patient

- Assess causative factors that place the patient at risk for injury and address each within the plan of care and during interdisciplinary rounds. These factors may include the medical diagnosis, medication effects, or other observable symptoms such as extreme anxiety or restlessness.
- Assess and report behavioral changes such as a marked mood or energy level change, expression of hopelessness, verbalization of a suicide plan, impulsivity, etc. every shift and as needed.
- Observe the patient at least hourly and ensure the HSA is conducting constant observation of the patient. Documentation safety checks and constant observation must be completed in the EHR.
- Encourage verbalization of feelings related to suicide ideation.
- Provide a safe environment as stated above in Section Ill. Documentation of this action will be completed in the electronic medical record.
- Perform mouth checks after administration of oral medications to ensure pills are swallowed.
- Provide discharge instructions for follow up care such as counseling, mental health resources, and the suicide crisis hotline number.

Suicidal Screening

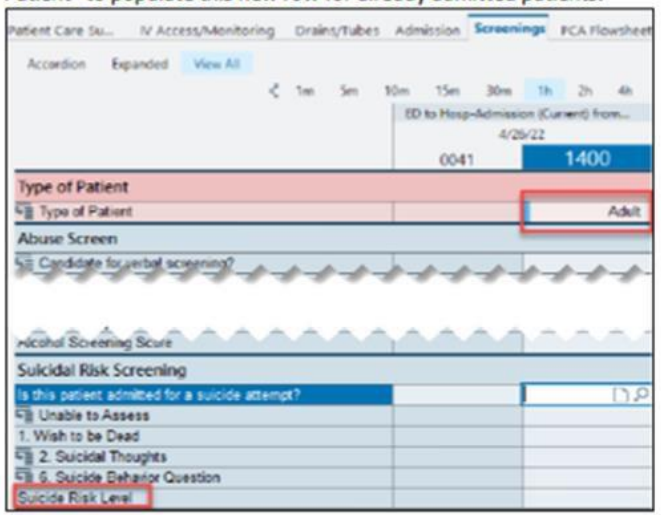
SANTA CLARA VALLEY HEALTHCARE

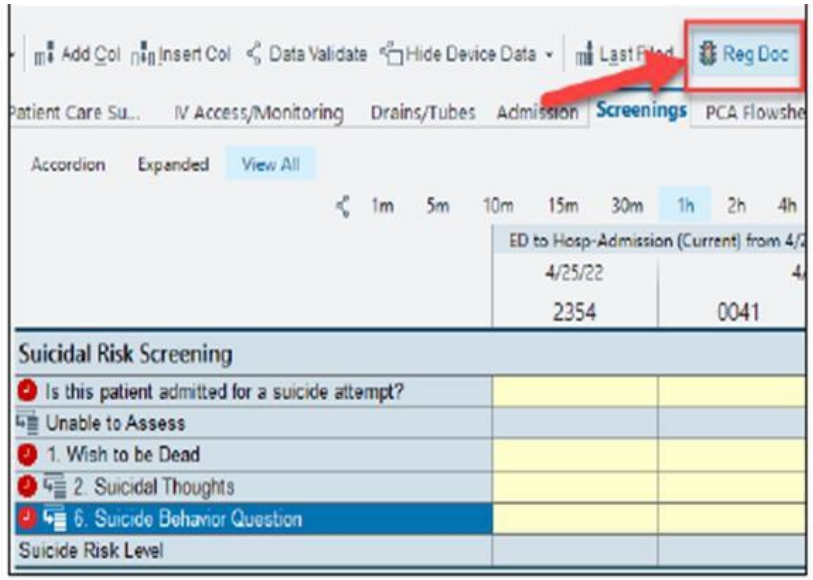
HealthLink

What You Need to Know
April (2nd Edition) 2022

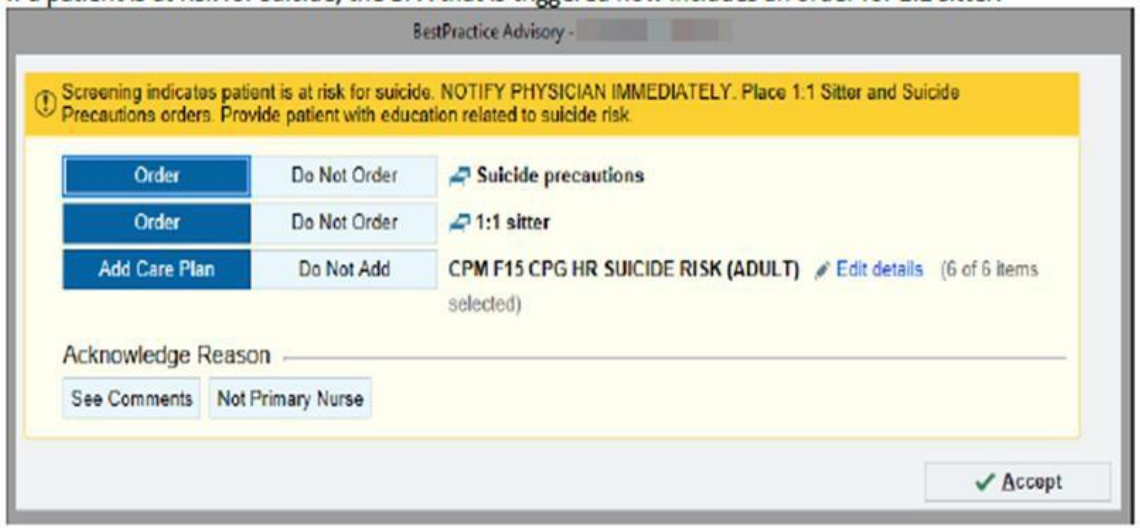
Suicide Risk Level

To meet The Joint Commission's requirement of having a Suicide Risk Level, there is now a new flowsheet row that will auto-calculate a risk level based on your documentation of the Suicide Risk Screening. In the row information you will see what follow up each risk level requires. Note: You will first need to select the "Type of Patient" to populate this new row for already admitted patients.



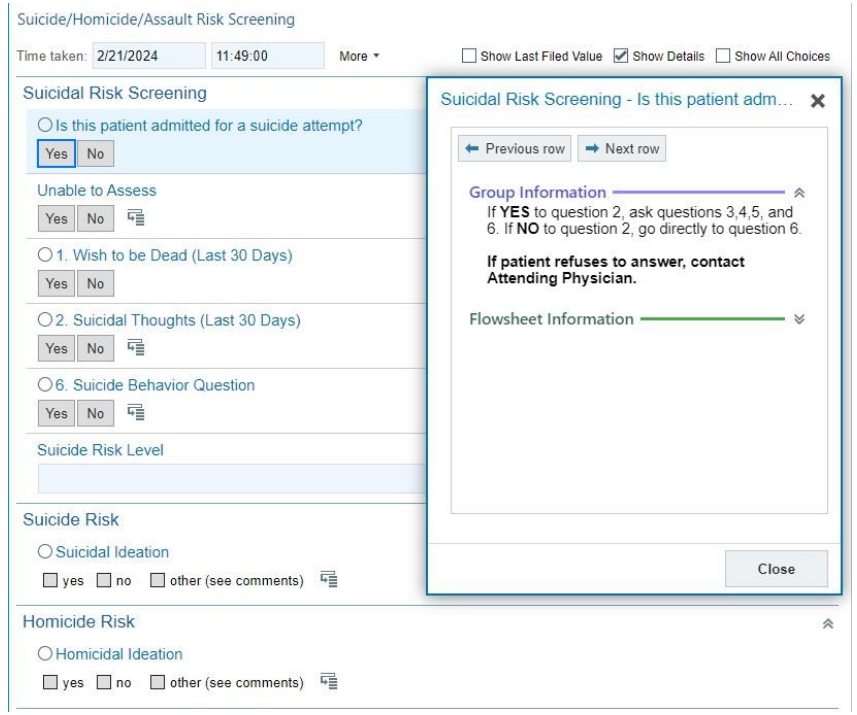


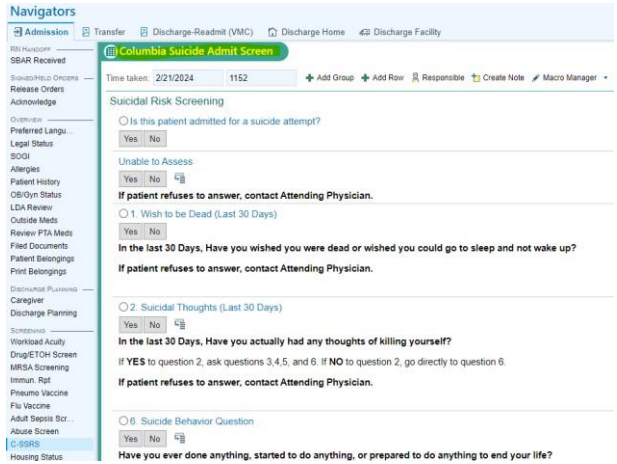
If a patient is at risk for suicide, the BPA that is triggered now includes an order for 1:1 sitter.



Suicidal Screening

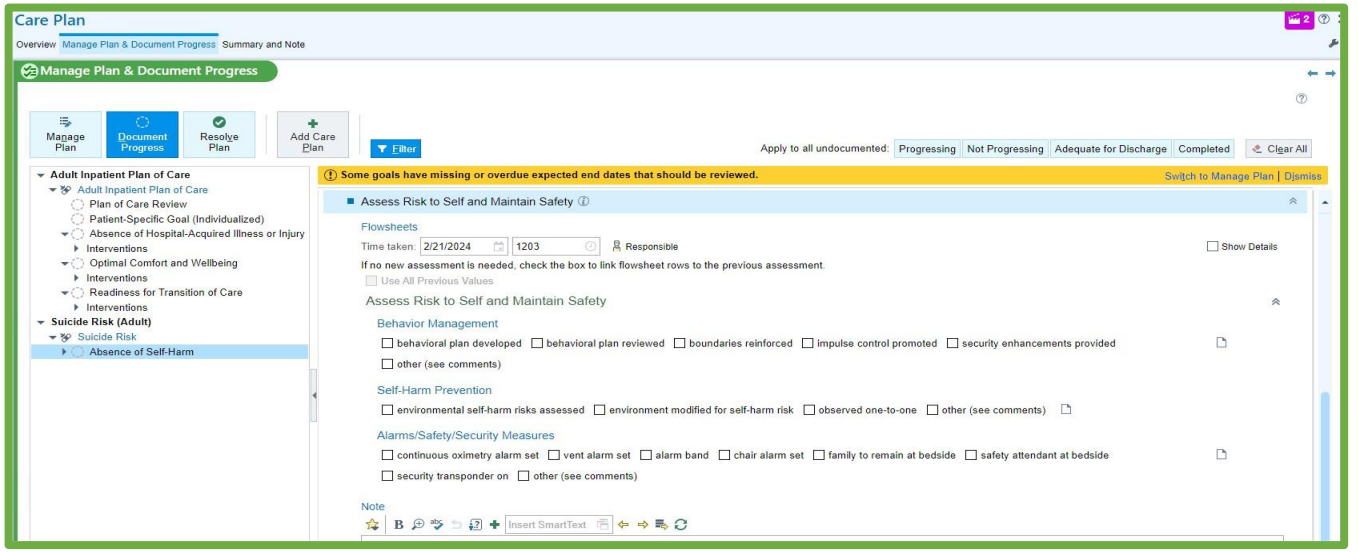
- Every patient is assessed for suicide, homicide, and assault risks.
- If the patient flags positive screen, notify the charge RN, provider, & place the patient in Constant Observation.
- Follow the Constant Observation policy and ensure a safe environment by completing the Room Safety Checklist.
- Dietary notifications: safe trays, no sharps.

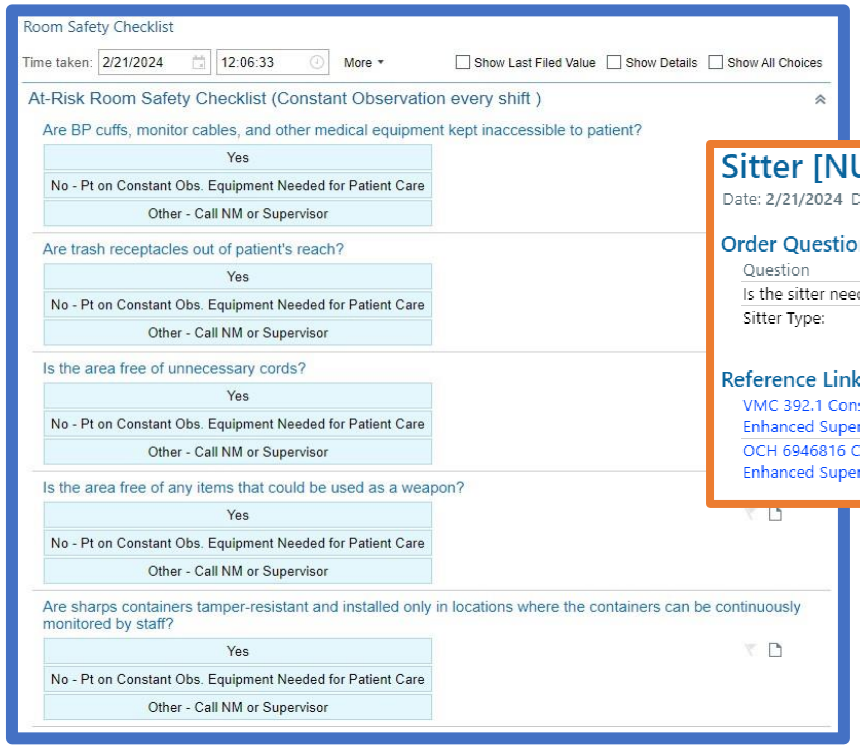


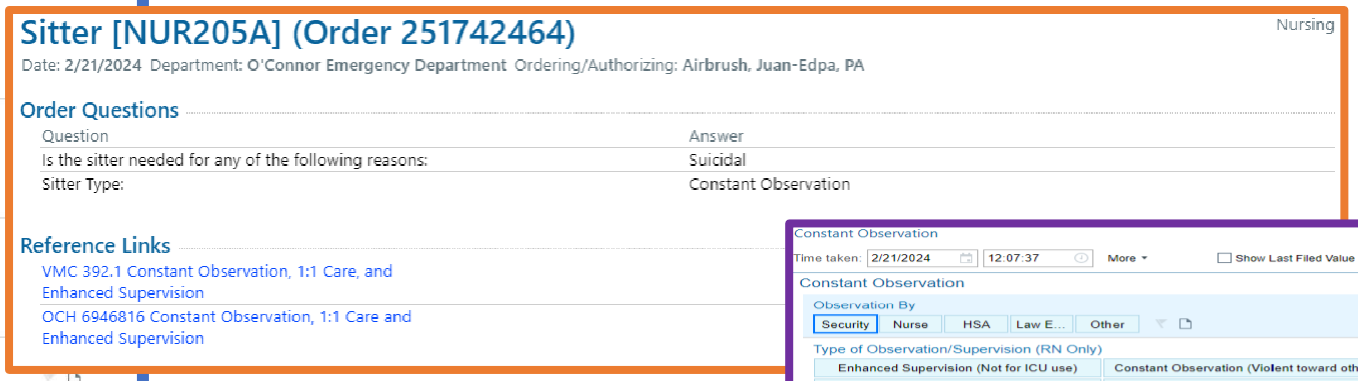


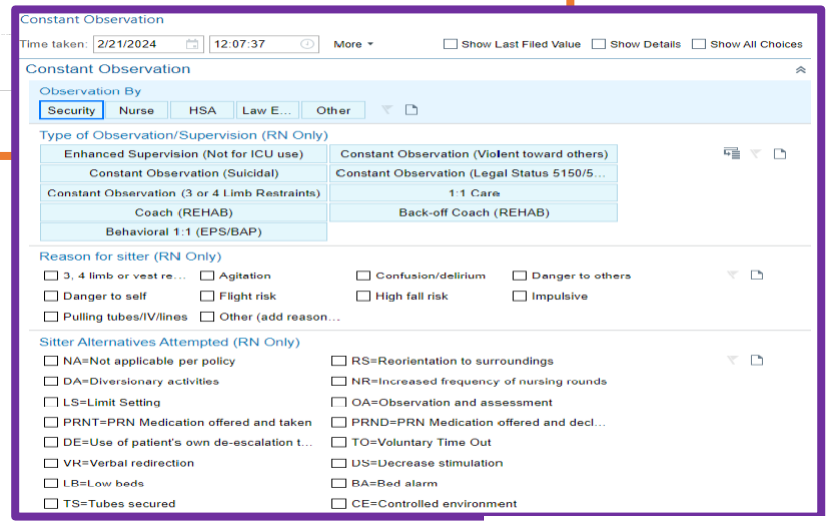
SANTA CLARA VALLEY HEALTHCARE

Suicidal Precautions









- FYI Suicidal Precautions are discontinued ONLY upon physician's orders after consultation with the psychiatry team.

SANTA CLARA VALLEY HEALTHCARE

Suicidal Precautions: Nursing and HSA

- Patient is placed under constant observation.
- Notifies the nurse manager, ANM, and or Charge RN.
- Ensures a safe environment free from any potentially harmful items or environmental conditions.
- The patient is informed that a nurse and another member of the nursing staff will conduct a search of clothing and personal belongings to identify any potential clothing risk and or hazardous items.
- Lime Green Scrubs shall be provided if available in the unit otherwise clothing with no strings or belts shall be available.
- All personal items that could be harmful will be returned to the patient's family or held in safekeeping for the patient per hospital policy.
- Initiates constant observation for all suicidal patients with self-harming behaviors.

REFER TO ENTERPRISE POLICY #0030 & #0179

SANTA CLARA VALLEY HEALTHCARE

Legal Holds: 5150 & 1799

- The provider upon notification from the RN team of a positive suicide screen shall make the determination if the patient is to be held on a 5150 or 1799.
- The provider will advise the patient of their rights and the determination that the patient is to be held.
- The patient must be re-evaluated within 24 hours after being placed on precautions.
- Legal holds must be medically cleared before being transferred to any mental health institution by the treating hospital provider.
- Follow the workflow at your specific enterprise work site. Resources for legal holds may be available remotely.

SANTA CLARA VALLEY HEALTHCARE

SANTA CLARA VALLEY HEALTHCARE

Definitions

Constant Observation (CO):

- Continuous, unbroken observation from distance of 1-2 arm lengths or 15 feet for observer's safety while maintaining constant view of patient

Enhanced Supervision:

- Frequent checks for patients who are at increased risk for falls or other types of injury

1:1 Care:

- For non-suicidal patient requiring more than enhanced supervision; can be more than one arm length distant

Constant Observation

Examples of patients who need CO:

- Danger to self and/or others
- Legal Hold (5150/5250/1799)
- Acute psychiatric disorders with potential to harm themselves and/or others
- Physician order or request (Follow order)
- Need for 3 or 4 limb restraints

Hourly Documentation : Staff will appropriately select constant observation based on patient needs

NEVER LEAVE A SITTER PATIENT UNATTENDED

SANTA CLARA VALLEY HEALTHCARE

Constant Observation Defined

Continuous uninterrupted observation by appropriate staff not more than one arm's length.

For agitated and infectious patients: the distance may be increased to 2 arm lengths or 15 feet for the observers' safety while maintaining a constant view of the patient.

Notify NM/designee, and Nursing Supervisor whenever a patient is placed on Constant Observation

Constant observation requires **hourly sitter documentation**

Any patient who is expressing suicidal ideation or is on a legal hold (5150/5250/1799) must be on CO with the sole exception of patients who are physically unable due to their medical condition (e.g., on ventilator, sedated, catatonic, unconscious) to harm themselves or others.

RN must document sections listed as “RN Only”.
***It is the RN’s ultimate responsibility to ensure all documentation is compliant and accurate per policy and over sees any ancillary licensed staff’s documentation.

At-Risk Room Safety Checklist

Observation/Supervision (RN Only - Q Shift)		
Type of Observation/Supervision (RN Only)		
Reason for sitter (RN Only)		
Sitter Alternatives Attempted (RN Only)		
Observation/Supervision		
Pt. communicates verbally		
Patient resting quietly?		
Safe Environment maintained?		
Assisted with ADL		
Pt. is non-threatening?		
Visitors present?		
Vitals		
BP		
Temp		
Temp Source		
Heart Rate		
Resp		

HOURLY DOCUMENTATION

VS PER ORDERS & PRN

At-Risk Room Safety Checklist (Constant Observation every shift)		
Are BP cuffs, monitor cables, and other medic...		
Are trash receptacles out of patient's reach?		
Is the area free of unnecessary cords?		
Is the area free of any items that could be use...		
Are sharps containers tamper-resistant and in...		
Is furniture secured or heavy enough to preve...		
Are closets and/or room free from hangers?		
Has dietary been notified of patient's need for ...		
Have all sharp objects, anything that can be s...		

SANTA CLARA VALLEY HEALTHCARE

Criteria for 1:1 Care

Definition:

1:1 Care is for non-suicidal patients and patients who are not on a legal hold requiring more than enhanced supervision.

1:1 care allows the caregiver to monitor patients at a further distance than one arm's length.

1:1 care provides flexibility for care while maintaining patient safety.

A 1:1 observation ratio must be maintained at all times.

SANTA CLARA VALLEY HEALTHCARE

Criteria for Enhanced Observation

Decisions to place patients on enhanced supervision are based on:

- **Registered nurses' clinical judgement of patient safety.**
- **Physician or practitioner prescribed orders.**

Frequent checks for patients that are at increased risk for falls or other types of injury.

Staff member assigned to 1-2 patients with frequent checks/rounding.

SANTA CLARA VALLEY HEALTHCARE

Elopement, High Risk Patient, Against Medical Advice (AMA), Temporary Absence

NOTE: All reasonable measures will be taken to prevent the elopement of any patient from the hospital.

Terms Defined

Elopement

- Cannot be found
- Left hospital without
  - Discharge
  - Signed AMA paperwork

High Risk Patient (Elopement)

- On legal hold
- Actively experiencing SI/HI
- Cognitively impaired
- Undergoing detox or sub abuse tx
- Requiring monitoring or attachment to infusion pump
- Any reason that the responsible caregiver believes is a threat to the patient health or wellbeing.

Leaving AMA

- Patients who have capacity to make medical decisions have the right to leave the hospital AMA
- The provider will be contacted about patient's decision with appropriate documentation in the medical record
- Refer to enterprise policy #0293

Temporary Absence

- Granted or denied at providers discretion
- When granted, pt signs a "Temporary Absence Release"
- If pt violates terms of the TAR, the patient shall be considered an eloped patient according to policy

SANTA CLARA VALLEY HEALTHCARE

Code Green: Elopement, Missing Patient

UPON NOTIFICATION OR DISCOVERY OF A MISSING/ABSENT PATIENT IN DEPT:

- **IMMEDIATELY Notify Supervisor (Charge Nurse, ANM, Manager)**
- **IMMEDIATELY Notify Hospital Operator to overhead page the patient, requesting they return to their unit/department.**
- **Initiate a search of the immediate area.**
- **If the patient is an AT RISK PATIENT notify House Supervisor & Security.**
- **House Supervisor & Security will collaborate to activate a CODE GREEN.**
- **Reporting Staff will initiate the Elopement Checklist & complete RL6 online incident report.**

(At Risk Patient = Patient is suicidal, on a legal hold, cognitively impaired, undergoing detox/substance abuse program, required monitoring or attached to equipment, any reason the patient health or wellbeing is at risk).

SANTA CLARA VALLEY HEALTHCARE

Code Green: Elopement, Missing Patient

- If a patient elopes from the unit or facility, the patients record is to be removed from the active patient census and a disposition of 'elopement' is assigned.

- This change in the EHR can be done as soon as the elopement is confirmed to have eloped but no later than 2 hours after the discovery.
(Follow Code Green policy).

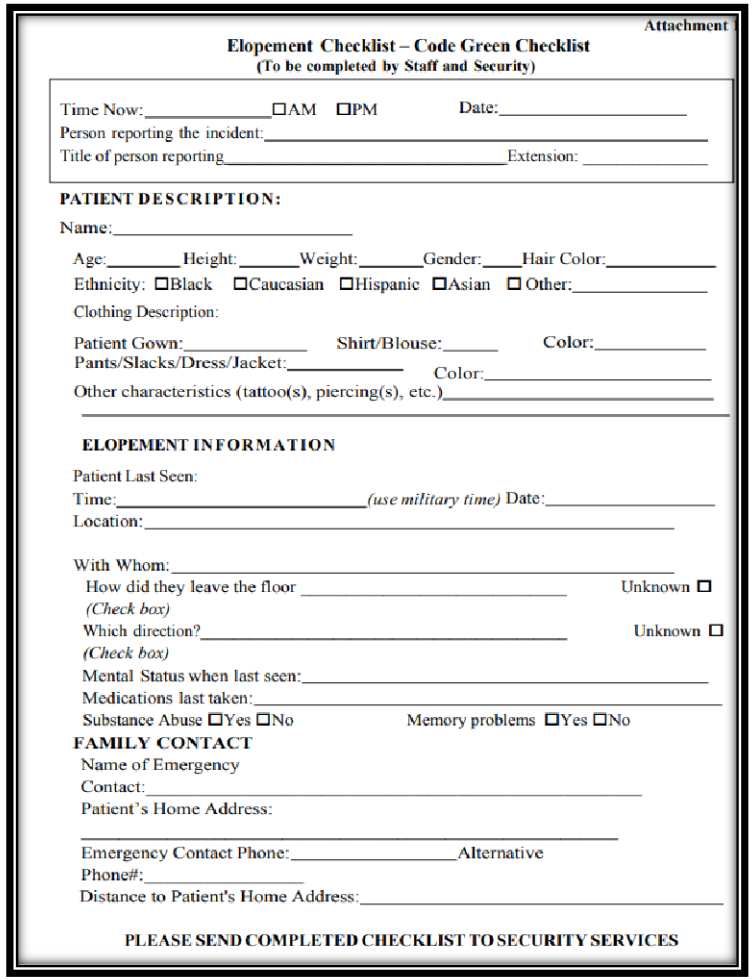
- If a patient who is gone for more than two hours subsequently returns to the hospital, the patient shall promptly be taken to the Emergency Department for evaluation, and a new patient encounter will be initiated in the patient's EHR.

- Create a RL6 for all elopements

Code Green-Elopement/Missing Patient, Enterprise 0179

SANTA CLARA VALLEY HEALTHCARE

Code Green Forms to Complete



Attachment 1

Elopement Checklist – Code Green Checklist
(To be completed by Staff and Security)

Time Now:_____☐AM ☐PM Date:_____
Person reporting the incident:_____
Title of person reporting_____Extension: _____

PATIENT DESCRIPTION:

Name:_____

Age:_____Height:_____Weight:_____Gender:____Hair Color:_____
Ethnicity: ☐Black ☐Caucasian ☐Hispanic ☐Asian ☐ Other:_____
Clothing Description:
Patient Gown:_____ Shirt/Blouse:_____ Color:_____
Pants/Slacks/Dress/Jacket:_____ Color:_____
Other characteristics (tattoo(s), piercing(s), etc.)_____

ELOPEMENT INFORMATION

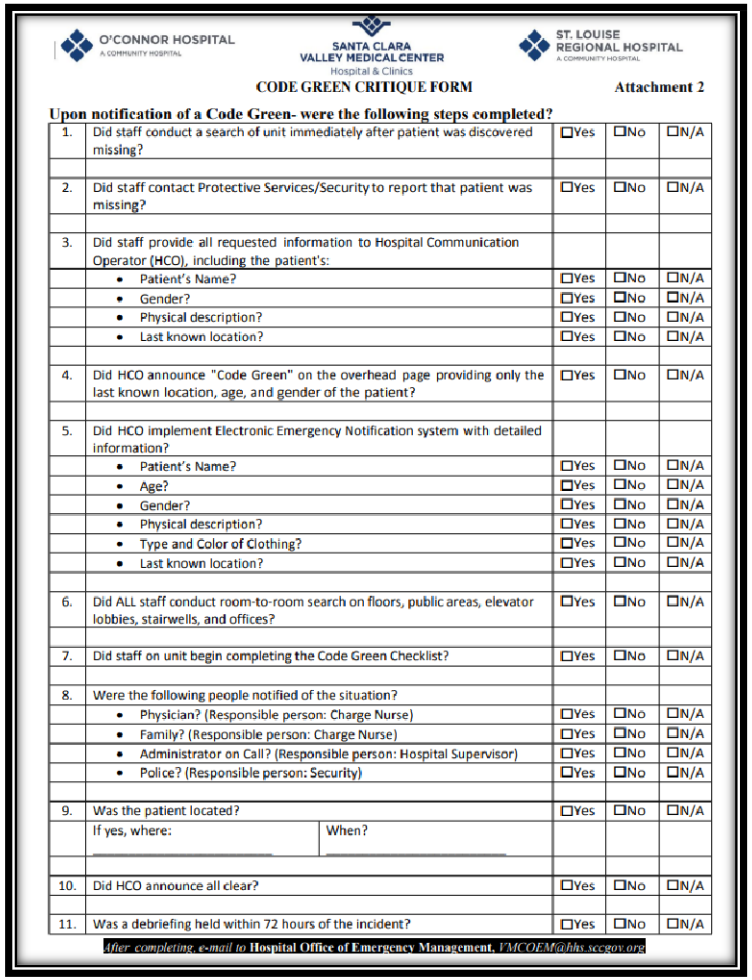
Patient Last Seen:
Time:_____*(use military time)* Date:_____
Location:_____

With Whom:_____
How did they leave the floor _____ Unknown ☐
(Check box)
Which direction?_____ Unknown ☐
(Check box)
Mental Status when last seen:_____
Medications last taken:_____
Substance Abuse ☐Yes ☐No Memory problems ☐Yes ☐No

FAMILY CONTACT

Name of Emergency
Contact:_____
Patient's Home Address:
_____
Emergency Contact Phone:_____Alternative
Phone#:_____
Distance to Patient's Home Address:_____

PLEASE SEND COMPLETED CHECKLIST TO SECURITY SERVICES



O'CONNOR HOSPITAL A COMMUNITY HOSPITAL
SANTA CLARA VALLEY MEDICAL CENTER Hospital & Clinics
ST. LOUISE REGIONAL HOSPITAL A COMMUNITY HOSPITAL

CODE GREEN CRITIQUE FORM Attachment 2

Upon notification of a Code Green- were the following steps completed?

1.	Did staff conduct a search of unit immediately after patient was discovered missing?	☐Yes	☐No	☐N/A
2.	Did staff contact Protective Services/Security to report that patient was missing?	☐Yes	☐No	☐N/A
3.	Did staff provide all requested information to Hospital Communication Operator (HCO), including the patient's:			
	• Patient's Name?	☐Yes	☐No	☐N/A
	• Gender?	☐Yes	☐No	☐N/A
	• Physical description?	☐Yes	☐No	☐N/A
	• Last known location?	☐Yes	☐No	☐N/A
4.	Did HCO announce "Code Green" on the overhead page providing only the last known location, age, and gender of the patient?	☐Yes	☐No	☐N/A
5.	Did HCO implement Electronic Emergency Notification system with detailed information?			
	• Patient's Name?	☐Yes	☐No	☐N/A
	• Age?	☐Yes	☐No	☐N/A
	• Gender?	☐Yes	☐No	☐N/A
	• Physical description?	☐Yes	☐No	☐N/A
	• Type and Color of Clothing?	☐Yes	☐No	☐N/A
	• Last known location?	☐Yes	☐No	☐N/A
6.	Did ALL staff conduct room-to-room search on floors, public areas, elevator lobbies, stairwells, and offices?	☐Yes	☐No	☐N/A
7.	Did staff on unit begin completing the Code Green Checklist?	☐Yes	☐No	☐N/A
8.	Were the following people notified of the situation?			
	• Physician? (Responsible person: Charge Nurse)	☐Yes	☐No	☐N/A
	• Family? (Responsible person: Charge Nurse)	☐Yes	☐No	☐N/A
	• Administrator on Call? (Responsible person: Hospital Supervisor)	☐Yes	☐No	☐N/A
	• Police? (Responsible person: Security)	☐Yes	☐No	☐N/A
9.	Was the patient located?	☐Yes	☐No	☐N/A
	If yes, where: _____ When? _____			
10.	Did HCO announce all clear?	☐Yes	☐No	☐N/A
11.	Was a debriefing held within 72 hours of the incident?	☐Yes	☐No	☐N/A

After completing, e-mail to **Hospital Office of Emergency Management**, *VMCOEM@hhs.sccgov.org*

Elopement Checklist &

Code Green Critique Form

Forms can be found in the policy attachments under "Enterprise #0179".

Collaborate with the charge RN, house supervisor, and the responding security team.

Submit forms to corresponding team listed on the bottom of each form.

SANTA CLARA VALLEY HEALTHCARE

Emergency Staff Response Guide

CODE GREEN – MISSING PATIENT

Overhead Announcement: Alert tones, "Code Green," (description of missing patient) and location.

Type of Incident: Missing/absent patient.

Emergency Operations: Nursing Manager or Staff will notify Hospital Operator Immediately.
Activation of the Hospital Incident Command System (HICS) will occur if the incident has the potential to overwhelm normal hospital operations.

SANTA CLARA VALLEY HEALTHCARE

Emergency Staff Response Guide

STAFF RESPONSE CHECKLIST

Upon notification or discovery of a missing/absent patient in department, immediately:

- ☐ Notify immediate supervisor
- ☐ Notify Hospital Operator to page overhead for the patient to return to the patient care area
- ☐ Initiate a search of the immediate area.

- ☐ If patient is not found within 10 minutes, notify Hospital Operator to overhead page "Code Green" with description of patient and location last seen.

- ☐ Notify Protective Services (VMC), Security (OCH, SLRH) and the Nursing Shift Supervisor with the appropriate information, including physical description and description of clothing, and reasons that the search is being initiated (e.g., cognitively impaired or on a 72-hour hold) and any precautionary information (TB, HIV, hepatitis, contagious diseases, etc.).

- ☐ Call Law Enforcement to report patient's absence.

Upon hearing "Code Green," all available hospital personnel will immediately stop all non-critical work and cover all exits, stairs, and elevators:

- ☐ Remain at exit locations until directed by Protective Services (VMC), Security (OCH, SLRH) or Nursing Shift Supervisor, or until "Code Green, All Clear" is announced.

- ☐ Widen the search to include the entire facility if the patient cannot be located and any of the following are concerns:
  - ☐ Legal status and competency issues (e.g., patient is a minor, or is under a 5150/72-Hour Hold (VMC), Conservatorship, or Guardianship).
  - ☐ Impaired cognitive ability (impaired orientation, ability to reason, suicidal ideation, and aggression).
  - ☐ Missing hospital equipment (e.g., an infusion pump or Holter monitor).
  - ☐ Any reason that the responsible caregiver (MD, RN, Therapist, etc.) believes is a serious threat to the patient's health or well-being.

- ☐ If the absent patient who presents any of these concerns is a custody patient, notify Department of Corrections.

Note: The Hospital Incident Commander, in collaboration with law enforcement, will determine the length of time for search based on the known facts at the time of the Code Green. No hard-and-fast rule can be applied prior to an incident regarding how long to search.

If the patient can be located, attempt to persuade the patient to return to the patient care area, informing the patient that it is in his/her interest to complete treatment. If patient refuses to return, notify the physician and the Nursing Shift Supervisor.

Report the occurrence/event by submitting an online Occurrence Report

- ☐ If a cognitively impaired patient (e.g., the staff member recognizes the patient or notes an obviously impaired patient in hospital garb) is unattended by appropriate personnel, attempt to return the patient to his or her nursing unit. If this is not possible, or the cognitively impaired patient refuses, notify Protective Services (VMC) or Security (OCH, SLRH).

- ☐ Whenever possible, remain with the patient until he or she is safely in the custody of Protective Services/Security. If the patient leaves the hospital campus, communicate this information to Protective Services/Security.

- ☐ Document in the medical record all attempts made to return the absent patient to the unit and the outcome.

ALL CLEAR

Upon announcement of All Clear:

- ☐ Resume normal department operations unless otherwise directed.

- ☐ Manager shall send an *Emergency Occurrence/Drill Critique* to the Emergency Management Coordinator (see Forms section).

IMPORTANT POINTS TO REMEMBER

- ☐ If an infant or small child is missing, implement Code Pink for infant or Code Purple for child.

- ☐ To minimize harm to patient, reunite the family as quickly as possible and provide support to patient's family through coordinated communication to the family and hospital staff.

- ☐ All requests for information will be directed to the Public Relations Department. No hospital employee or volunteer will make any public statement concerning the incident or communicate with any media representative.

SANTA CLARA VALLEY HEALTHCARE

DIAL EXT. 133 (VMC), EXT. 555 (OCH/SLRH) FOR ALL EMERGENCIES IN HOSPITAL BUILDINGS
DIAL 911 FOR CLINICS OR OTHER LOCATIONS

- If your patient meets the criteria to use Lime Green Scrubs—Please locate them in your unit and assist your patient into this wardrobe.
- If you are unable to locate these in your unit, ask your charge RN or the House Supervisor for assistance.
- For any patient at risk for SI, please remove the draw string if it is noted on the wardrobe you receive.

Lime Green Scrubs

Patients on **legal holds** for danger to self or danger to others will be placed in lime-green colored scrubs

Patients in lime green scrubs should always be accompanied by staff

For gravely disabled patients, the use of lime green scrubs is **situation dependent**

Reminder:
Please complete all assigned CMS Condition of Participation modules in Health learning

If a patient is removed <u>from a legal hold status,</u> change them to a regular hospital gown

Contact Nursing Supervisor to get a set of the lime green scrub for now until you have your own unit supply.

SANTA CLARA VALLEY HEALTHCARE

Restraints

- **Restraint:**
  - Any manual method, physical or mechanical device, material , or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely. (Examples: Enclosure beds, mittens tied or untied, lap belts (if patient can't release them), geri chairs if they can't remove the tray.)
- **Chemical/ Drug Restraint:**
  - Any drug or medication which is used as a restriction to manage behavior or restrict freedom of motion and which is not a standard treatment or dosage for the patient's condition(excludes routine and prn medications)
- **Seclusion:**
  - Involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving

CHEMICAL RESTRAINT

- Medication used to control extreme behavior or restrict the patient's freedom of movement in an emergency.
- Not a standard treatment for patient's medical or behavioral conditions.
  - These drugs are not part of the patient's usual prescribed medications including prn medications.
- Are not to be used outside of the psychiatric units. The use of restraints in the psychiatric units is governed by Acute Psychiatric Services policies

SHACKLES

Handcuffs
Manacles
Shackles

- Other restrictive devices applied by law enforcement officials is intended for custody, detention, and law enforcement purposes, and is not involved in the provision of patient care.
- Hospital staff do not participate in law enforcement activities.

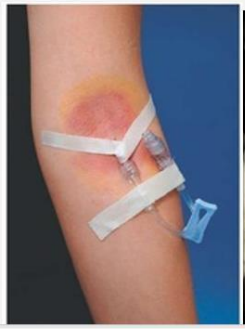
SECLUSION

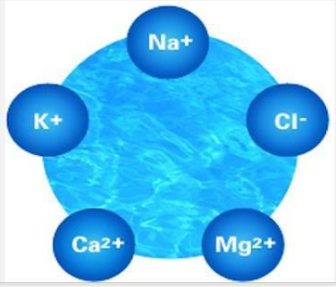
The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving

- Seclusion is not to be used outside of the psychiatric units
- Use of seclusion in the psychiatric units is governed by Acute Psychiatric Services Policies

ALTERNATIVES TO RESTRAINTS

- Prior to restraint application, patient assessment must occur, consider:
  - *Infection, Pain, Skin Irritation, Electrolyte Imbalance*





ALTERNATIVES

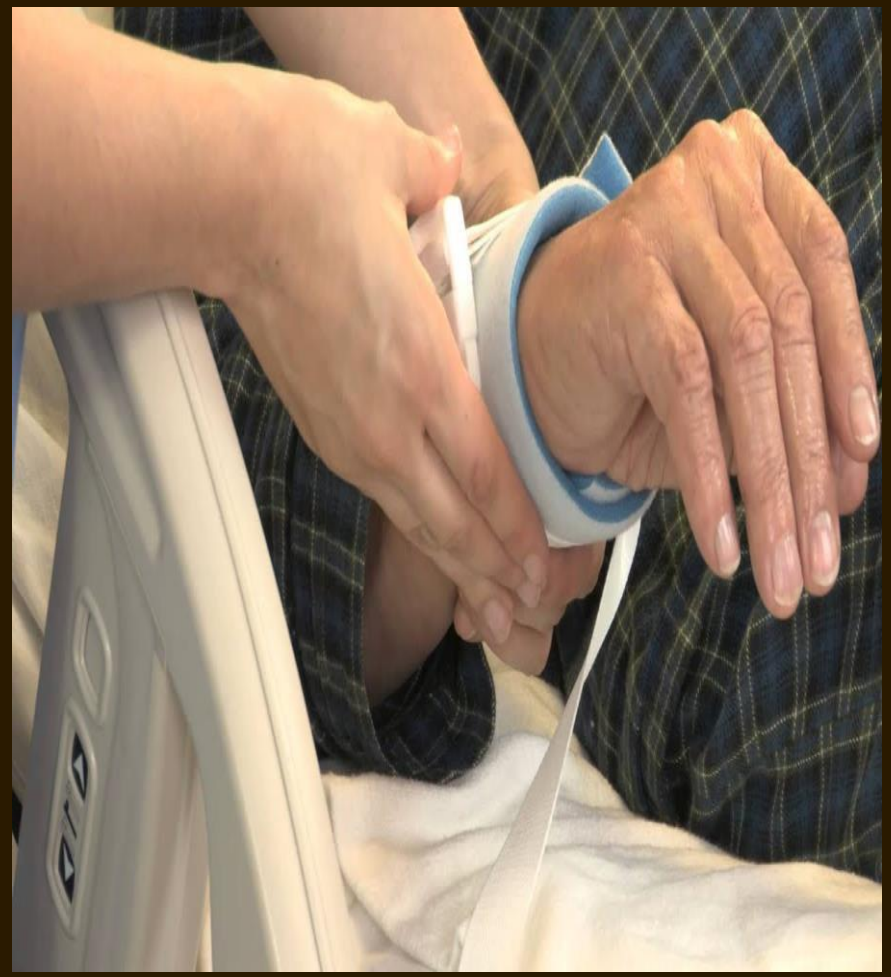
- Hourly Rounding
- Bedside Shift Report
- Family at Bedside
- Pain Control
- TV, Care Channel, Music
- Games, Hand Gadgets
- Physical Therapy

- Documentation for the Non-Violent Behavior Restraint should be done on the **even hours (0800, 1000, 1200 etc.)**

NON-VIOLENT RESTRAINTS

- Renew orders every 24 hours
- Mittens, wrist restraint order should coincide with the restraint the patient is using & documentation
- There are no PRN orders for restraints.

RESTRAINTS STANDARD OF PRACTICE



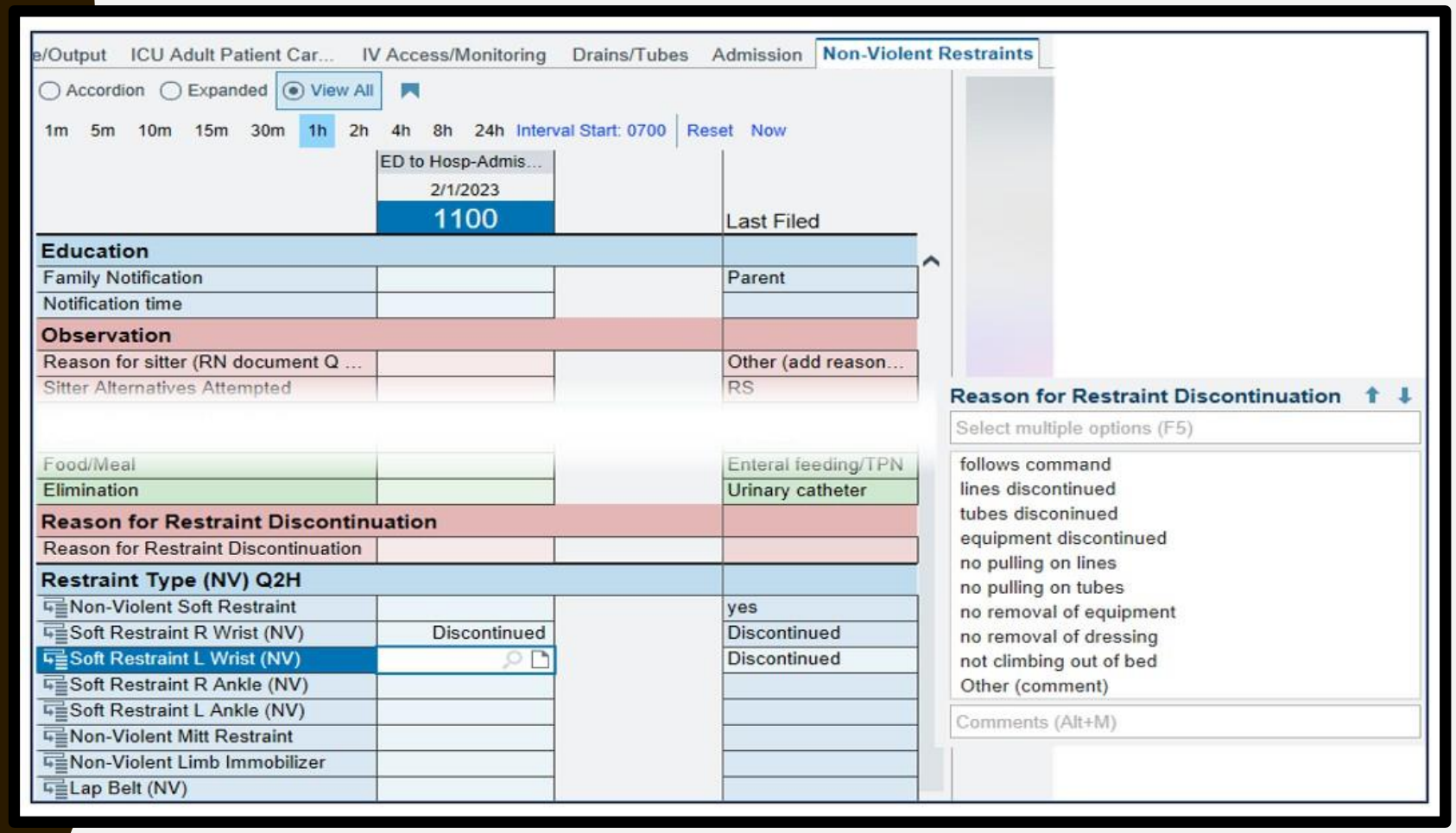
REPORTING A DEATH OR SERIOUS DISABILITY ASSOCIATED WITH USE OF RESTRAINT (OR SECLUSION)

- Deaths or serious disability associated with the use of restraint must be reported to the California Department of Public Health (CDPH) as an adverse event associated with the use of restraints or bedrails while being cared for at any County Hospital.
- Deaths or serious disability to be reported
  - Occurs while patient is in restraints
  - Occurs within 24 hours after the patient has been removed from restraints
  - Occurs within 1 week where it is reasonable to assume that the use of restrain contributed directly or indirectly to the patient's death, regardless of the type(s) of restraints used on the patient during that time.
- Follow the appropriate chain of command for notification of adverse events and file an incident report.

VIOLENT/HARD RESTRAINTS

- Types of Violent, Self-Destructive Behavior Restraints:
  - Any device approved for restraints may be used for a Violent, Self-Destructive Behavior purpose e.i., soft wrist, mittens, or polyurethane restraints.
  - Leather/Hard restraints—if a patient is placed in a restraint that requires a key, the person directly caring for the patient will be provided a key. The Charge RN keeps a "backup" restraint key.
- Used only when necessary & requires close monitoring & treatment
- An RN may place the patient in Violent, Self-Destructive Behavior restraints when a patient presents an immediate or likely danger to themselves or a danger to others.
- RN must inform the provider and obtain an order for the restraints.
- RN must be present while restraints being placed by other staff, HSA, Emergency Technician, or other hospital personal.
- Must be secured to a non-moving part of the bed.
- Keys are needed to remove restraints—The Charge RN & the Primary RN will possess the key.
- 1:1 nursing care
- Orders:
  - Age dependent & time sensitive
  - Provider must assess the patient's behavior within 30 minutes
  - Physician documentation of assessment related to the behavior that requires the restrain use must be completed within 1 hour.

DISCONTINUING A RESTRAINT



- **Initial documentation would be "start" & succeeding documentation would be "continued" unless patient no longer needs restraint.**
- **Then you would be removing restraints & documenting "Discontinued"**

- **Each time you document "Discontinued" under Restraint Type; you need to get a new restraint order. You can not use the same order.**
- **If type of restraint was changed (e.g. soft wrist to mitt restraint), a new order is needed.**
- **Initiate a Care Plan & update every shift. Care plan should match the type of restraint ordered (Non-violent or Violent)**

REPORTING A DEATH OR SERIOUS DISABILITY ASSOCIATED WITH USE OF RESTRAINT (OR SECLUSION)

- Deaths or serious disability associated with the use of restraint must be reported to the California Department of Public Health (CDPH) as an adverse event associated with the use of restraints or bedrails while being cared for at any County Hospital.
- Deaths or serious disability to be reported
  - Occurs while patient is in restraints
  - Occurs within 24 hours after the patient has been removed from restraints
  - Occurs within 1 week where it is reasonable to assume that the use of restrain contributed directly or indirectly to the patient's death, regardless of the type(s) of restraints used on the patient during that time.
- Follow the appropriate chain of command for notification of adverse events and file an incident report.

Certified Primary Stroke Program

O'CONNOR HOSPITAL
A COMMUNITY HOSPITAL

SANTA CLARA
VALLEY MEDICAL CENTER
Hospital & Clinics

ST. LOUISE
REGIONAL HOSPITAL
A COMMUNITY HOSPITAL

Providing Best Practice Clinical Care

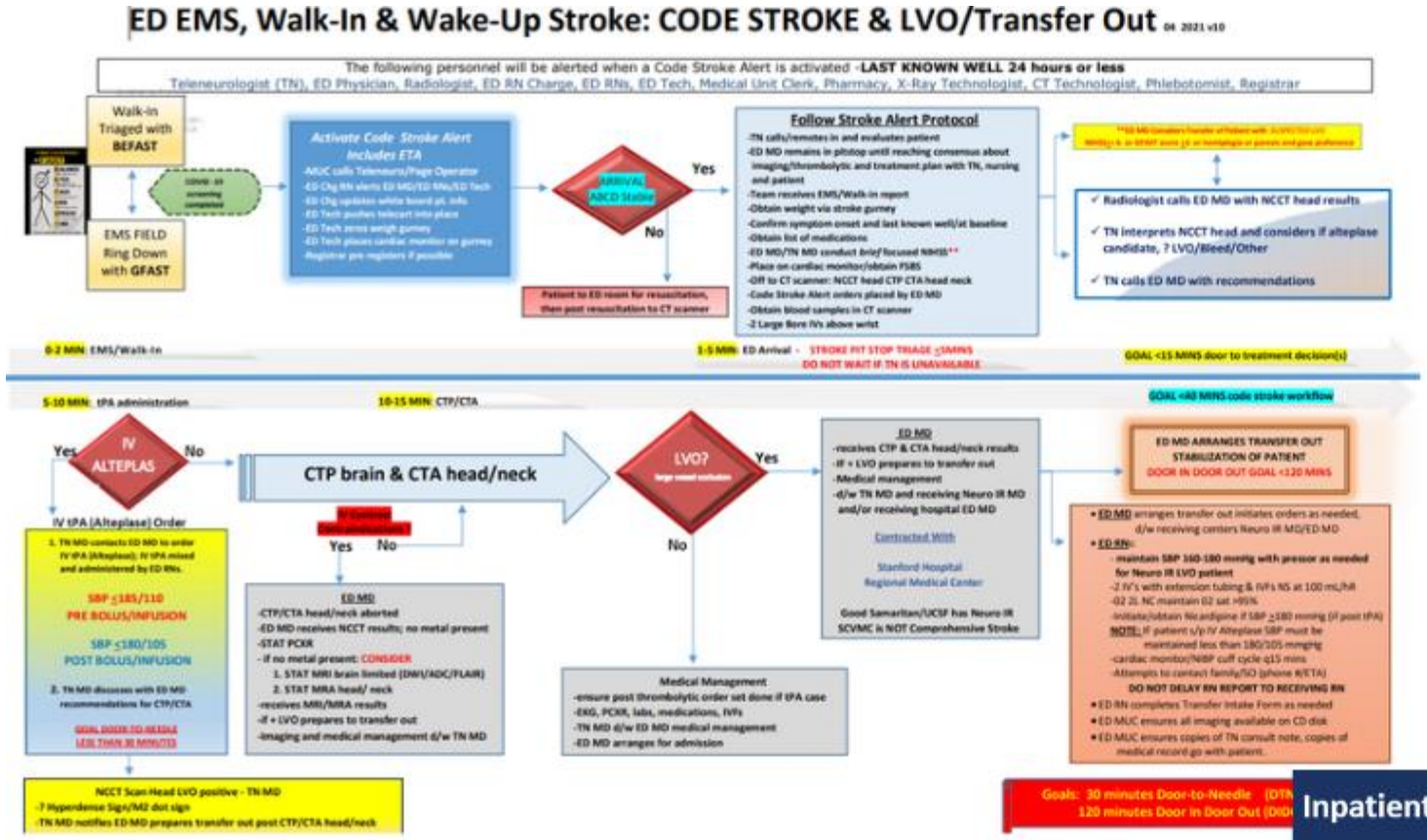
Emergency Room - Key Time Intervals
Maximum Time to Completion

Action:	**Target Stroke Time:**
Door to Physician	≤ 5 minutes
Door to stroke team	≤ 15 minutes
Door to CT/MRI	≤ 20 minutes
Door to CT/MRI	≤ 35 minutes interpretation
Door to needle time	≤ 30 minutes

**Neurologist consultation within 15 minutes of "stroke alert" being called

ED patients with suspected stroke should be triaged with the **same priority as patients with AMI or serious trauma**, regardless of the severity of neurological deficits

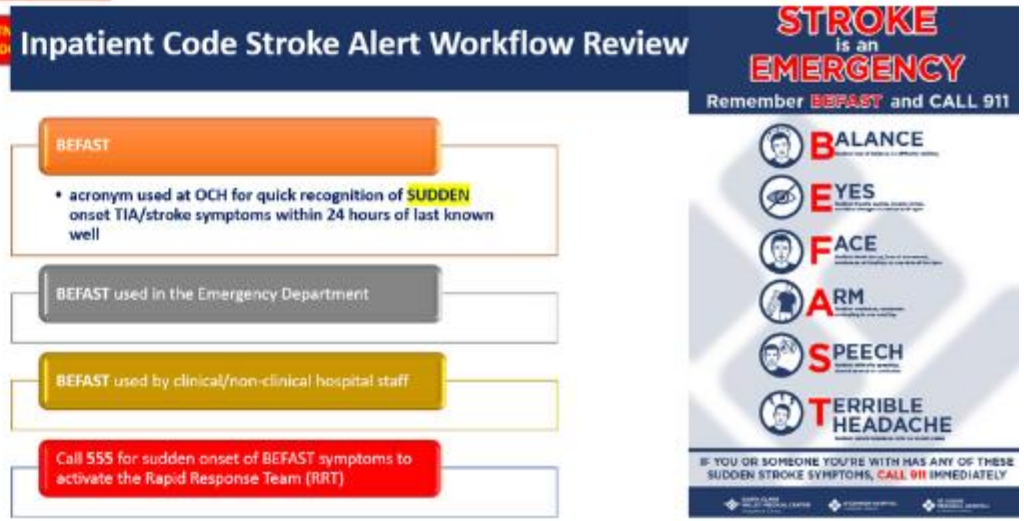
PHASE III
TARGET: STROKE™
HIGHER GOALS FOR GREATER GOOD



OCH Code Stroke Alert Workflows

SLRH: Dial 555 to activate
VMC: Dial 113 to activate

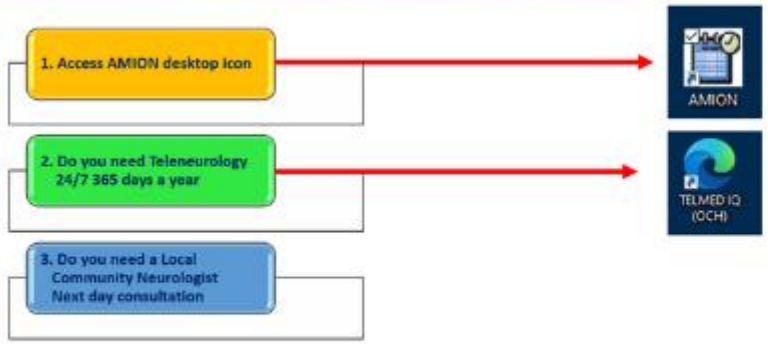
Follow Site Specific Workflows

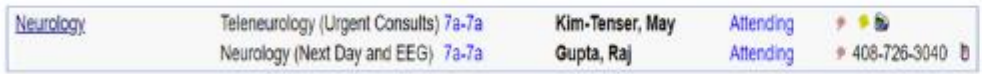


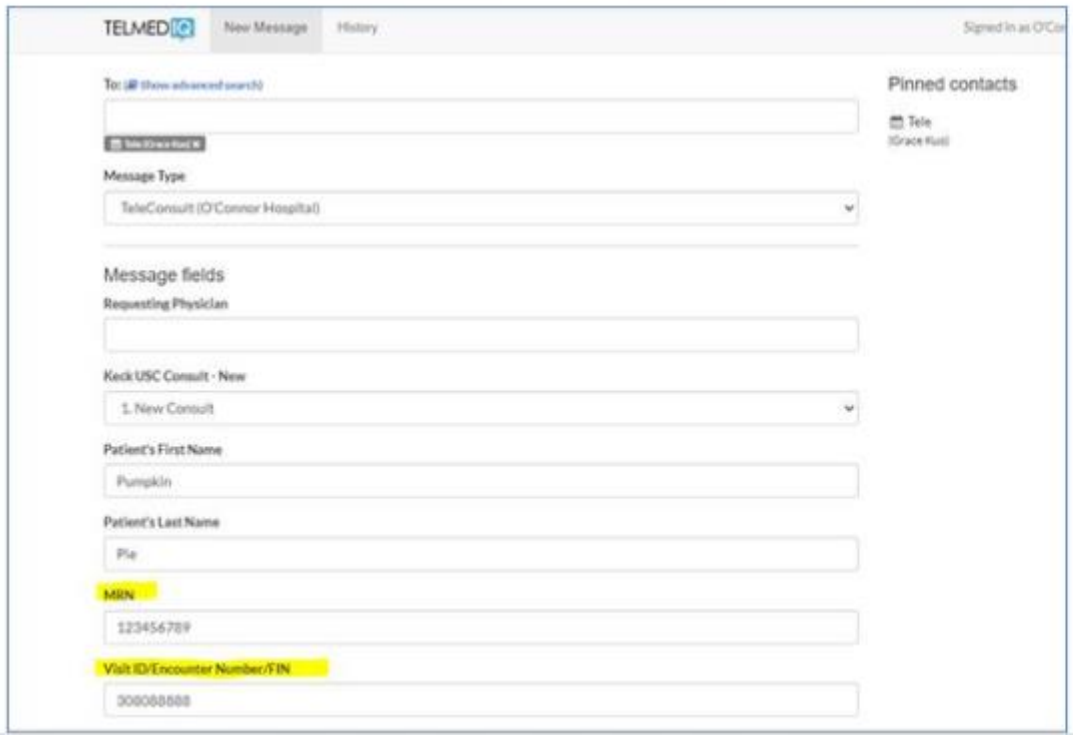
Activating Teleneurology at SLRH & OCH

AMION Call Schedule-Follow procedures for VMC

Teleneurology/Local Community Neurologist







Follow VMC protocol for calling neurology on-call.

Troubleshooting Telecart (ONLY AT SLRH & OCH)

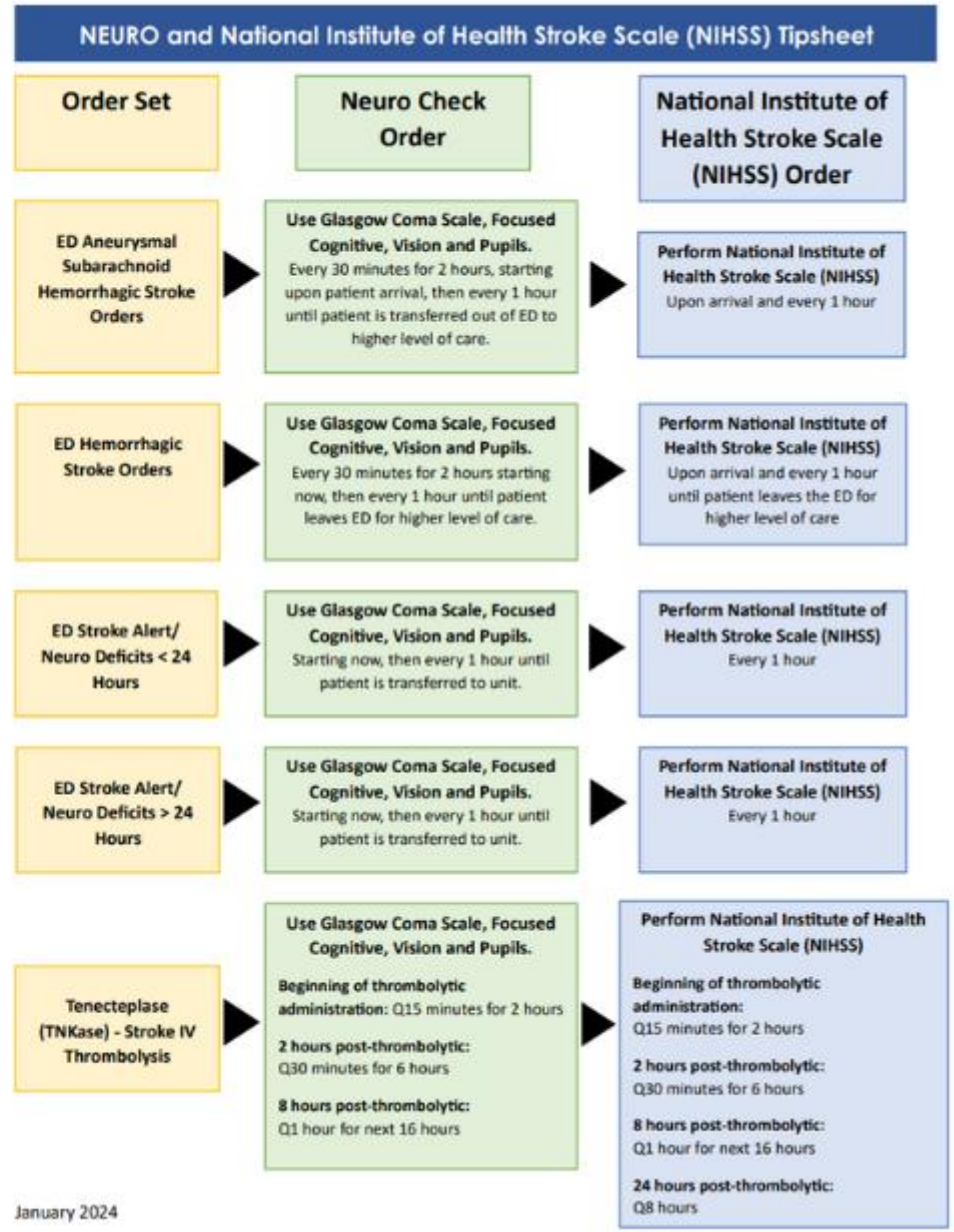
Telecart QC every night by Teladoc Health

Troubleshoot
- Audio
- Visual
- Wi-Fi

- **ONLY when instructed by Teladoc**
- **Button back of LCD panel**
- **Switch under base of cart**

Telecart Daily Checklist - Charge RN
- Plugged in
- Battery full
- Wi-Fi connected
- ? Call 877-484-9119
- IV Pumps and WOW inside CT scanner

Code Stroke Alert Order Sets and Documentation



In Summary

- Stroke/TIA is a very common medical condition.
- Majority of strokes are ischemic.
- Treatment window for stroke has increased up to 4.5 hours .
- Stroke treatments are available up to 24 hours via endovascular therapy.
- Focus on modifiable risk factors for stroke by healthy lifestyle changes.
- **CALL OCH &SLRH 555/911**
- **CALL VMC 1-3-3**

Protecting our Patient's Interest…
Protecting our License

LEGAL DEFINITIONS

A "complex procedure" is a procedure, as determined by hospital policy and approved by the Medical Executive Committee ***that inherently involves a known risk of death or serious bodily harm or for which the average layperson would not understand*** the nature of the procedure and its risk and benefits.

All complex procedures require informed consent.

LEGAL DEFINITIONS

INFORMED CONSENT

The process by which a patient learns about and understands the following:

- The nature of the procedure or treatment
- The risks, benefits, and potential complications of the procedure(s) or treatment(s)
- It includes the risks and benefits of not performing the procedure or treatment, and any possible alternatives.
- Potential conflicts of interest the physician may have (e.g. research or financial interests) are also discussed.

INFORMED CONSENT

Informed consent is a discussion between the physician and the patient. A consent form is documentation that it happened.

Failure to Obtain Informed Consent is “Malpractice” and can constitute “Battery”.

PROCEDURES REQUIRING INFORMED CONSENT

All Procedures Performed in the

- ✓Operating Room
- ✓Cardiac catherization laboratory
- ✓Gastrointestinal laboratory
- ✓Lithotripsy center

- Chemotherapy
- Hemodialysis
- Radiation therapy
- Cardioversion
- Insertion of central lines and PICC lines
- Blood transfusion
- Para/thoracentesis
- *Bilateral tubal ligations, hysterectomies, and other procedures that result in sterilization*

If there is doubt as to whether a procedure requires an informed consent, it is appropriate for the physician to obtain one.

GUIDE TO CONSENT

PROVIDER'S NAME

- Must contain legal FIRST and LAST name.

**** Check EPriv for Provider's Full Legal Name**

PROCEDURE DESCRIPTION

- No abbreviations
- Numbers are spelled out in letters
  - For spinal surgery, specific spinal level should be spelled out (e.g. discectomy procedures)
- Specify laterality (e.g. left or right or both)
- No two different types of proceduralists on one consent form (e.g. General Surgeon and an Ortho Surgeon)

GUIDE TO CONSENT

PATIENT SIGNATURE

If patient is unable to sign, write down the reason why:

- Minor
- Any Limitations
- Conserved

WITNESS

PHONE CONSENT: The person giving phone consent must have been provided informed consent by the proceduralist.

Write “phone consent:” followed by...

- The printed name of the person consenting on the phone and the relationship to the patient.
- Two employee signatures, dated and timed. *Both shall make their presence known to the representative.*

INTERPRETER SERVICES

An **"interpreter"** means an SCVMC or County employee who is ***a County certified interpreter in the patient's or patient representative's preferred language***, certified Hospital Interpreter staff or ***County's contracted interpreter service's personnel***.

If the patient does not speak proficient English, interpreter services must be used in the patient's preferred language. The patient may however elect to use a family member or friend.

*****Document the interpreter's name and ID#(if Language Line) on the Consent Form and in HealthLink.**

CAPACITY

CAPACITY is the patient's ability to understand the nature and consequences of a decision, and to make and communicate a decision.

- **Incapacity is determined by a physician or court.**
- **If the adult patient is not competent, the primary physician should document this on the patient's medical record.**
- If there is no guardian, conservator, agent or surrogate the patient's ***closest available relative may make health care decisions for an incompetent patient***
- **Leadership, Risk Management, and Ethics Committee can provide guidance.**

MEDICAL EMERGENCY

The emergency treatment exception may be invoked when:

- Immediate services are required for the alleviation of severe pain or
- When the immediate diagnosis and treatment of a life-threatening medical condition is required.
- If there is an emergency exception, only the life-saving treatment may be provided.
- The physician does not sign a consent form on behalf of the patient, and a second physician consult is not required.

INFORMED CONSENT DURATION

- A consent remains effective until:
  - ✓ the patient revokes it or
  - ✓ circumstances change that materially affect the nature of, or the risks of, the procedure and / or the alternatives to the procedure to which the patient consented.

- Consents for recurring procedures or treatments (such as chronic dialysis or blood transfusion) remain valid for the patient's current admission.

- Any future admission requires a new consent.

SPECIAL SITUATIONS

DEAF?

Language Line console has capability for video sign language.

BLIND?

Guide Patient Hand to the Spot where to Sign and need TWO witnesses

QUADRIPLEGIC?

On the consent: Print patient name, "Unable to sign, because...", put reason, need TWO witnesses.

ILLITERATE?

Have patient sign an "X" on Signature Line
"Unable to sign, because...", put reason, need TWO witnesses.

ONE ENTERPRISE, THREE HOSPITALS

We have different consent forms at each facility. One form from Valley providers is used Enterprise wide. And there is a different form for private doctors, used at O'Connor and St. Louise. Each location has a different process.

VALLEY MEDICAL CENTER

- Generated electronically when the case is booked. There is a paper form available in case of last-minute changes.
- Contains a blood consent OPT OUT field requiring a separate Blood Refusal Form *if initialed*.
- You are ONLY signing as a witness to the patient's or patient's legal representative signature in the consent.
- Your signature serves only to verify that it was the patient or the patient's legal representative who signed the consent form.
- The witness does not obtain consent or verify the patient's competency to give consent.

O'CONNOR AND ST. LOUISE

- Must have a physician's order (Verify Informed Consent).
- When transcribing onto the form, it should state what was written on the physician's Verify Informed Consent order. "Consent to read..." With no abbreviations, etc.
- The nurse must ensure patient understands consent and has no further questions. Refer patient to MD before signing as witness if this is the case.

O'CONNOR AND ST. LOUISE

- Nurse must refer to H&P and / or Consult Note to confirm that the planned procedure matches the consent order and plan of care.
- A separate paper blood consent form is required for all procedures.
- At St. Louise, anesthesia has a separate consent form.
- Both sites accept the Valley Consent. Valley consent policy applies.

REFERENCES

1. Informed Consent. PolicyStat ID: 5667672. Compliance 360 Policies. From https://hhsconnect.sccgov.org/Pages/360compliancepolicies.aspx
2. Informed Consent. PolicyStat ID: 301.7. Compliance 360 Policies. From https://sccconnect.sharepoint.com/sites/scvhhs-compliance/SitePages/C360%20Policy.aspx
3. California Hospital Association (2023). Consent Manual (49th ed.). CHA.

Safe Patient Handling (SPH)

Morse Fall risk Scale

Total Scores	Intervention/s
Score 0 - 44 = provide universal fall precautions	Give patient/family teaching material: "Call, Don't Fall! Tips to help prevent falls" brochure available in English form #5920-E, Spanish #5920-S, and Vietnamese #5920-V. Ordered through forms department. Orient patient/family to room environment and bathroom. Assess/ask about patient's voiding patterns. Ensure clutter-free environment & clear path to bathroom.
Score 45 - 74 = Initiate fall protocol, initiate or revise falls plan of care	A score of 45 or greater means the patient is at high risk for falls. Follow ***Fall Precaution Care Plan***
Score 75 and above = Consults plus *Fall Precaution Care Plan*	Order OT/ PT consult and follow ***Fall Precaution Care Plan.*** Request a physician to order a Behavior Psychology consult for Rehabilitation patients.

MORSE SCALE - Assess for Fall Risk
High Risk = Yellow Armband

Fall Risk (Neon Yellow

Blood Band (Yellow Band with Numbers)

Restricted Extremity (Neon Pink)

Allergy (Red)

Patient ID (White)

Patients who are assessed to be at high risk for Fall are identified by

Outside Patient Door

FALL PREVENTION

PATIENT CONTRACT

Humpty Dumpty Falls Program

Used for Pediatric patient population (17 years and below)

Parameters being assessed

- Age
- Gender
- Diagnosis
- Cognitive Impairments
- Environmental Factors
- Response to Surgery/Sedation/Anesthesia
- Medication usage

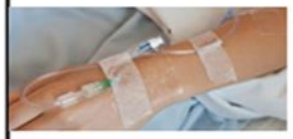
At risk for falls
if score is 12 or Above

Minimum Score 7
Maximum Score 23

Prevent Falls

With Safe Transfers

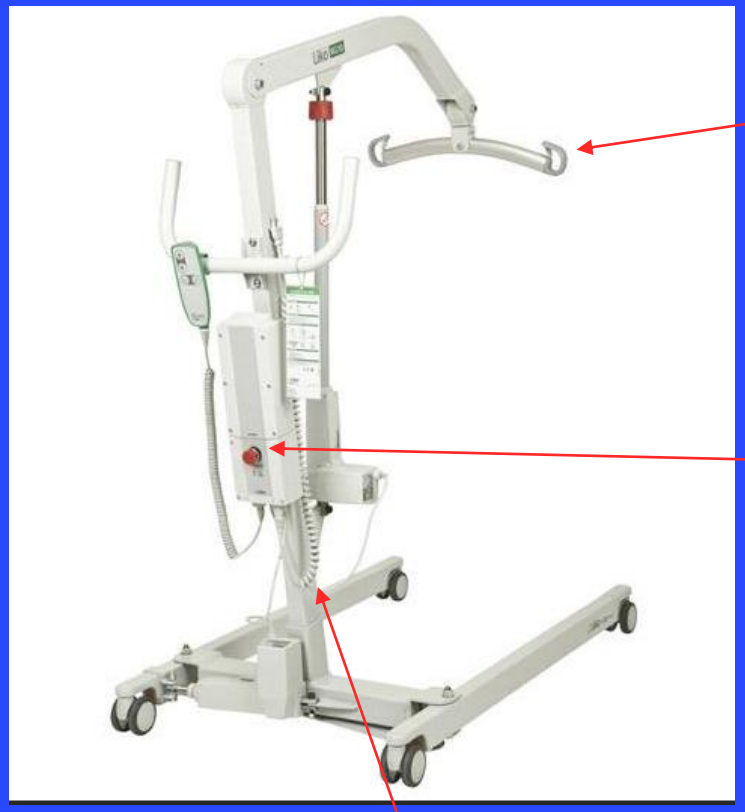
TIME OUT For PATIENT TRANSFERS

1. Plan for Transfer	Determine SPH Status   Determine how many associates needed. Determined proper equipment.
2. Must use (2) Must use a minimum of (2) associates for transfer when using the ARJO Lift or the AIR Mats.	Air Mat Must be FULLY inflated during transfers. Use bilateral handles for transfers. 
3. Check ALL Brakes Physically & Visually. 	W/Cs, all Lift/Transfer Equipment, Beds  
4. Verbal Confirmation that all are ready.	Check that all IVs, Tubings and Catheters are Safeguarded.  
5. On 3 Pull the Patient over 1 pushes, 1 pulls.	Make sure patient is properly positioned in bed/comfortable and secure before deflating the Air Mat.

SPH Equipment

Equipment	Indication
 Hover Jack (Mattress & Pump)	▪ Used with an air matt to move a patient form the floor to a bed or gurney ▪ Weight capacity of >1,200 lbs. ▪ Hover Jack is brought to the scene in an event of patient fall
Air Matt 	• Used with Hover Jack
Comfort Glide 	▪ A repositioning sheet using a low-friction glide that helps reduce the risk of musculoskeletal strain and injuries ▪ Safely boost, turn, reposition and transfer patients ▪ 575 lbs. weight capacity

SPH Equipment – Liko Lift



Ensure that mobile lifts safety clips attached

Liko M220/Liko M230 maximum load = 400 lbs

Check emergency stop button – make sure it is not pushed to make sure that lift/battery works appropriately

Make sure lift is plugged in and ready to use

Size	Height	Weight (kg.)	Weight (lbs.)
Junior	< 4'	<50kg.	<110lbs
Small	4' - 5'6"	43 - 68kg	95 - 150lbs
Medium	5' - 6'	56 - 113kg.	125 - 250lbs
Large	6' - 7'	113 - 181kg	250 - 400lbs
X-Large	6' - 7'	181 - 218kg	400 - 480lbs
XX-Large	> 6'6"	>218kg	>480lbs

SPH Equipment – Viking Lift

*Viking XL – 600 lbs

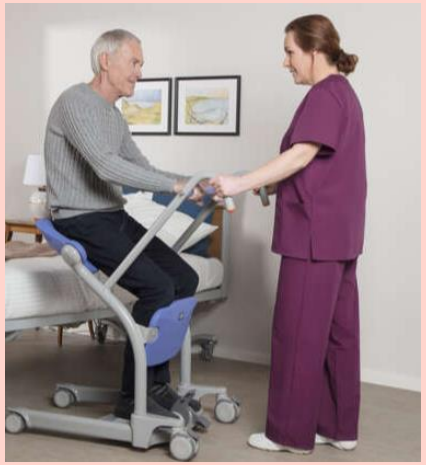
Viking M lift – 450 lbs

Viking L lift – 550 lbs

SPH Equipment – MEDCO Overhead Lift

Depending on the motor options – safe working loads can be between 400 – 800 lbs

SPH Equipment

Equipment	Indication
Steady 	▪ Enable a single caregiver to assists patient from sit to stand transfers ▪ Non powered devices for patients who can bear weight and follow directions ▪ Knee support – provide support for raising into standing ▪ Crossbar handle – allows the patient to support themselves actively by pulling ▪ Max safe working load = 400 lbs.
Gait Belt 	▪ Has a buckle that can securely fasten around the patient's waists. ▪ Belt is snug with just enough room to get your finger under it. ▪ To safely transfer a patient from a wheelchair to bed or vice versa ▪ To help a patient with standing and sitting

In the Event of Patient Fall

The Most Commonly Used Safe Patient Handling Equipment for a Patient Fall are:

Liko/Viking XL:

Hover Jack: (Mattress & pump)

- Weight capacity of > 1,000 lbs
- Locate Hover Jack Resource in your unit
- Hover Jack is brought to the scene

The Primary Nurse is responsible for :

- Assessing the Patient
  - Do not leave patient unattended
- With the assistance of the CFST determine the correct equipment to transfer the patient back to his/her bed
- Notify the patient's physician and family
- Document patient assessment in Health Link
- Document online incident report – on the event of patient Fall

References (Policies)

- Safe Patient Handling – O’Connor Hospital - 6993168
- Safe Patient Handling and Movement, Guidelines for – VMC 413.0
- Safe Patient Handling Policy and Procedure: St Louise Regional Hospital - 4605179

May 2020

SANTA CLARA COUNTY INFORMATION TECHNOLOGY USER RESPONSIBILITY STATEMENT INSTRUCTIONS

In May 1995 the Board of Supervisors charged each County organization with the responsibility for ensuring that all County employees had read and signed a statement of responsibility concerning use of the County's networks and information systems. The resulting County-wide User Responsibility Statement is intended as a *minimum* statement of User responsibility, and individual County Agencies and Departments may require Users to read and sign additional statements to meet any special requirements that apply within their own environments.

- The County User Responsibility Statement must be signed by anyone who might reasonably require access to a County network and/or information system. This includes all County employees, as well as any other individual who needs authorized access for County business purposes. All Users who are allowed to access County resources remotely must also sign an additional attachment specifically related to remote access; this is included as Attachment A of the User Responsibility Statement. In addition, Users who are granted approval to use a personally-owned device for County business must also sign Attachment B of the User Responsibility Statement.
- By signing the Statement or its attachments, Users acknowledge that they have read and understand the contents and that violation of any of the provisions may result in disciplinary action, up to and including termination of employment and/or criminal prosecution.
- If an individual refuses to sign the Statement, the Department can choose to read the Statement to the individual, who will be required to verbally acknowledge understanding of the Statement's contents in the presence of two or more responsible managers. These managers will attest in writing that this reading and verbal attestation of understanding occurred. Failing this verbal acknowledgement of understanding, the involved individual will be denied access to all County information systems and networks.
- Each County organization is responsible for storing and maintaining the signed Statements of its own Users.
- All County organizations shall have their Users re-execute the Statement and/or attachments annually, or whenever there is an update or other change to the Statement or attachments (Department Heads will be notified by the County CIO's office of any updates or changes to the Statement or attachments).
- Each County organization should identify a "User Responsibility Statement Administrator." This is an occasional personnel function that should NOT be filled by a member of the organization's information system support staff. Because it is a

personnel function, a good choice would be an employee in an administrative position who is responsible for other routine personnel issues.

The User Responsibility Statement Administrator is responsible for the following tasks:

1. Identifying employees and other Users within the organization that will need to read and sign the Statement, as well as the relevant attachments.
2. Managing the signing process, including arranging for any briefings to be held in conjunction with Users signing the Statement and attachments.
3. Maintaining the signed Statements and attachments.
4. Ensuring that new employees and other new Users read and sign the basic Statement and any relevant attachments, and that the Department signing process is performed by all Users on an annual basis.

SANTA CLARA COUNTY IT USER RESPONSIBILITY STATEMENT

This User Responsibility Statement establishes a uniform, County-wide set of minimum responsibilities associated with being granted access to Santa Clara County information systems and/or County networks. A violation of this Statement may lead to disciplinary action, up to and including termination.

Definitions

County information systems and networks include, but are not limited to, all County-owned, rented, or leased servers, mainframe computers, desktop computers, laptop computers, handheld devices (including smart phones, wireless PDAs and Pocket PCs), equipment, networks, application systems, data bases and software. These items are typically under the direct control and management of County information system support staff. Also included are information systems and networks under the control and management of a service provider for use by the County, as well as any personally-owned device that a User has express written permission to use for County business purposes.

County-owned information/data is any information or data that is transported across a County network, or that resides in a County-owned information system, or on a network or system under the control and management of a service provider for use by the County. This information/data is the exclusive property of the County of Santa Clara, unless constitutional provision, State or Federal statute, case law, or contract provide otherwise. County-owned information/data does not include a User's personal, non-County business information, communications, data, files and/or software transmitted by or stored on a personally-owned device if that information/data is not transported across a County network or does not reside in a County-owned information system or on a network or system under the control and management of a service provider for use by the County.

A *mobile device* is any computing device that fits one of the following categories: laptops; Personal Digital Assistants (PDAs); handheld notebook computers and tablets, including but not limited to those running Microsoft Windows CE, PocketPC, Windows Mobile, or Mobile Linux operating systems; and "smart phones" that include email and/or data storage functionality, such as BlackBerry, Treo, Symbian-based devices, and iPhones. Note that the category "Mobile Device" does not include devices that are used exclusively for the purpose of making telephone calls.

A *public record* is any writing, including electronic documents, relating to the conduct of the people's business as defined by Government Code section 6252.

"*Remote access*" is defined as any access to County Information Technology (IT) resources (networks or systems) that occurs from a non-County infrastructure, no matter what technology is used for this access. This includes, but is not limited to, access to County IT resources from personal computers located in User's homes.

Users includes County employees who are on the permanent County payroll, as well as any other individual who has been authorized to access County networks and systems.

Key Points

1. General Code of Responsibility

The following General Code of Responsibility defines the basic standards for User interaction with County information systems and networks. All Users of County information systems and networks are required to comply with these minimum standards.

1.1 Users are personally responsible for knowing and understanding the appropriate standards for User conduct, and are personally responsible for any actions they take that do not comply with County policies and standards. If a User is unclear as to the appropriate standards, it is that User's responsibility to ask for guidance from appropriate information systems support staff or Department management.

You are responsible for your own behavior.

If you're unclear about a security standard, it's your responsibility to ask for guidance.

1.2 Users must comply with basic County standards for password definition, use, and management.

You must comply with County password standards.

1.3 With the exception of County-owned and approved devices issued to specific authorized County users, only authorized information systems support staff may attach any form of computer equipment to a County network or system unless express written permission to do so is given by Department management. This includes, but is not limited to, attachment of such devices as laptops, PDAs, peripherals (e.g., external hard drives, printers), and USB storage media.

Don't attach computer equipment of any kind to County systems or networks without permission.

1.4 The use of personally-owned USB storage media on any County computer system is prohibited. All such devices must be County-owned, formally issued to the User by the Department, and used only for legitimate County business purposes.

Use only County-owned and issued USB storage media.

1.5 Users must take precautions when connecting County owned computing equipment to a non-County network and must use a secure connection when performing County duties. Users are prohibited from connecting non-County computer peripherals including USB storage media, to County-owned computing equipment unless express written permission is given by executive management in the User's department and by the

Don't attach County equipment of any kind to non-County computers or networks.

Key Points

User's direct supervisor that the practice will align with the policies of the Information Security Office.

1.6 No User, including information systems staff, may install, configure, or use any device intended to provide connectivity to a non-County network or system (such as the Internet), on any County system or network, without express written permission. All such connections must be approved in writing by the County Chief Information Officer (CIO) or designee. If authorized to install, configure or use such a device, the User must comply with all applicable County standards designed to ensure the privacy and protection of data, and the safety and security of County systems.

Don't install or activate communication devices, such as modems, on County computers or networks.

1.7 The unauthorized implementation or configuration of encryption, special passwords, biometric technologies, or any other methods to prevent access to County resources by those individuals who would otherwise be legitimately authorized to do so is prohibited.

Don't use encryption except when directed to do so.

1.8 Users must not attempt to elevate or enhance their assigned level of User privileges unless express written permission to do so has been granted by Department management. Users who have been granted enhanced privileges due to their specific jobs, such as system or network administrators, must not abuse these privileges and must use such privileges only in the performance of appropriate, legitimate job functions.

Don't attempt to enhance your assigned user privileges.

1.9 Users must use County-approved authentication mechanisms when accessing County networks and systems, and must not deactivate, disable, disrupt, or bypass (or *attempt* to deactivate, disable, disrupt, or bypass) any security measure or security configuration implemented by the County.

Don't attempt to disable or bypass County login procedures.

1.10 Users must not circumvent, or attempt to circumvent, legal guidelines on software use and licensing. If a User is unclear as to whether a software program may be legitimately copied or

Follow the terms of all software licensing agreements.

Key Points

installed, it is the responsibility of the User to check with Department management or information systems support staff.

1.11 All software on County systems must be installed by authorized systems support staff. Users may not download or install software on any County system unless express written permission has been obtained from Department management or authorized system support staff.

Don't download or install software without permission.

1.12 Loss or theft of County-owned computer equipment, or of personally-owned computer equipment that has been approved for use in conducting County business, is to be reported immediately to designated Department management, administrative, or systems support staff. Users are also expected to be aware of security issues, and are encouraged to report incidents involving breaches of security, such as the installation of an unauthorized device, or a suspected software virus.

Immediately report the loss or theft of computer equipment, and also report any suspected security incidents.

1.13 Users must respect the sensitivity, privacy and confidentiality aspects of all County-owned information. In particular:

- Users must not access, or attempt to access, County systems or information unless specifically authorized to do so, *and* there is a legitimate business need for such access.

Don't access computers or data unless such access is related to your job.

- Users must not allow unauthorized individuals to use their assigned computer accounts; this includes the sharing of account passwords.

Don't share your user accounts or passwords with anyone.

- Users must not knowingly disclose County information to anyone who does not have a legitimate need for that information.

Don't share information with someone not entitled to have it.

- Users must take every precaution to ensure that all information classified as either Confidential or Restricted (or an equivalent classification) is protected from disclosure to unauthorized individuals.

Protect sensitive data from those not authorized to see it.

Key Points

- Users must not make or store paper or electronic copies of information unless it is a necessary part of that User's job.

Don't make copies of information unless this is required by your job.

1.14 Users must respect the importance of County-owned systems and data as a valuable asset, and should understand that any data stored or processed on any County computer, or transmitted over any County network, is County property. In particular:

- Users must not change or delete data or information unless performing such changes or deletions is a legitimate part of the User's job function.

Don't change or delete data unless doing so is part of your job.

- Users must avoid actions that might introduce malicious software, such as viruses or worms, onto any County system or network.

Don't introduce computer viruses onto County computers.

- A User who leaves employment with the County must not retain, give away, or remove any County data or document from County premises, other than information provided to the public or copies of correspondence directly related to the terms and conditions of employment. All other County information in the possession of the departing User must be returned to the User's immediate supervisor at the time of departure.

When leaving County employment, don't take County data with you.

1.15 Users should be aware that electronic information transported across any County network, or residing in any County information system, is potentially subject to access by County technical support staff, other County Users, and the general public. Users should not presume any level of privacy for data transmitted over a County network or stored on a County information system.

You should have no expectation of privacy for electronic data stored on County computers.

1.16 Users must respect all intellectual property rights, including but not limited to rights associated with patents, copyrights, trademarks, trade secrets, proprietary information, and confidential

Respect all intellectual property rights associated with data that you deal with while doing your job.

Key Points

information belonging to the County or any other third party.

1.17 All information resources on any County information system or network are the property of the County and are therefore subject to County policies regarding acceptable use. No User may use any County-owned network, computer system, or any other County-owned device or data for the following purposes:

- Personal profit, including commercial solicitation or conducting or pursuing their own business interests or those of another organization

Don't use County computers to conduct your personal business.

- Unlawful or illegal activities, including downloading licensed material without authorization, or downloading copyrighted material from the Internet without the publisher's permission

Don't use County computers for illegal activities.

- To access, create, transmit, print, download or solicit material that is, or may be construed to be, harassing or demeaning toward any individual or group for any reason, including but not limited to on the basis of sex, age, race, color, national origin, creed, disability, political beliefs, organizational affiliation, or sexual orientation, unless doing so is legally permissible and necessary in the course of conducting County business

Don't create or send demeaning or harassing material.

- To access, create, transmit, print, download or solicit sexually-oriented messages or images, or other potentially offensive materials such as, but not limited to, violence, unless doing so is legally permissible and necessary in the course of conducting County business

Don't view, download, or send pornography or other potentially offensive materials.

- Knowingly propagating or downloading viruses or other malicious software

Don't download or transmit malicious software.

- Disseminating hoaxes, chain letters, or advertisements

Don't send chain letters.

Key Points

1.18 Users that are employed by, or are otherwise associated with, a HIPAA impacted Department, are responsible for understanding and carrying out their responsibilities and duties as identified in the County HIPAA policies and procedures training, and other HIPAA-related materials that may be distributed from time to time.

Handle all protected health information according to HIPAA regulations.

2. Internet and Email

The following items define the basic standards for use of County Internet and email resources. All Users of County information systems and networks are required to comply with these minimum standards.

2.1 In general, Users must not use County systems or networks for personal activities. However, reasonable incidental (*de minimus*) personal use of County resources, such as Internet access and email, is allowed as long as such use does not violate the County's acceptable use policies, and does not interfere with the performance of work duties or the operation of the County's information systems. If a User is unclear as to what is considered appropriate incidental personal use, it is the responsibility of the User to ask for guidance from Department management.

Limit personal use of County computers.

2.2 When conducting County business, Users may not configure, access, use, or participate in any Internet-based communication or data exchange service unless express written permission has been given by Department management. Such services include, but are not limited to, Internet Instant Messaging (such as AOL Instant Messaging), Internet email services (such as hotmail and gmail), peer-to- peer networking services (such as Kazaa), and social networking services (such as blogs, MySpace, Facebook and Twitter).

Don't use Internet email or data exchange services (such as FaceBook, MySpace, or other social networking sites) to conduct County business.

Key Points

2.3 It is the User's responsibility to become familiar with the specific County policies, procedures, and guidelines associated with the use of Internet-based communication and data exchange services. Users who have been granted permission to use an Internet-based communication or data exchange service for conducting County business are expected to adhere to all relevant County policies, procedures, and guidelines associated with the use of these services.

You are responsible for understanding County guidelines for using Internet data exchange services, such as social networking sites.

2.4 Users are responsible for understanding and following the County's policy with respect to the retention of email messages, including immediately deleting non-business related email messages once these messages have been read.

Follow County standards for retaining and deleting email messages.

2.5 Users may not use an internal County email account assigned to another individual to either send or receive email messages unless they have received delegated access from the account owner.

Don't use anyone else's email account.

2.6 Users may not configure their County email account so that it automatically forwards messages to an external Internet email system unless express written permission has been given by the Department Head. When automated forwarding is used, it must be for legitimate business purposes only, and is to be implemented with the User's full understanding of, and willingness to accept responsibility for, the associated risks for disclosure of sensitive information.

Don't automatically forward County email to an Internet email system.

3. Remote Access

The following items define the basic standards for remote access to County information systems and networks. All Users of County information systems and networks are required to comply with these minimum standards. Users actually granted remote access privileges must sign the statement provided as Attachment A.

Key Points

3.1 All remote access to County resources must be via the secure, centralized, County-controlled mechanisms and technologies approved by the County CIO or designee, and installed by authorized County systems support staff. Users are not permitted to implement, configure, or use any remote access mechanism other than the County-owned and managed remote access systems that have been formally approved and implemented by authorized system support staff.

Use only existing, approved County remote access systems.

3.2 Written approval for use of County remote access mechanisms is to be granted to a specific User by the appropriate Department Head or designee. Remote access to County resources will be implemented on a case-by-case basis based on job-related necessity, and only for those Users that have read and signed both the County's general User Responsibility Statement and the Remote Access agreement (Attachment A).

Get approval for all remote access to County systems.

3.3 Remote access sessions may be monitored and/or recorded, and complete information on the session logged and archived. Users have no right, or expectation, of privacy when remotely accessing County networks, systems, or data. Audit tools may be used to create detailed records of all remote access attempts and remote access sessions, including User identifier, date, and time of each access attempt.

Remember that remote access sessions may be monitored and/or recorded.

3.4 All computer devices used to access County resources from a remote location must be configured according to County-approved security standards. These include approved, installed, active, and current: anti-virus software, software or hardware-based firewall, full hard drive encryption, and any other security software or security-related system configurations that are required and approved by the County.

Computers used for remote access must be configured according to County standards.

3.5 Users that have been provided with a County-owned device intended for remote access use, such as a laptop or other Mobile Device, will

Key Points

take all reasonable measures to ensure that the device is protected from damage, access by third parties, loss, or theft. Loss or theft of such devices must be reported immediately to designated Department management or support staff.

Take measures to prevent the loss or theft of County-owned Mobile Devices used for remote access, and report loss or theft of such devices immediately.

3.6 Users will practice due diligence in protecting the integrity of County networks, systems, and data while remotely accessing County resources, and will immediately report any suspected security incident or concern to their Department management and IT support staff.

Take appropriate measures to protect County computers and data when using remote access.

3.7 Remote access sessions are subject to all other relevant County IT security policies and standards, including Local User Authentication (passwords), Data Classification, Internet Use, and Email.

When using remote access, continue to follow all County security policies.

4. Personally-Owned Devices

The following items define the basic standards for the use of personally-owned devices to conduct County business. All Users of County information systems and networks are required to comply with these minimum standards. Users actually granted the privilege of using a personally-owned device to conduct County business must also sign the statement provided as Attachment B.

Note that in the case of Mobile Devices, the following provisions apply only to those devices that include email and/or data storage capability (such as BlackBerry devices and other "smart" phones), and do not apply to devices that are used strictly for the purpose of making telephone calls. This Section does not apply to authorized use of Outlook Web Access, provided that Users do not store or retain any downloaded County data on a non-County-owned device.

4.1 Use of personally-owned devices to conduct County business is prohibited unless express written permission is obtained from both the Department Head and IT Manager. If the User in question is a Department or Agency Head,

Use of a personally-owned device to conduct County business requires approval.

Key Points

express written permission must also be obtained from the County Chief Information Officer or designee. The use of personally-owned devices to conduct County business is a privilege, not a right, and employment at the County does not automatically guarantee the granting of this privilege.

4.2 The personally-owned device in question must use existing, County-approved and County-owned access/authentication systems when accessing County resources. Installation by Users of any hardware, software, or network interface components that provide unauthorized network connectivity, either wired or wireless, is prohibited.

If you are allowed to use your own computer or mobile device for County business, you must still use County-approved user login procedures.

4.3 The User shall allow the County to configure personally-owned devices as appropriate to meet security requirements, including the installation of specific security software that is mandated by County policy. When reasonably possible and practical, the County shall strive to provide a minimum of 24-hours notice to the User before configuring the personally-owned device. While the device is in the County's possession, the County shall not access, alter, retrieve or delete the User's personal information, communications, data, software or files stored on the device unless (a) it is reasonably necessary to do so to configure the device to meet security requirements, or (b) the User agrees to the specific access, alteration, retrieval or deletion.

You must allow authorized IT staff to configure, and periodically update, security software on any personally-owned device used to conduct County business.

4.4 Users authorized to use a personally-owned device must follow designated Department procedures for ensuring that software updates and patches are applied to the device according to a regular, periodic schedule. All software installations and updates are subject to verification by management-designated Department staff.

Follow Department procedures for updating and patching software on personally-owned devices.

Key Points

4.5 Users have no expectation of privacy with respect to any County-owned communications, information, or files on any personally-owned device. Except as otherwise provided in this policy or as required by law, the County shall not access any of the User's personal information, communications, data or files on the User's personally-owned devices.

4.6 Clause removed subject to revision.

4.7 If a user is contacted on a personally-owned device by someone from the County conducting County business, and the User has not obtained permission to conduct County business with that personally-owned device, then the County may not access that device regarding that User-received communication other than through legally permissible methods such as a subpoena, request for voluntary disclosure, etc. The preceding sentence shall not limit the County's right to direct a User to disclose the communication at issue upon reasonable notice.

The County will not require you to allow access to your personally-owned device for unsolicited, incoming County communications if that device has not been approved for use in conducting County business

4.8 The User shall adhere to all relevant County security policies and standards, just as if the personally-owned device were County property. This includes, but is not limited to, policies regarding password construction and management, physical security of the device, device configuration, and hard drive sanitization prior to disposal. This does not restrict the User's personal use of the device so long as that personal use does not include or result in (a) the User's failure to adhere to all relevant County security policies and standards, or (b) the breach of the County's security policies or standards

Even when using your own computer or other device for County business, you must still follow all County security policies.

Under most circumstances, you can continue to use an approved device for personal use as well as County business.

Key Points

4.9 The User will make no modifications of any kind to operating system configurations implemented by the County on the device for security purposes, or to any hardware or software installed on the device by the County, without the express written permission of the County CIO's Office.

Don't modify any security configuration settings or security software on your computer.

4.10 The User must treat the work- related or County-owned communications, information or files as County property. The User must not allow access to or use of any work-related or County-owned communications, information, or files by individuals who have not been authorized by the County to access or use that data.

The User must immediately report to designated Department management or support staff any incident or suspected incident of unauthorized access and/or disclosure of County resources, data, or networks that involve the device, including loss or theft of the device.

4.11 The User must immediately report to designated Department management or support staff any incident or suspected incident of unauthorized access and/or disclosure of County resources, data, or networks that involve the device, including loss or theft of the device.

Immediately report the loss or theft of a personally-owned device that has been used for County business.

Key Points

Acknowledgement of Receipt

This Acknowledgement hereby incorporates the main body of the User Responsibility Statement. Attachments A and B are additional signature pages that apply only to those individuals that have been granted either remote access privileges (Attachment A) or permission to use a personally-owned device (Attachment B). These Attachments should only be signed if either of these conditions apply.

All Users must sign this Acknowledgement; Users with permission to use Remote Access should also sign Attachment A, and Users with permission to use personally-owned devices must complete and sign Attachment B.

The User should understand that the County's failure to enforce any provision of this Statement does not mean that the County will not enforce that or any other provision in the future. The User should also understand that if a clause, sentence or paragraph of this Statement is determined to be, invalid by a Court or County commission, this does not affect the validity of any other portion of the Statement.

By signing below, I acknowledge that I have read and understand all sections of the County of Santa Clara's User Responsibility Statement. I also acknowledge that violation of any of its provisions may result in disciplinary action, up to and including termination of employment and/or criminal prosecution.

Violation of any of the provisions in this User Responsibility Statement may result in disciplinary action.

If at any time, I have questions or doubts, or I feel ambivalent or unclear on any matter related to IT security and/or data confidentiality, I understand that it is my responsibility to request clarification from my supervisor or other appropriate manager before taking any action.

It is your responsibility to ask for clarification if you don't understand any aspect of the County IT security policy.

IT User Responsibility Statement
Acknowledgement Form

I acknowledge that this Statement will still be in effect following a transfer to another County Agency or Department, and that all of its provisions will continue to apply to me as long as I am a County employee or other individual who needs authorized access for County business purposes.

User Signature:

_____

Print User Name:

_____

Agency/Department:

_____

Date Signed:

_____