Mission Statement:
(Who we are!!)
Medical Center Health System is a community-based teaching organization dedicated to providing high-quality and affordable healthcare to improve the health and wellness of all residents of the Permian Basin.

Vision Statement:
(Where we are going!!)
MCHS will be the premier source for health and wellness.

Values:
(How we are going to get there!!)
“I CARE”
Integrity, Customer Centered, Accountability, Respect, Excellence

MCHS Strategic Priorities 2016-2017

• Quality: Provide high quality affordable patient-centered care
• Clinical Integration: Continue development of an integrated community health system
• Empowering Excellence: Make MCHS a better place for employees to work, for physicians to practice, and for patients to receive care
• Community Health: Working with our community to improve health and wellness
• Financial Sustainability: Identify opportunities for revenue growth while reducing waste and variation in our day to day operations
SAFETY

Medical Center Hospital has established a Safety Officer/Environment of Care (EOC) Committee program. The Safety Officer develops investigative, safety and educational programs directed at decreasing both the frequency and severity of liability exposure and improving overall safety. The Safety Officer conducts departmental safety inspections, safety reports, random surveys and reviews safety department plans.

The EOC Committee is responsible for oversight of all seven areas of the Environment of Care:

1. Safety
2. Security
3. HazMat
4. Utilities
5. Life Safety
6. Medical Equipment
7. Emergency Management

Every employee is responsible to observe and report safety issues to the Safety Officer or EOC Committee member. Employees are urged to report any safety concerns to their direct supervisor and/or the EOC Committee by calling 640-1101 or by email to;

Brad Timmons-Safety Officer btimmons@echd.org
Sara Smith-Mallory-Safety Coordinator smiths@echd.org
THREE CLASSES OF FIRE

- **CLASS A – Ordinary Combustibles**
  - Examples Include: Wood, Paper, Textiles

- **CLASS B – Flammable Liquids**
  - Examples Include: Gasoline, Oil, Fats

- **CLASS C – Live Electrical**
  - Examples Include: Wiring, Appliances

FIRE EXTINGUISHERS

- **DRY CHEMICAL – Smothers/Interrupts Flame**
  - For Class A, B, C Fires

- **MULTI – PURPOSE**
  - For Class A, B, C Fires

- **CARBON DIOXIDE**
  - For Class B, C Fires

The Acronym “PASS” will help you remember the use of most fire extinguishers:

- **P** — PULL
  - Pull the pin

- **A** — AIM
  - Aim at the base of the fire

- **S** — SQUEEZE
  - Squeeze the trigger

- **S** — SWEEP
  - Sweep from side-to-side the base of the fire until it goes out
FIRE AND/OR EXPLOSION PROTOCOL

➢ Fire Alert within the hospital is “Fire Alarm Activation”.
   o This is **NOT** an order to evacuate.
   o PBX Operator will announce “**Fire Alarm Activation + Location**” over the paging system three times.
   o All areas not covered by the paging system will be notified by phone.

➢ If the fire is in your work area, **R.A.C.E.**!
   o **RESCUE**
     ▪ Escort patients or other persons in immediate danger to a safe area by whatever means possible.
   o **ALERT**
     ▪ If visible smoke is present, but no flame can be seen, treat as if it were a fire and turn on the alarm.
     ▪ Pull a manual fire alarm by following instructions on the box.
     ▪ Notify the PBX Operator by dialing ext. 2000 and give your name, exact location of fire.
   o **CONFINE**
     ▪ Close all doors and windows to stop air movement.
     ▪ Know where oxygen shut off valves are located
     ▪ Disconnect electrical equipment in the fire area.
     ▪ **Do NOT** move burning mattresses or chairs out of rooms.
   o **EXTINGUISH**
     ▪ Secure proper Fire Extinguisher
       ‣ Know what’s burning before you grab an extinguisher.
       ‣ Use a blanket if necessary.
     ▪ All personnel on duty in the area will report to the person “in charge” immediately after “**Fire Alarm Activation**” is paged.
       ‣ The person “in charge” will assign an employee to be stationed by the telephone and a person to keep a complete and portable list of patients in the area in case of an evacuation.

➢ Rules to observe when a fire is in a Patient Care Area.
   o Reserve the telephone for emergency use.
   o Keep visitors with patients.
   o Supervisor will assign personnel to reassure patients and visitors in a quiet and calm manner.
   o Do not attempt to remove patients from any area other than from immediate danger until ordered to do so.
The order to evacuate will be given only by the Incident Commander or the Fire Department Battalion Chief.

- If the fire is NOT in your work area and it is a Patient Care Area:
  - Close doors and windows.
  - Report to your Supervisor or Charge Nurse.
  - Supervisor will assign personnel to reassure patients and visitors in a quiet and calm manner.
  - Supervisor will assign an employee to stay at the telephone. Keep a complete and portable list of patients in case evacuation is ordered.
  - Do NOT tie-up phone lines except for emergency use.
  - All personnel are to remain in their assigned area unless directed otherwise by the Incident Commander or the Fire Department Battalion Chief.

- If the fire is NOT in your work area and it is a Non – Patient Care Area:
  - Close doors and windows.
  - Report to your Supervisor.
  - Remain in your department unless otherwise directed.
  - Do NOT tie up phone lines.

- Each department shall be responsible for developing, and maintaining, its own complete Fire Evacuation Plan, which will include:
  - A detailed list by type and location of hand firefighting equipment in each area.
  - A prominently displayed Fire Evacuation Route by stairs that leads directly to exits outside the building.
    - This must include a primary route and secondary route.

- Each employee shall be responsible for knowing his/her specific assignment and the contents of his departmental fire plan.

- Fire Drill Procedure
  - Only the Safety Coordinator, Lead Security Officer and the Evening Shift Coordinator are authorized to conduct a fire drill.
  - The procedure for a fire drill is the same as in the case of an actual fire.
USE OF ELECTRICAL APPLIANCES

ADMINISTRATION

POLICY MEMORANDUM

<table>
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<tr>
<th>POLICY TITLE:</th>
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<td>Management of the Environment of Care</td>
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<td>All Hospital Personnel &amp; Visitors</td>
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ALTERNATE WORD SEARCH:

POLICY STATEMENT:

To insure that all electrical equipment is electrically safe prior to initial use; all electrically line powered equipment, regardless of ownership, must be inspected and approved for its specific use.

PROCEDURE:

1. **Personal equipment** will be inspected and approved for use by the employee’s supervisor. Discretion will be used upon approval. Equipment must be in good working condition. UL APPROVED, and double insulated (if two prong). Example of equipment: am/fm radios, stereos, clocks, coffee makers, pencil sharpeners, desk fans, microwave ovens, hot plates, and decorations. Safety tags are not required.

2. **Hospital owned equipment** will be inspected prior to initial use and tagged with a permanent blue I.D. control number and the ECHD asset bar code tag. Equipment will be UL APPROVED and double insulated if two prong. Records will be filed in the Engineering Department. Example of equipment to be tested: microwave ovens, refrigerators, address-o-graphs, time clocks, power tools, wet-vacs, buffers, vacuum cleaners, dietary equipment, and office equipment, i.e. calculators, copiers, fax machines.

3. **Non-hospital owned equipment**: loaner, rental, demo/evaluation, and physician owned equipment will be inspected and approved prior to initial use by Engineering/Clinical Engineering. Equipment will be logged into the
Clinical Engineering Inventory System by serial number. A safety inspection sticker will be attached.

4. **Patient and visitor equipment** will be inspected and approved for use by the attending charge nurse; and in the event of questionable equipment the Engineering/Clinical Engineering Department will be notified for assistance. To insure patient safety the following equipment is strictly forbidden in patient areas: televisions, space heaters, electric blankets/pads, spark emitting toys/decorations, non-UL APPROVED devices, i.e. hair dryers, hot irons, shavers and any electrical device that will have direct patient contact.

**CLINICAL PATIENT USE EQUIPMENT**

1) **Hospital owned equipment** will be inspected prior to initial use. Two prong equipment is prohibited. A permanent red Clinical Engineering I.D. control number and the ECHD asset bar code tags will be issued and logged into the Clinical Engineering Inventory System.

**Non-hospital owned equipment**: loaner, rental, demo/evaluation, physician owned and/or personally owned clinical patient use equipment will be inspected and approved prior to initial use by Engineering/Clinical Engineering. These devices will be entered into the Clinical Engineering Inventory System by serial number and an inspection sticker will be attached to the unit.

| AUTHOR'S SIGNATURE | Brad Timmons  
| Chief of Police, Director Safety/EM |
| AUTHORIZING SIGNATURE(S) | Matt Collins  
| Vice President, Support Services |
| | William W. Webster  
| President/Chief Executive Officer |

END OF POLICY
ADMINISTRATION

POLICY MEMORANDUM

<table>
<thead>
<tr>
<th>POLICY TITLE:</th>
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<td>POLICY APPLICABLE TO:</td>
<td>All Hospital Employees</td>
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<td>POLICY EFFECTIVE DATE:</td>
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<td>4/01, 4/02; 1/07; 09/16</td>
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ALTERNATE WORD SEARCH:

PROCEDURE:

1) HAZARDS:

a) Fire - can be started by faulty wiring, extension cords, poorly maintained equipment, and unsafe practices.

b) Burns - can occur from direct contact with overheated electrical wires or by contact with other items that have been heated by contact with faulty wires.

c) Electrocutio or Shock - any direct contact with 110 or 220 volt wiring has the potential for electrocutio. Low-voltage currents frequently affect the heart, causing ventricular fibrillation. Electrical shock may cause complication such as vascular injury, LOC, damage to the respiratory center, infection, cardiac arrhythmias or eye damage.

2) PREVENTATIVE MEASURES:

a) Use appropriate precautions with flammable liquids, i.e., alcohol.

b) Before use, check the integrity of all electrical equipment, including cords, switches, plugs and wall receptacles.

c) Do not use multiple-outlet adapters or two-wire extension cords. Do not remove ground pins from three-pin plugs.
d) Avoid routing power cords through heavy traffic areas and avoid rolling equipment over electrical cords.

e) Follow manufacturer’s recommendations and standards for all electrical equipment.

f) Equipment testing will be performed by Engineering/Clinical Engineering in conformance with policy number MCH-4002.

g) Remove and report any questionable electrical equipment.

h) Never place containers of liquid on electrical equipment.

Hospital Fire and Safety Policies and Procedures should be reviewed at least yearly and inservices on such must be attended.

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END OF POLICY
SAFE MEDICAL DEVICES ACT (SMDA)

- The Safe Medical Devices Act requires the hospital to report all death or serious injuries which occur due to a medical device.
- This notice must be made within ten (10) days from the incident or pay a $10,000 fine.
- Make sure all incidents involving medical equipment are reported to the Clinical Engineering Department immediately so they can expedite this report.
- Remember to report all incidents on the Occurrence Report Trending System (ORTS) and attach a red equipment tag to the equipment.

ELECTROMAGNETIC INTERFERENCE (EMI)

- EMI occurs when two-way radios or cellular phones interfere with electrical equipment.
  - This may even involve life-sustaining equipment.
- Studies show that two-way radios interfere with electrical equipment when the user is transmitting over the radio.
- The recommendation for the health-care industry is that the use should be a minimum of 15 feet away from patient care areas before transmitting.
- Radio traffic may be received on a two-way radio without danger of EMI.
- The two primary departments using two-way radios at Medical Center Hospital are the Engineering department and the Security department.
  - The department policy for these departments is the staff must be a minimum of 15 feet away from patient care areas before transmitting (depressing the transmit button and talking on the radio).
HAZARDOUS MATERIALS TRAINING

I. Introduction (Purpose of this training)
   A. Be familiar with the provisions of the OSHA Hazard Communication Standard and the written Medical Center Hospital Hazardous Communication Program.
   B. Understand the content and uses of the hazardous chemical listings, labels, and SDS's.
   C. Know the locations and availability of the written Hazardous Materials and Waste Management Program, hazardous chemical listings, and SDS's.
   D. Know the hazards of chemicals in the work area and protective measures to be taken.
   E. Know the proper handling and disposal of infectious waste.

II. Hazard Communication Standard
   A. The purpose of this standard is to ensure that the hazards of all chemicals produced or imported are evaluated and that information concerning these hazards is transmitted to employers and employees.
   B. The Hazard Communication Standard is also known as the Right-To-Know Law.
   C. The Hazard Communication Standard is required under the:
      2. The Texas Communication Standard.
      3. Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
   D. The OSHA standard provides for:
      1. Hazard determination.
      2. A hazard communication program.
      3. Hazardous chemical listing(s).
      4. Labels and other forms of warning.
      5. Safety Data Sheets.
      6. Employee information and training.
   E. Under the law and the Medical Center Hospital program, you have specific employee rights:
      1. You will not be required to work with hazardous chemicals until you have received information on the hazardous chemicals and their locations or operations practices, emergency and first aid procedures, and have been provided with appropriate personal protective equipment.
      2. You will not be required to work with hazardous chemicals from unlabeled containers, except portable containers for immediate use and you are aware of the contents.
      3. You may file complaints with OSHA or the Texas Department of Health, and may not be discharged, disciplined, or discriminated against for exercising any rights provided by the regulations.
      4. You cannot waive any benefit or requirement of hazard communication regulations nor can you be asked or required to do so by any employer.
      5. In order to address any questions or concerns regarding hazardous chemicals, you should first contact your supervisor or departmental safety coordinator for information. If these individuals are unavailable you may contact the Hazardous Materials Coordinator.

III. Definition of Hazardous Materials
   A. A hazardous material is any material in use that is considered to represent a threat to human life or health, or to the environment. Manufacturers or importers must evaluate their chemicals to determine if they are hazardous before they supply them to any user.
   B. OSHA's definition of a hazardous material is: A substance or material which has been determined by OSHA and the EPA to be capable of posing an unreasonable risk to health, safety and property.
   C. A hazardous waste is a material that is no longer in use that represents a threat to human life or health, and to the environment.

IV. Hazardous Materials Management Manual and Location
   A. Medical Center Hospital has a written hazard communication program, which can be found in the Hazardous Materials Management Manual covering several required subjects.
B. This copy of the hazard communication program gives you information on

1. Hazardous chemical listings.
2. Safety Data Sheets.
3. Labels and other forms of warning.
4. Physical and health hazards of chemicals.
5. Non-routine tasks involving hazardous chemicals.
6. The employee information and training program.
7. The sharing of hazard information between Medical Center Hospital and contractor personnel.

V. Chemical Inventories

A. A list of all hazardous chemicals used or located in your work areas, regardless of quantity, has been compiled. The list uses the same common names or trade names used on the labels and Safety Data Sheets, so that they can be easily cross-referenced.

B. The department chemical inventory should list any hazardous characteristics associated with the chemical and whether the product enters the waste stream.

C. Hazardous chemical listings will be updated whenever changes occur and the most current list will be available to you.

D. There is a complete set of Chemical Inventories at Medical Center Hospital, located in the Customer Service Office.

VI. Labels

A. Labels are used to identify products, to alert you to product hazards, and to provide some basic use and safety information about the products. Original container label information meets all labeling requirements. Secondary or "in-house" labeling of transferred materials is also subject to these requirements. Chemical transferring done in areas, such as the Lab, will utilize the NFPA Identification secondary labeling. The hazard rating codes are outlined in the Hazardous Materials Management Manual under Labels.

B. Labels must show the chemical identity, using common name or trade name, appropriate hazard warnings, such as, "Caution", or "Poison". The label will list the primary hazard(s) after these signals word. In addition, more information on the hazard(s) and precautions, first aid procedures, and protective measures will be stated on the label. There should also be information on whether the product is a concentrate and must be diluted, or is ready-to-use.

C. Always use chemicals in accordance with label directions. The SDS may also provide more detailed information.

D. Exceptions to required labeling include:
   1. Portable containers that you fill from labeled containers for your immediate use do not need to be labeled.
   2. Laboratory chemicals do not need to be labeled after they are removed from the original container. However, laboratory procedures may require this labeling.
   3. Pipes and piping systems do not need to be labeled, however, tags will be placed at outlet valves to alert you if any hazardous chemical are contained in the pipes.

VII. Safety Data Sheets

A. Safety Data Sheets (SDS) provide information on the characteristics, safe handling, fire and health hazards, first aid procedures, spill or leak procedures, waste disposal methods, and special protection for all hazardous chemicals.

B. Safety Data Sheets are required for all products that have hazardous characteristics under state and federal regulations, or Right-To-Know laws.

C. While format may vary, each SDS is required to contain the specific information:
   1. Product identity.
   2. Manufacturer information.
   4. Physical/chemical characteristics.
   5. Fire and explosion data.
   6. Reactivity data.
7. Health hazard data.
8. Precautions for safe handling and use.
9. Control measures.
10. Date of preparation or revision of MSDS.

D. SDS's are located on the Intranet.
E. Remember that it is up to you to become familiar with the information provided in SDS's for chemicals in your work area.

VIII. Personal Protective Equipment.
A. SDS's and labels specify personal protective equipment (P.P.E.) that should be used with specific chemicals. Personal protective equipment includes gloves, eyewear, face shields, masks, respirators, clothing, etc. This equipment is provided to you and you are responsible for wearing the proper equipment whenever it is required.
B. Always be sure that your personal protective equipment is in working order. If your P.P.E. is worn or broken be sure to get it replaced immediately.

IX. Spill Instructions
A. When there is a spill:
   1. Rescue anyone in the area.
   2. Alert the spill team - Call Hospital Extension #2000 and ask for spill team to be sent to the area.
   3. Confine the spill.
   4. Extinguish or Evacuate.

X. Infectious Waste
A. Definition of Infectious Waste: Infectious waste is any solid, semisolid, or liquid waste which contains pathogens of sufficient strength and quantity so that exposure to the waste by a person could result in an infectious disease.
B. Types of Infectious Waste
   1. Microbiological waste.
   2. Pathological.
   4. Sharps.
C. Segregation and Removal of Infectious Waste
   1. Infectious waste shall be segregated from the general waste stream at the point of origin.
   2. Infectious waste shall be discarded in appropriate containers and stored in red biohazard bags inside biohazard containers.
   3. The housekeeping department shall provide biohazard red bags and containers for each area in the hospital and will be responsible for its removal out of the area.
   4. **Do NOT pack too much** infectious waste in a biohazard container. This can create a hazardous and infectious situation.
   5. Sharps shall be placed directly into an impervious, puncture-resistant sharps container. Needles shall not be recapped, bent, broken, or clipped before discarded. Broken glassware shall be segregated from hypodermic needles where possible.
   6. All personnel handling bulk infectious material shall be required to wear appropriate personal protective gloves. Masks, goggles, and gowns may be necessary when splashing is likely.
WORKER RIGHT-TO KNOW PROGRAM

Texas Community Right-To-Know Acts (TCRAs)

The community right-to-know program has been established under both federal and state laws. As a result of these laws, all facilities which store significant quantities of hazardous chemicals must share this information with state and local emergency responders and planners. Facilities in Texas share this information by filing annual hazardous chemical inventories called Texas Tier Two Forms with the state, with Local Emergency Planning Committees (LEPCs), and with local fire departments. The Texas Tier Two Reports contain facility identification information and detailed chemical data about hazardous chemicals stored at the facility. Emergency response personnel, such as fire fighters, can use information contained in Texas Tier Two Reports, as well as custom reports generated from Texas Tier Two data.

The Tier Two Registration Section serves as the state repository for community right-to-know information, provides outreach for compliance on both the federal and state laws, supports Local Emergency Planning Committees (LEPCs) in community right-to-know endeavors, and administers an enforcement program. In 1999, the Section received and processed over 50,000 Texas Tier Two Reports, which are required to be maintained for 30 years. Annual inventory filing fees, which are collected under the TCRAs, provide the funding for both the community and worker right-to-know programs.

Texas Hazard Communication Act (THCA)

The worker right-to-know program is administered under the authority of the Texas Hazard Communication Act (THCA). The THCA requires public employers* to provide information, training, and appropriate personal protective equipment to their employees who may be exposed to hazardous chemicals in their workplaces. The Section provides both consultative and enforcement related evaluations of public workplaces to ensure that public employees are protected from hazardous chemicals in their workplaces. Public employers include (but are not limited to) cities, counties, state agencies, public schools, public colleges and universities, and volunteer service organizations.

*Public employers include (but are not limited to) cities, counties, state agencies, public schools, public colleges and universities, and volunteer service organizations. Employees of private facilities in Texas are covered by a similar federal law, which is enforced by the U.S. Occupational Safety and Health Administration (OSHA).
NOTICE TO EMPLOYEES

The Texas Hazard Communication Act, codified as Chapter 502 of the Texas Health and Safety Code, requires public employers to provide employees with specific information on the hazards of chemicals to which employees may be exposed in the workplace. As required by law, your employer must provide you with certain information and training. A brief summary of the law follows.

HAZARDOUS CHEMICALS
Hazardous chemicals are any products or materials that present any physical or health hazards when used, unless they are exempted under the law. Some examples of more commonly used hazardous chemicals are fuels, cleaning products, solvents, many types of oils, compressed gases, many types of paints, pesticides, herbicides, refrigerants, laboratory chemicals, cement, welding rods, etc.

SAFETY DATA SHEETS
Employees who may be exposed to hazardous chemicals shall be informed of the exposure by the employer and shall have ready access to the most current Safety Data Sheets (SDSs) or Material Safety Data Sheets (MSDSS) if an SDS is not available yet, which detail physical and health hazards and other pertinent information on those chemicals.

LABELS
Employees shall not be required to work with hazardous chemicals from unlabeled containers except portable containers for immediate use, the contents of which are known to the user.

WORKPLACE CHEMICAL LIST
Employers must develop a list of hazardous chemicals used or stored in the workplace in excess of 55 gallons or 500 pounds. This list shall be updated by the employer as necessary, but at least annually, and be made readily available for employees and their representatives on request.

EMPLOYEE RIGHTS
Employers shall provide training to newly assigned employees before the employees work in a work area containing a hazardous chemical. Covered employees shall receive training from the employer on the hazards of the chemicals and on the measures they can take to protect themselves from those hazards. This training shall be repeated as needed, but at least whenever new hazards are introduced into the workplace or new information is received on the chemicals which are already present.

EMPLOYERS MAY BE SUBJECT TO ADMINISTRATIVE PENALTIES AND CIVIL OR CRIMINAL FINES RANGING FROM $50 TO $100,000 FOR EACH VIOLATION OF THIS ACT

Further information may be obtained from:
Texas Department of State Health Services
Division for Regulatory Services
Policy, Standards, & Quality Assurance Unit
Environmental Hazards Group
PO Box 149347, MC 1987
Austin, TX 78714-9347

(800) 452-2791 (toll-free in Texas)
(512) 834-6787
Fax: (512) 834-6726
TXHazComHelp@dshs.texas.gov

Worker Right-To-Know Program
Publication #: E23-14173
Revised 03/2014
ABDUCTION OF AN INFANT/CHILD

ADMINISTRATION

POLICY MEMORANDUM

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ALTERNATE WORD SEARCH: infant, child, abduct, missing infant

POLICY STATEMENT:

At no time during the early stages should anyone without a valid need-to-know be told that an infant/child is missing. The police and the Communications and Marketing Department will make that determination. No hospital employee or volunteer is authorized to make a public statement concerning this incident nor to communicate with a member of the media without prior clearance from the Public Information Officer. Nursing staff assigned to Labor and Delivery, NICU, and Pediatrics must wear their Unit Specific badge at all times during working hours.

PROCEDURE:

1) When a staff nurse has suspicion an infant or child is missing, she/he will call extension 2000 (Emergency Operator Number) and state, "Missing Infant/Child" and the location of the occurrence as she/he collaborates with the charge nurse. Infants or children located on the Pediatric floor will be announced as "Missing Infant Pediatrics along with age, race and gender."

2) Simultaneously, the following actions will occur:

   a) PBX will announce "Missing Infant/Child and location" over the hospital P.A. system. Department supervisors will assign staff to every
exit on their floor.

b) The charge nurse will notify the Unit Director and/or Administrative Coordinator.

c) PBX will notify Security, ECHD Police, and Engineering staff on duty:

Police/Security and Engineering staff will immediately go to all first floor exits and stop the flow of traffic out of the hospital until the ECHD police arrive.

i) Guests attempting to leave the hospital will be asked to cooperate until the police arrive.

ii) Security will immediately archive the video recording of the hospital interior for immediate review

d) ECHD Police personnel will begin an investigation and contact local law enforcement. ECHD PD will maintain the liaison with all law enforcement agencies.

e) PBX will notify the ECHD Police Captain to assist in the response if not already notified.

f) The following members of Incident Command System will be notified by PBX and informed to report to the Emergency Operations Center (ECC located in Conference Room A of Administration):

i) Administrator on Call

ii) Public Information Officer

iii) Divisional Director of Women's and Children's Services

iv) Chief of ECHD Police

v) House Supervisor

vi) Chief Medical Officer

3) If an abduction has been confirmed, the Unit Director and Attending M.D. will notify the parents.

4) The mother will be transferred to a surgical floor to further ensure privacy. The family of a Pediatric patient will be taken to a designated area.

5) PBX and Admitting Departments will initiate “No Information Status (NI)” for the patient.

6) The parent-child nursing staff will be told of the occurrence. All staff on
duty when the abduction occurred will remain on the unit until the authorities complete proper questioning. All staff members are requested to refrain from discussing this incident with anyone other than the authorities.

7) All infants/children will be placed in their mother's room with parents to promote a sense of security.

8) The collaborative administrative group will develop an action plan to meet the needs of each situation. This plan will include the following:

   a) Inform the other patients.

   b) Ensure additional nursing staff, security staff, social services staff are placed where needed.

   c) Administrative coverage during this crisis.

9) Assessing the needs of the parents of the abducted child and clarifying their specific requests; i.e., visitors, media coverage, assistance with contacting other family members, etc.

<table>
<thead>
<tr>
<th>AUTHOR'S SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanie Conant BSN, RN</td>
</tr>
<tr>
<td>Educations and Quality Assurance</td>
</tr>
<tr>
<td>4E/Labor and Delivery</td>
</tr>
</tbody>
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<thead>
<tr>
<th>AUTHORIZING SIGNATURE(S)</th>
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</thead>
<tbody>
<tr>
<td>Brad Timmons</td>
</tr>
<tr>
<td>Chief of Police/Director Safety</td>
</tr>
<tr>
<td>Emergency Preparedness</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>END OF POLICY</th>
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</thead>
<tbody>
<tr>
<td>William W. Webster</td>
</tr>
<tr>
<td>President/Chief Executive Officer</td>
</tr>
</tbody>
</table>
VIOLENCE-FREE WORKPLACE

Our hospital is committed to maintaining a safe, healthful, and efficient working environment where patients, visitors, and employees are free from threat of workplace violence.

Workplace violence is any act that:
- Threatens the safety of an employee, patient, or visitor.
- Affect the health, life, or well-being of an employee, patient, or visitor.
- Results in damage to hospital, employee, patient, or visitor property.

Prohibited acts include, but are not limited to:
- Threats, intimidation, coercing, harassment, or assault.
- Sexual harassment.
- Carrying a concealed weapon.
- Allowing unauthorized access.
- Using, duplicating, or possessing keys without authorization.
- Theft.
- Vandalism.

Any employee who has been threatened, is a victim of a violent act, witnesses any threats or violent acts, or learns of any threats or violent acts, is to report such activity to Human Resources immediately. Staff may use the Compliance boxes or the Hotline at 1-800-805-1642. The caller may remain anonymous and does not have to reveal their name. All reports received will be confidential.

In an emergency, staff should contact Security or dial Extension 2000. All employees are encouraged to take an active role in creating a safe work environment.

Keep on the look out for any constructive suggestions for improving the safety and security of our hospital and direct these suggestions to Human Resources or the Safety Officer.
POTENTIAL BOMB THREAT

Prolong the conversation as long as possible.

Potential Bomb Threat!

Be Alert For:

- Distinguishing voice characteristics.
- For background noises such as music, voices, aircraft, church bells, etc.
- Refer to the question section of the Bomb Threat Checklist (see attached).
- Note if the caller expresses knowledge of the hospital by the description of the location of the bomb.
- Complete a Bomb Threat Checklist.

Written Warning

- Handle the written warning of a bomb threat as little as possible.
- Do not fold, crumple, or write on the paper.
- Do not pass the note to another to read.
- Leave the handling of the note to the law enforcement.

When Potential Bomb Threat is announced:

Search Procedure

Supervisor in the Bomb Threat Area should call the EOC at ext. 2410 to inform the Incident Commander of their location.

Employees with master keys will report to the Supervisor of the area.

The Supervisor will advise employees to:

- Conduct a complete search of their area
- Search for anything unusual
- Do not disturb or touch anything found that appears unusual
- Report back to the Supervisor if any suspicious or unusual items are found
- Report back to the Supervisor when the search is complete.

Second employee should relate the information to the PBX Operator by dialing ext. 2000 to report the receipt of a bomb threat.

Give your name, department, phone number, and any available information you have received.

Attempt to relay the information being received to another employee while the call is still in progress.
Medical Center Hospital
Potential Bomb Threat Checklist

Instructions: Listen. Do not interrupt the caller except to ask:

When will it go off? ____________________ Where is it? ____________________________

What does it look like? ________________________________________________________

What floor is it on? ____________________________________________________________

Was the caller familiar with the plant or the building? ____________________________

Time of call: ______________ Date: ______________________________________________

Caller’s identity: Sex___________ Adult__________ Child___________ Approx. Age__________

Origin of Call: Local_________ Long Distance______ Booth_____________ Internal_______

Voice: Loud________ Soft_________ High pitched________ Raspy_________ Drunk__________

Speech: Fast________ Slow________ Distorted_________ Slurred_Nasal_________

Language: Excellent__________ Fair___________ Foul___________ Foreign_Other________

Manner: Calm_Rational Angry________ Deliberate_________ Righteous__________

Background Noises: Office____ Factory_Traffic________ Animals_______ Party_______ Quiet____

Write out the message exactly as you received it from the caller:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Pretend difficulty in hearing. Keep the caller talking. If caller will converse beyond essential questions (at the top of the sheet), continue asking questions. The more information you can gather, the better your choices of responding appropriately.

Tell the caller that the bomb may cause injury or death.
TOBACCO FREE CAMPUS

ADMINISTRATION POLICY MEMORANDUM

<table>
<thead>
<tr>
<th>POLICY TITLE:</th>
<th>Tobacco Free Campus</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY NUMBER:</td>
<td>MCH-1033</td>
</tr>
<tr>
<td>JCAHO FUNCTION AREA:</td>
<td>Environment of Care</td>
</tr>
<tr>
<td>POLICY APPLICABLE TO:</td>
<td>All Hospital Employees, Patients,</td>
</tr>
<tr>
<td></td>
<td>Physicians, Auxiliary, Visitors,</td>
</tr>
<tr>
<td></td>
<td>Contract Employees &amp; Tenants</td>
</tr>
<tr>
<td>POLICY EFFECTIVE DATE:</td>
<td>July 1, 2009</td>
</tr>
<tr>
<td>POLICY REVIEWED:</td>
<td>1/2012; 1/2013</td>
</tr>
<tr>
<td>POLICY REVISED:</td>
<td>08/26/09</td>
</tr>
</tbody>
</table>

ALTERNATE WORD SEARCH: Nicotine Replacement Therapy (NRT), Tobacco Free, Smoking, Smoke Free

PHILOSOPHY:
Medical Center Hospital recognizes the health hazards caused by tobacco products. As a healthcare campus, Medical Center Hospital is committed to the establishment and enforcement of a healthier, tobacco-free environment. The purpose of this MCHS operating policy and procedure is to establish a policy prohibiting tobacco use in or on all MCHS Campuses and is applicable to anyone, including but not limited to employees, physicians, patients, vendors, contractors, visitors and volunteers at Medical Center Hospital.

POLICY STATEMENT:
Medical Center Health System prohibits smoking or tobacco product use while on any Medical Center Health System Campus.

CAMPUS DEFINITION:
Campus means all properties leased or owned in any location by Medical Center Health System. This includes the interior of all buildings, together with adjacent parking lots, parked cars, garages and sidewalks. Medical Center Hospital's perimeter coverage will encompass the area between 2nd Street to 6th Street and between Dotsy and Sam Houston. (Attachment A)

TOBACCO USE DEFINITION:
Tobacco use is defined as the burning of any type of tobacco product, as well as the use of oral tobacco products, electronic cigarettes or any other product that derived from tobacco covered under the Food, Drug & Cosmetic Act (FD&C Act).

PROCEDURE:
1. Signage shall be posted at the boundaries of all Campuses and entrances of any Medical Center Health System owned or leased property.
2. Appropriate signage will be posted in the facilities and MCHS vehicles.
3. This policy will be incorporated into Staff Orientation and Handbook material that will be available on the staff intranet.
4. Any Medical Center Health System employee is encouraged to inform any visitor or patient that they are on a tobacco-free campus.
5. A tobacco-free environment information card will be provided to anyone found to be using tobacco products of any kind, including cigarettes, cigars, electronic cigarette and oral tobacco products on any Medical Center Health System campus.
ENFORCEMENT:
1. Enforcement of this policy is the responsibility of department heads, supervisors and security. Any employee found to be in violation of this policy will be subject to disciplinary action as set forth in the Medical Center Hospital employee handbook.
2. Supervisors will discuss the issue of work breaks and tobacco use with their staff.
   a. Employees must clock out when leaving Medical Center Hospital campus for personal business. (MCH-3045)
   b. The employee must obtain approval from the supervisor before leaving Medical Center Hospital campus. (Employee Handbook Hours of Work and Break periods)
   c. This includes properties not owned by Medical Center Hospital but within Medical Center Hospital boundaries.
3. Tobacco use in personal vehicles is prohibited while parked on Campus.
4. Visitors observed violating this policy will be approached in a non-offensive manner and informed that Medical Center Health System is a Tobacco Free Campus. The visitor will also be given a courtesy card and map identifying the Tobacco Free Campus area. Visitors who continue to ignore all requests to cease tobacco use may be escorted from the Campus by security personnel.
5. Patients observed violating this policy will be approached in a non-offensive manner and informed that Medical Center Health System is a Tobacco Free Campus. The patient will also be given a courtesy card and map identifying the Tobacco Free Campus area. In the event a patient continues to violate this policy, the charge nurse may contact the patient’s attending physician.
6. All inpatients will be requested to sign “patient using tobacco release and hold harmless agreement.” (Attachment B)
7. A patient found to smoking in a public area of the hospital as defined by section 6-7, division 3 of the Odessa City Ordinances, may be punished by a fine not to exceed $500.

TOBACCO INTERVENTION PROGRAM:
1. A smoking cessation program (Quitline) will be available to employees, eligible dependents, patients and medical Staff through American Cancer Society and Department of State Health Services.
2. Patients admitted to Medical Center Hospital who wish to quit tobacco use or obtain NRT will be referred to their primary nurse. The patient's nurse and physician will work together to assist the patient, as needed, and the patient will receive educational information about the cessation of tobacco use.
3. Medical staff and employees will be educated on the tobacco-free environment, and assisted with information regarding smoking cessation and NRT.

COMMITTEE APPROVALS
E-Team June 17, 2009 Approved

END OF POLICY
Tobacco Free Zone Campus Map
Attachment A
Patients Leaving the Campus to use Tobacco
Attachment “B”

PATIENT USING TOBACCO RELEASE AND HOLD HARMLESS AGREEMENT

I understand that Medical Center Hospital Campus is a Tobacco Free facility. I understand that if I choose to use tobacco, I must leave the campus property. I understand that if I leave campus property, I will be in a non-monitored area and there may be certain risks (including leaving the Hospital) that could have an adverse (negative) effect on my medical condition. I understand that my physician will be notified of my desire to leave campus property and I may be leaving the campus “Against Medical Advice.” I accept full responsibility for leaving the campus to use tobacco. I also agree that if I take any hospital equipment (such as IV pole) with me when I leave the campus, I will be responsible for the cost of the equipment if it is damaged. I have been given an opportunity to ask questions about my condition and the risks, and I believe that I have sufficient information to make this decision.

I HEREBY RELEASE AND HOLD HARMLESS HOSPITAL, IT’S AFFILIATES, AND THEIR TRUSTEES, OFFICERS, EMPLOYEES, AGENTS, AND REPRESENTATIVES, AND ALL PRACTITIONERS ATTENDING OR TREATING ME, FROM ANY AND ALL LIABILITY, CLAIMS AND DAMAGES AND COSTS AS A RESULT OF UNFAVORABLE OUTCOMES OR INJURY OCCASIONED BY MY LEAVING CAMPUS PROPERTY, INCLUDING ANY CLAIMS FOR ILLNESS OR INJURY, OR CAMPUS PROPERTY TO USE TOBACCO.

I certify this form has been fully explained to me, that I have read it or have had it read to me, and I understand its contents.

THIS IS A LEGAL CONSENT FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED.

___________________________      _____________________
Signature         Date
ADMINISTRATION

POLICY MEMORANDUM

<table>
<thead>
<tr>
<th>POLICY TITLE:</th>
<th>Identification Badges</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY NUMBER:</td>
<td>MCH-3000</td>
</tr>
<tr>
<td>TJC FUNCTION AREA:</td>
<td>Management of Human Resources</td>
</tr>
<tr>
<td>POLICY APPLICABLE TO:</td>
<td>All MCH Employees, Students, Faculty, Clergy, Medical Staff, Licensed Independent Practitioners, MCH Auxiliary, Hospital Volunteers, Texas Tech Employees, and Contract Workers</td>
</tr>
<tr>
<td>POLICY EFFECTIVE DATE:</td>
<td>March 8, 1991</td>
</tr>
<tr>
<td>POLICY REVIEWED:</td>
<td>12/1/96; 4/98; 3/99; 4/00; 10/15/04; 10/05; 2/06; 8/13/10; 8/2012, 10/2016; 1/2017</td>
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<tr>
<td>POLICY REVISED:</td>
<td>4/16/97; 3/9/99; 10/15/04; 2/06; 5/06; 6/2012</td>
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</table>

ALTERNATE WORD SEARCH:

POLICY STATEMENT:

While in the hospital performing tasks related to hospital operations persons in the above listed positions are required to wear Medical Center Hospital photo-identification badges for identification and security purposes. Badges must be worn at all times above the waist with the picture and name visible so they can be readily seen by security personnel, patients, visitors, etc.

PROCEDURE:

1) Badges will be made by the Support Service Department on Monday through Friday from 8:00 a.m. to 5:00 p.m. The initial identification (ID) badge will be issued to persons when they provide the following:
   a. MCH Placement Checklist with requested signatures
   b. A valid photo ID – A valid photo identification is one issued by the federal or state government (driver’s license), or any agency thereof, or by a foreign national government (passport).
   c. Students 16 and younger who may not have a government issued ID must present a current school ID badge.

2) Subsequent identification (ID) badges will be issued to persons when they provide the following:
   a. A valid photo ID – (as defined above)
b. Students 16 and younger who may not have a government issued ID must present a current school ID badge.

c. A Support Services ID form with requestor's signature (This form will be made available at time of request for badge)

3) To help identify various categories of persons to whom identification badges are issued, either the margin around the badges or the background of the photo are color-coded, as follows:

   a. White margin – MCH employees

   b. Light Pink margin – Employees of MCH’s Maternal Child department

   c. Yellow margin – Medical Staff & Licensed Independent Practitioners

   d. Dark Pink – MCH Auxiliary

   e. Light Blue margin – Junior Volunteer

   f. Purple margin – Clergy

   g. Red margin – Students of Odessa College and Midland College

   h. Lime green photo background – City of Odessa employees

   Identification badges for Texas Tech faculty, students and employees will include the Texas Tech University logo.

4) Badges must be worn at all time above the waist, with the picture and name visible so they can be readily seen by security personnel, patients, visitors, etc.

5) Due to the proximity care capability of the badges, pins and/or decorations may not be placed on the badges. These items will interfere with the card function.

6) Due to safety and security concerns, every person receiving an ID badge is responsible for maintaining their badge. A fee of $5.00 will be assessed for replacement of lost badges. This fee will increase in $5.00 increments for subsequent lost badges ($10.00, $15.00, etc.)

7) Lost or stolen badges must be reported to Security. If the badge is not located within 24 hours, staff is required to replace their badge immediately.

8) Employees will be issued an identification badge upon assignment of an employee number and being entered in the employee payroll and Human Resources system.

   a. Supervisors and managers are required to insure that employees were their badges while on duty and otherwise conform to this policy.

   b. Employees will not make photocopies of their badges for any reason.

9) It is the responsibility of each school to make arrangements with the Support Service Department to have badges made for their students, faculty and employees, as well
as to recover and return badges to the Support Service Department at the end of clinicals and/or when a person terminates their affiliation with the school.

10) Members of the Clergy must present authorization from the Hospital's Chaplain before a badge will be made and issued.

11) Volunteer Services Department will authorize the placement of all MCH auxiliary and volunteers. ID badges will be issued after completing the medical screening of Employee Health.

12) Members of the Medical Staff, their allied health professionals and assistants will be issued badges after:

   a. Being entered into the hospital computer system,

   b. Being issued a physician number

Allied health professionals and assistants must be credentialed according to the Medical Staff By-Laws before badges will be issued.

13) Contract employees, whether employed by MCH or by outside contractors, will be issued temporary badges to wear while working in the Hospital.

It is the responsibility of the respective department and director to recover and return badges to the Support Service Department when persons terminate their affiliation and/or association with Medical Center Hospital.

<table>
<thead>
<tr>
<th>AUTHOR'S SIGNATURE</th>
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<tbody>
<tr>
<td>Robbi Banks,</td>
</tr>
<tr>
<td>Vice President, Human Resources</td>
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</tbody>
</table>

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<tbody>
<tr>
<td>William W. Webster</td>
</tr>
<tr>
<td>President, Chief Executive Officer</td>
</tr>
</tbody>
</table>

END OF POLICY
EMPLOYEE PARKING

ADMINISTRATION

POLICY MEMORANDUM

<table>
<thead>
<tr>
<th>POLICY TITLE:</th>
<th>EMPLOYEE PARKING</th>
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<tbody>
<tr>
<td>POLICY NUMBER:</td>
<td>MCH-1055</td>
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<td>TJC FUNCTION AREA:</td>
<td>Leadership</td>
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<td>POLICY APPLICABLE TO:</td>
<td>All Hospital Employees, Patients, Physicians, Auxiliary, Contract, Students, and Texas Tech</td>
</tr>
<tr>
<td>POLICY EFFECTIVE DATE:</td>
<td>9/1/99</td>
</tr>
<tr>
<td>POLICY REVIEWED:</td>
<td>4/00; 4/01; 4/02; 5/04; 1/07; 3/11</td>
</tr>
<tr>
<td>POLICY REVISED:</td>
<td>4/01; 5/04; 1/07; 3/11; 5/12; 12/13; 06/17</td>
</tr>
</tbody>
</table>

ALTERNATE WORD SEARCH: Parking; Citations; Tickets

POLICY STATEMENT:

It is the policy of Medical Center Health System (MCHS) to ensure efficient use of the hospital’s parking facilities and to enforce fire lane and other parking violations.

PROCEDURE:

The below locations are designated parking locations for MCHS patients, visitors, physicians and staff.

MAIN PARKING GARAGE (Garage A): The first and second floors of the parking garage are designated for patients and visitors. Employees can park on the up-ramp and the down-ramp from the 2nd to the 3rd level, 3rd, 4th and 5th floor of the garage.

SOUTH PROFESSIONAL TOWER LOT (Lot #2): This parking area has designated parking stalls for patient and visitors parking on the north end, marked with white lines. The south end is designated for employees and is marked with yellow lines.

West Texas Cancer Center Parking (Lot #3) Stalls designated with blue or yellow lines are reserved for patients and visitors of the West Texas Cancer Center. All other non-marked curbs are open parking, unless otherwise designated. MCHS employees may park in this area during night time hours. The MCHS employees are required to be out of this area by 0830 daily.

ANNEX PARKING (Lot #5): The Annex parking area is designated for patients and visitors of the Women’s Clinic

Wound Care Parking: Spaces on 4th Street designated for Wound Care outpatient visitors.

GOLDER PARKING (West): The lot south of the L-Building is designated for visitors and staff of Pro Care Family Medicine and Urgent Care only. The North lot is reserved for staff and customers of the Golder Pharmacy.
GOLDER PARKING (East): This lot is open parking for staff, visitors and patients.

AUXILIARY LOT: This area is reserved for the auxiliary and is a secured by key-card access. This area is designated parking for Auxiliary, Physicians, and Auxiliary designated personnel.

MEDICAL PAVILION GARAGE (WSMP) (Garage B): Open parking for patients and visitors. Employees of physician office tenants and MCHS employees are permitted to park on the 3rd floor and above.

CENTER FOR HEALTH & WELLNESS (CHW): The CHW parking area contains parking for patient/visitors, physicians and staff. Employee parking is designated as the outer curb line of parking on both the West and South lots. Physician parking is designated by signage. All other parking is designated for patients and visitors.

Center for Women and Infants (Lot 4) Designated for patients and visitors only. Other designated parking is posted.

All designated and assigned parking will be enforced by the Ector County Police Department.

VIOLATIONS:

1. The ECHD Police Department personnel may issue MCHS citations or place boots on all vehicles illegally or improperly parked on all MCHS property. Cost for removal of the boot is $35 per incident.

2. Employees must ensure that parking violations are paid within 30 days of the date of issue. Full payment of parking violations is required. Failure to pay for parking violations will delay the processing of any potential merit increase earned based on job performance until unpaid violations are cleared.

3. Continued violation of parking regulations by an employee will result in a request for Administration decision for disciplinary action including possible termination.

4. Should it become necessary to tow a vehicle, the following guidelines will be observed:
   a. The towing company will be called and informed of the vehicle to be towed.
   b. ECHD Police personnel will meet the towing company driver and identify vehicle to be towed.
   c. ECHD Police personnel will accompany the towing company while said vehicle is towed.
   d. A towing charge will be billed to the employee by the towing company.
| AUTHOR'S SIGNATURE | Brad Timmons  
|                   | Chief of Police, Director Safety/EM |
| AUTHORIZING SIGNATURE(S) | Matt Collins  
|                           | Vice President Support Services |
|                           | William W. Webster  
<p>|                           | President/Chief Executive Officer |
| END OF POLICY |</p>
<table>
<thead>
<tr>
<th>Failure of:</th>
<th>What to Expect</th>
<th>Who to Contact</th>
<th>Responsibility of User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Systems</td>
<td>System down</td>
<td>Information Technology Computer Support, Ext. 1385</td>
<td>Use backup manual/paper systems</td>
</tr>
<tr>
<td>Electrical Power Failure—Emergency Generators Work</td>
<td>Many lights are out. Only RED plug outlets work.</td>
<td>Engineering, Ext. 2600</td>
<td>Ensure that life support systems are on emergency power (red outlets). Ventilate patients by hand as necessary. Complete cases in progress ASAP. Use flashlights.</td>
</tr>
<tr>
<td>Electrical Power Failure—Total</td>
<td>Failure of all electrical systems.</td>
<td>Engineering, Ext. 2600 Respiratory Care, Ext. 1235</td>
<td>Utilize flashlights &amp; lanterns; hand ventilate patients; manually regulate IVs; don’t start new cases.</td>
</tr>
<tr>
<td>Elevators Out of Service—Fire</td>
<td>All vertical movement will have to be by stairwells.</td>
<td>Engineering, Ext. 2600 Shift Supervisors</td>
<td>Review fire &amp; evacuation plans; establish services on first or second floor; use carry teams to move critical patients and equipment to other floor.</td>
</tr>
<tr>
<td>Elevators Out of Service</td>
<td>All vertical movement will have to be by stairwells</td>
<td>Contact Engineering for repair, Ext. 2600</td>
<td>Mark elevators “Out of Service” Review evacuation procedures</td>
</tr>
<tr>
<td>Elevator Stopped Between Floors</td>
<td>Elevator alarm bell sounding.</td>
<td>Engineering, Ext. 2600 Security, Ext. 2239</td>
<td>Keep verbal contact with personnel still in elevator and let them know help is on the way.</td>
</tr>
<tr>
<td>Fire Alarm System</td>
<td>No fire alarms or sprinklers</td>
<td>Engineering, Ext. 2600</td>
<td>Institute Fire Alarm Activation; minimize fire hazards; use phone or runners to report fire.</td>
</tr>
<tr>
<td>Medical Gases</td>
<td>Gas alarms; no O₂ or medical air or Nitrous Oxide (N₂O₃)</td>
<td>Engineering, Ext. 2600 Storeroom, Ext. 2600 Respiratory Care, Ext. 1235</td>
<td>Hand ventilate patients; transfer patients if necessary; use portable O₂ and other gases; call for additional portable cylinders.</td>
</tr>
<tr>
<td>Medical Vacuum</td>
<td>No vacuum; vacuum systems fail &amp; in alarm.</td>
<td>Engineering, Ext. 2600 Respiratory Care, Ext. 1235 Central Supply, Ext. 1060</td>
<td>Call Central Supply for portable vacuum; finish cases in progress; don’t start new cases.</td>
</tr>
<tr>
<td>Natural Gas Failure or Leak</td>
<td>Odor; no flames on burners; etc.</td>
<td>Engineering, Ext. 2600</td>
<td>Open doors to ventilate; turn off gas equipment; don’t use any spark-producing devices, electric motors, switches, etc.</td>
</tr>
<tr>
<td>Nurse Call System</td>
<td>No patient contact.</td>
<td>Information Technology Computer Support, Ext. 1385</td>
<td>Use bedside patient telephone, if available; move patients; use bells; detail a rover to check patients.</td>
</tr>
<tr>
<td>Patient Care Equipment/Systems</td>
<td>Equipment/system does not function properly</td>
<td>Clinical Engineering, Ext. 2600</td>
<td>Replace &amp; tag defective equipment with red equipment tag. Complete ORTS form.</td>
</tr>
<tr>
<td>Sewer Stoppage</td>
<td>Drains backing up</td>
<td>Engineering, Ext. 2600</td>
<td>Do not flush toilets; do not use water.</td>
</tr>
<tr>
<td>Steam Failure</td>
<td>No building heat, hot water, or laundry; sterilizers inoperative; limited cooking.</td>
<td>Engineering, Ext. 2600</td>
<td>Conserve sterile materials &amp; all linens; provide extra blankets; prepare cold meals.</td>
</tr>
<tr>
<td>Telephones</td>
<td>No phone service</td>
<td>Information Technology Computer Support, Ext. 1385</td>
<td>Use overhead paging, pay phones. Use runners as needed. Activate red phones.</td>
</tr>
<tr>
<td>Water</td>
<td>Sinks &amp; toilets inoperative.</td>
<td>Engineering, Ext. 2600 Central Supply, Ext. 1060</td>
<td>Conserve water; use bottled water for drinking; be sure to turn off water in sinks.</td>
</tr>
<tr>
<td>Water Non-Potable</td>
<td>Tap water unsafe to drink</td>
<td>Engineering, Ext. 2600 Shift Supervisors</td>
<td>Place “Non Potable Water—Do Not Drink” signs at all drinking fountains and wash basins.</td>
</tr>
<tr>
<td>Ventilation</td>
<td>No ventilation; no heating or cooling</td>
<td>Engineering, Ext. 2600</td>
<td>Open windows or obtain blankets if needed; restrict use of odorous/hazardous materials.</td>
</tr>
<tr>
<td>Blanketrol</td>
<td>Device shuts down and alarms</td>
<td>Clinical Engineering, Ext. 1142</td>
<td>Find alternate unit, use extra blankets/ice</td>
</tr>
<tr>
<td>Defibrillator</td>
<td>No energy output</td>
<td>Clinical Engineering, Ext. 1142</td>
<td>Find alternate unit, begin CPR</td>
</tr>
<tr>
<td>ECG Monitor</td>
<td>No waveform display</td>
<td>Clinical Engineering, Ext. 1142</td>
<td>Find alternate unit, increase nurse contact</td>
</tr>
<tr>
<td>External Pacemaker</td>
<td>No pacing</td>
<td>Clinical Engineering, Ext. 1142</td>
<td>Use defibrillator, continue ACLS</td>
</tr>
<tr>
<td>Ventilator</td>
<td>Device alarms and does not ventilate patient</td>
<td>Clinical Engineering, Ext. 1142, Respiratory Care, Ext. 1235</td>
<td>Start manual ventilation with Ambu-bag</td>
</tr>
<tr>
<td>Fluid Warmer</td>
<td>Device will not heat</td>
<td>Clinical Engineering, Ext. 1142</td>
<td>Use alternate method, microwave, warm water</td>
</tr>
</tbody>
</table>

**Phone Numbers:**
- Support Service: 2600
- Respiratory Care: 1235
- Clinical Engineering: 1121
- Central Supply: 2239
- Nutrition Services: Information Technology Computer Support 1385

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**Page 36**
## EMERGENCY CONDITION & BASIC STAFF RESPONSE

<table>
<thead>
<tr>
<th>ALERT</th>
<th>DESCRIPTION</th>
<th>INITIAL RESPONSE</th>
<th>SECONDARY RESPONSE</th>
<th>FOLLOW UP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POTENTIAL BOMB THREAT</strong></td>
<td>Bomb Threat. Notification of a bomb at hospital. Usually by caller. May be by note.</td>
<td>Try to keep caller on the phone. Get the attention of other staff and alert to call Extension 2000. Obtain as much information as possible—where is bomb; when will it go off; what does it look like; why was it placed; etc.</td>
<td>Report information to supervisor.</td>
<td>Search your area. Do not touch if found. Report anything suspicious. Complete bomb threat form in Emergency Preparedness Manual. Statement to law enforcement.</td>
</tr>
<tr>
<td><strong>EVACUATION</strong></td>
<td>Imminent danger to life, health, or safety or as instructed by Administration to evacuate.</td>
<td>Notify all in area to evacuate. Evacuate ambulatory, wheelchair, the non-ambulatory. Take patient records if safety permits.</td>
<td>Report to designated assembly area and account for all staff, patients, and visitors.</td>
<td>Report evacuation to EOC command center, Extension 2410. Identify any personnel unaccounted for.</td>
</tr>
<tr>
<td><strong>CODE BLUE</strong></td>
<td>Cardiac and/or Respiratory Arrest.</td>
<td>Units should dial Extension 2000 and give patient’s name, room number, location, and doctor’s name.</td>
<td>Telecommunications will announce “Code Blue” over the P.A. System and notify the attending physician. Assigned physicians, nurses, respiratory therapists, and security will respond.</td>
<td></td>
</tr>
</tbody>
</table>
| **RAPID RESPONSE** | Person in Distress. Precursor to Code Blue if the situation escalates. | 1) Notify nurse if a patient has a change in condition such as difficulty breathing, sudden pain or change in ability to speak or mental status.  
2) Nurse will determine the seriousness of the situation and, if necessary, dial 2000 and tell the operator to activate the Rapid Response Team, supplying the Patient’s name and room number.  
3) PBX will page “Rapid Response” on the intercom and page RRT on the “code blue” pager system. | The Rapid Response Team will arrive to assess and stabilize the situation. Nurse and RRT will complete an SBAR. Nurse communicates situation to the patient’s family and provides SBAR to MD. RRT directs nurse in assessment and care of patient and documents assessment of patient’s condition on the *RRT Protocols and Team Report*. RRT also facilitates nurse communication with MD and writes orders as needed. | |
| **FIRE ALARM ACTIVATION** | Fire, smoke, or smell of something burning. | RACE  
Rescue those in immediate danger  
Activate alarm (Dial 2000/pull alarm)  
Contain the fire (close doors)  
Extinguish the fire | PASS  
Use an extinguisher  
Pull the pin  
Aim the nozzle  
Squeeze the handle  
Sweep from side to side | Evacuate if appropriate. Remove patients horizontally. Use staircase down. Do not go to roof. |
| **HAZARDOUS SPILL** | Any spill or identified contaminated individual in which could present a hazard to people, to the environment, or effects unknown. | Contact Spill Team through Telecommunications and give location and type of hazard. Use appropriate personal protective equipment. Isolate spill area. Evacuate area. Deny entry. Assist any victims. | Seek medical treatment of any victims. Complete ORTS. |
| **MISSING INFANT** | Missing infant/child. Call 2000. | Go to closest exit and watch for anyone with an infant or with a bag that could hold an infant. | Ask to verify infant identity (wrist name tag) or see contents of bag. Get good description of person and note direction of travel. | Immediately report information to Security. |
| **WEATHER ALERTS** | Warning or strike. | Language from the National Oceanic and Atmospheric Administration (NOAA) | Follow posted weather alert plan. Stay diligent with plan until all clear. | |
| **UNUSUAL INCIDENT** | Not covered by other plans. | Notify supervisor. | Follow instructions of supervisor. Complete ORTS. | |
| **ACTIVE SHOOTER** | Active Shooter | Run—exit the area quickly if it’s safe to do so and notify 2000. Hide—Close doors, turn lights off, barricade doors. Notify 2000. Fight—As a last resort. Use anything necessary as a weapon to survive and protect. | ECHD police will respond. Wait for their instructions. | Cooperate with any investigation; witness statements. |
MRI Safety
Magnetic Resonance Imaging

- Strong magnetic fields are present at all times – the machine is **ALWAYS “ON.”**

- Any ferrous (attracted to a magnet) object can be pulled into the core of the machine with considerable force and cause patient injury/death and/or equipment damage. This can include metal oxygen tanks, metal stretchers and wheelchairs, watches, beepers, jewelry, IV pumps, scissors, tools, etc.

- Implanted pacemakers will malfunction if exposed to this level of magnetism.

- **ALL** personnel must check with MRI staff prior to entering scan room!

- Help us keep Medical Center Hospital a safe place for MRI – for you and our patients!
M.R.I. SAFETY

MAGNET TYPE
The MRI magnet used at MCH is the superconducting type. Superconducting magnets use a special wire which loses all resistance when cooled to ~270 degrees Centigrade. This requires liquid helium to surround the magnet wire. Current is applied to the wire during installation, which generates the magnetic field as it flows. Superconducting magnets are normally **FULLY ENERGIZED** at all times.

MAGNETIC FIELD
While MRI is considered to be a safe imaging technique, it is not without hazards. The magnet field will attract many ferromagnetic metals in an uncontrolled fashion and cause them to fly towards the magnets bore and turning them into high velocity projectiles. The bore of the magnet is where the fringe field is strongest, as all the lines of force are constricted and their relative strengths heightened. Various objects can be considered projectiles see below:

<table>
<thead>
<tr>
<th>Reported Projectiles in a Magnetic Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Writing Pens</td>
</tr>
<tr>
<td>2. Clipboards</td>
</tr>
<tr>
<td>3. Ankle Weights</td>
</tr>
<tr>
<td>4. Calculators</td>
</tr>
<tr>
<td>5. Hand Held Radios</td>
</tr>
<tr>
<td>6. Floor Buffers</td>
</tr>
<tr>
<td>7. Stretchers</td>
</tr>
<tr>
<td>8. Wheelchairs</td>
</tr>
<tr>
<td>9. Infusion Pumps</td>
</tr>
<tr>
<td>10. I.V. Poles</td>
</tr>
<tr>
<td>11. Jewelry</td>
</tr>
<tr>
<td>12. Hairpins</td>
</tr>
<tr>
<td>13. ID Badges</td>
</tr>
<tr>
<td>14. Keys</td>
</tr>
<tr>
<td>15. Oxygen Tanks</td>
</tr>
<tr>
<td>16. Stethoscope</td>
</tr>
<tr>
<td>17. Wrist Watches</td>
</tr>
<tr>
<td>18. Pocket Knifes</td>
</tr>
<tr>
<td>19. Hearing Aids</td>
</tr>
<tr>
<td>20. Pagers</td>
</tr>
<tr>
<td>21. Cigarette Lighter</td>
</tr>
<tr>
<td>22. Scissors</td>
</tr>
</tbody>
</table>

The magnetic field extends outside the poles of the magnet in all directions. It is always important to remember that the MRI magnet is the source of an invisible but powerful force, and this force grows considerably stronger as you come closer to the magnet.

When transporting a patient to the MRI Suite always use Non-magnetic stretchers, oxygen bottles, I.V. Poles and wheelchairs. These devices are normally located at the MRI Suite, if you have any questions regarding what can & can not enter the MRI vault consult the technologist on duty.

Before entering the magnetic field you should remove all personal effects. The characteristics of the magnet field will harm digital and analog watches, magnetized strip on credit cards, pagers, radios and some car alarm activators (found with most car keys).

If you are to stay inside the MRI vault during a procedure insure you use auditory protection. During the exam the MRI gradients make enough noise, 95 dB, to cause discomfort. Disposable hearing protection is located inside the vault, or contact the technologist on duty.

If you have a pacemaker, aneurysm clips, metal orthopedic implanted prosthesis, ocular implants, some dental implants, heart valve prosthesis, intravascular stents, permanent eyeliner tattoos, shrapnel wounds from combat, or have a past history as a welder or machinist contact the technologist **BEFORE** entering the magnetic field.

**BE ALERT !!** Do not become a victim to the adverse effects of the magnet field, an incident can occur when you least expect it due to inattention.
**RADIATION SAFETY/PROTECTION**

**RADIATION PROTECTION AND YOU**

Medical diagnostic x-rays contribute more to the exposure of the population than do all other man-made sources of radiation. As an occupational radiation worker, you may be exposed to more radiation than the general public. However, Medical Center Hospital, as a TCR license holder, has established a basic exposure limit for all occupationally exposed adults of 5.0 rem (5000 mr) in any year. No clinical evidence of harm could be expected in an adult working within these levels for a lifetime.

Because the risks of undesirable effects may be greater for young people, persons under 18 years of age are permitted to be exposed to only 10% percent of the adult occupational limits. This lower limit is also applied to members of the general public.

The amount of radiation a person receives is called a "dose" and is measured in "Rem" (R), "Milli-Rem" (mr). The average person in the United States gets a dose of 1.0 rem (1000 mr) from natural sources every twelve (12) years. The dose from natural radiation is higher in some states, such as Colorado, Wyoming, and South Dakota, primarily because of cosmic radiation. There the average person gets 1.0 rem (1000 mr) every eight (8) years.

Natural background radiation levels are also much higher in certain global areas. A dose of 1.0 rem (1000 mr) may be received in some areas on the beach at Guarpari, Brazil, in only about nine (9) days, and some people in Kerala, India, get a dose of 1.0 rem (1000 mr) every five (5) months. Radiation can also be received from natural sources such as rock or brick structures, from consumer products such as television and glow-in-the-dark watches, and from commercial air travel. The possible annual dose from working eight (8) hours a day near a granite wall at the Redcap Stand in Grand Central Station, New York City, would only be 0.0026 rem (2.6 mr).

All absorbed x-radiation, no matter how small the dose, has biological effects. All medical radiography is considered harmful. These harmful consequences result from the ionizing effects of the radiation within the human body. The fact that it nevertheless continues to be used is due to the undoubted benefits it also brings.

Many people receive additional radiation for medical reasons. The annual radiation dose averaged over the entire United States population from diagnostic medical X-rays is 0.072 rem (72 mr) per year. The average dose from one chest X-Ray is only 0.045 rem (45 mr).

Radiation, like many things, can be harmful. A large dose to the whole body (such as 600 rems [600,000 mr] in one day) would probably cause death in about thirty (30) days, but such large doses result only from rare accidents. Here at Medical Center Hospital the risk of receiving such a large dose is almost impossible. This in part is due to the fact that the diagnostic and therapeutic levels of radioactivity and the electronic radiation producers are considered very low radiation emitters.

The control of exposure to radiation is based on the assumption that any exposure, no matter how small, involves some risk. The occupational exposure limits are set so low, however, the medical evidence gathered over the past fifty (50) years indicates no clinically observable injuries to individuals due to radiation exposures when the established radiation limits are not exceeded.

This was true even for exposures received under the early occupational exposure levels, which were many times higher than the present limits. Thus the risk to the individual at the occupational exposure levels is considered to be very low.

But still so little is known about such things as the carcinogenic effects of radiation it is impossible to say that the risk is zero. Every care must continue to be taken to keep all irradiation to an absolute minimum.
The current exposure limits for people working in the radiation environment have been developed and carefully reviewed by nationally and internationally recognized groups of scientists. All TRCR licensees are now required, (Title 10, Part 19 of the Code of Federal Regulations), to inform all individuals who work in a restricted area of the health protection problems associated with radiation exposure. The regulations also state, (Title 10, Part 20), that licensees should keep radiation exposure “as low as reasonably achievable”, (ALARA).

Occupational exposures to radiation are being kept very low. However the National Council on Radiation Protection, the Nuclear Regulatory Commission, and the Texas Department of Health/Bureau of Radiation Control have recommended that the radiation dose to a pregnant women should not exceed 0.5 rems (500 mr). Since this 0.5 rems (500 mr) is lower than the radiation dose generally permitted to adult workers, the declared pregnant women should take special actions to avoid receiving unnecessary radiation exposures.

If you do become pregnant and your work assignment is in the radiation environment you should contact your immediate supervisor and declare your pregnancy status. If they are unavailable, please contact the Radiation Physicist or the Quality Control Coordinator/Radiology Services (see listing in this packet).

**DO SO WITHOUT DELAY ! !.**

**CONTROLLING YOUR RADIATION EXPOSURE**

The radiation protection programs, here at Medical Center Hospital, have two facets: the continuous evaluation of exposure -the reduction of exposure by any applicable control. We have touched on the evaluation of exposure in the previous section, in this training section we will be concentrating on the methods/techniques that are available to you, the employee, for reducing your exposure in the radiation environment.

There are three (3) cardinal rules for personal radiation protection. These radiation protection rules were developed in the early atomic pioneering years. These methods work and are the standard industry vanguards for radiation safety.

The three methods of reducing radiation exposure are:

1. **MINIMIZE TIME:**

   The radiation dose to an individual is directly related to the duration of exposure. If the time during which an individual is exposed to radiation is doubled, then the radiation exposure will be doubled. Exposure time should be kept to the minimum consistent with sound economical operation.

   **RULE OF THUMB:** Do not enter any area where ionizing radiation is present unless absolutely necessary. Listen for the technologist to announce “X-Ray”, “X-Ray” remove yourself from the area if possible. If not, utilize the protection of shielding and/or distance.

2. **MAXIMIZE DISTANCE:**

   As the distance between the source of radiation and an individual increases, the radiation exposure decreases rapidly. Radiation intensity decreases according to the Inverse Square Law. Doubling the distance drops the radiation exposure rate by 1/4, tripling the distance, 1/9 and so on.

   **RULE OF THUMB:** This concept of radiation protection is the easiest method to use. At any time that ionizing radiation is present simply increase your distance from the source or X-Ray tube. Remember ever six (6) feet is equal to one (1) Half Value Layer. Reference “Maximize Shielding” below.
 ***Note***: How far is six (6) feet? Each square of tile on the floor is roughly one (1) square foot. Count six square and you have approximately six (6) feet. This distance is equal to one Half Value Layer.

3. **MAXIMIZE SHIELDING:**

By placing shielding material between the radiation point source (i.e.: X-Ray tube) and you. The principle follows that the denser a material, of a barrier, the greater is its ability to attenuate (absorb) the passage of radiation.

Shielding used in Diagnostic Radiology usually consists of high density materials such as lead (Pb) or its equivalent. The protective barriers used, will provide a Half Value Layer from the radiation or better stated one Half Value Layer is the thickness of material that will reduce the radiation intensity to one half its original value.

**RULE OF THUMB:** The concept of shielding can be satisfied by using the lead protective aprons whenever ionizing radiation is present. Remember alternate protective shielding includes:

- a. Shielding incorporated into any equipment’s design.
- b. Mobile or temporary devices such as movable screens, lead aprons/gloves.
- c. Permanent protective barriers such as walls, doors, and concrete.
- d. Any other materials that can be placed between you and the point source of ionizing radiation.

Ideally you will want to combine any combination of two (2) of the three (3) radiation protection rules listed above.

Examples of these combinations could be the scenario where:

- If you were not in control of the duration (time) of your radiation exposure, you would then seek to increase your distance from the source of radiation and increase your shielding from the radiation source.

- If you were unable to control your distance from the radiation source, you would then seek and increase your shielding from the radiation source and decrease your duration (time) of radiation exposure.

- If you were not in control of your shielding from the radiation source, you would then seek to increase your distance from the radiation source and decrease the duration (time) of radiation exposure.
SEVEN BASIC RADIATION PROTECTION PRINCIPLES

1. Understand and apply the cardinal principles of radiation protection: **Time - Distance - Shielding.**

2. **DO NOT** allow familiarity to result in false security.

3. **NEVER** stand in path of the primary radiation beam.

4. **ALWAYS** wear protective aprons and gloves when not behind a protective barrier.

5. **ALWAYS** wear a personnel monitoring device (i.e.: film badge dosimeter or TLD ring dosimeter) and position it **OUTSIDE** the protective lead apron at collar level.

6. **IF POSSIBLE NEVER** hold a patient during radiographic examination. Use mechanical restraining devices whenever possible. Otherwise utilize staff on a rotating basis. **NO OTHER HOSPITAL EMPLOYEES SHALL BE USED ROUTINELY TO HOLD PATIENTS.**

7. The person holding the patient **MUST ALWAYS** wear a lead apron and, if possible, lead gloves and thyroid shield.

This training session has been provided to help inform you of your role in Medical Center Hospital's "Radiation Safety Programs". As I'm sure you are all aware, we have tried to lightly touch on only the critical areas of concern.

Please be aware that there is a system currently in place to provide radiation safety information and guidance to this facilities' patients and staff.

If you have questions or would like more information on any subject presented in this packet/lecture please do not hesitate to contact:

**RADIATION SAFETY OFFICER:** Dr. George Rodenko, M.D.
EXT: 640-1273

**SAFETY OFFICER:** Mr. Brad Timmons
EXT: 640-2234

**SUPERVISOR NUC. MED. SERVICES:** Virginia Limon, RT (R), CNMT
EXT: 640-1290

**DIVISIONAL DIRECTOR OF IMAGING SERVICES:** Ms. Carol Evans, R.T.
EXT: 640-1294

**RADIOLOGY CLINICAL COORDINATOR:** Mr. Cecil Sailors, R.T.
EXT: 640-1299

**QUALITY CONTROL COORDINATOR:** Mr. Rodney Venters, R.T.
EXT: 640-1282
This section discusses the sources of radiation exposure to the general U.S. population. Both naturally-occurring and man-made radiation sources are discussed.

**Natural Background Radiation**

<table>
<thead>
<tr>
<th>Source</th>
<th>REM / Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmic</td>
<td>28-75</td>
</tr>
<tr>
<td>Terrestrial</td>
<td>15 – 140</td>
</tr>
<tr>
<td>Internal</td>
<td>15 – 20</td>
</tr>
<tr>
<td>Average</td>
<td>= 100</td>
</tr>
<tr>
<td>Radon</td>
<td>= 400</td>
</tr>
<tr>
<td>TOTAL</td>
<td>= 500</td>
</tr>
</tbody>
</table>

The average American receives a dose of about 500 m REM each year due to background radiation.

**Man-Made Radiation Sources**

<table>
<thead>
<tr>
<th>Source</th>
<th>REM / Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Exposures</td>
<td>90</td>
</tr>
<tr>
<td>Building Materials &amp; Consumer Products</td>
<td>5</td>
</tr>
<tr>
<td>Weapons Fallout</td>
<td>5</td>
</tr>
<tr>
<td>Average</td>
<td>= 100</td>
</tr>
</tbody>
</table>

Examples of some medical exposures:

- Whole body CT scan: 5000 m REM
- Fluoroscopic procedures: 2000 m REM
- Chest X-Ray: 22 m REM

Medical procedures (both diagnostic and therapeutic) are the largest sources of man-made radiation exposure to the general public. The use of building materials containing trace amounts of natural radioactivity, some consumer products, and fallout from nuclear weapons add slightly to the total man-made radiation dose.

**Cellular Damage**

Radiation can cause cellular damage by ionization and by the potentially harmful effects of forming new chemical compounds as a result of the ionization process.

At low levels of radiation (such as normal background), the affected cell can usually repair (overcome) any damage resulting from the exposure. At high levels of radiation, cellular damage may ultimately result in the death of the affected cell or in the inability of the cell to reproduce. If genetic damage occurs, the cell may reproduce, but the resultant daughter cells may not live (or may live but be incapable of further reproduction).
Natural Background Radiation Sources

- Outer Space
  - Air
  - Water
- Ground Minerals
- Body Tissues

Our bodies are penetrated thousands of times each second by naturally-occurring radiation. Natural background radiation comes from the Sun and other stars and the decay of naturally-occurring radioactive elements in the ground, air, water, plants, and animals, and inside our own bodies.

Background

Cosmic Radiation
- Protons
- Neutrons
- Betas
- Gammas
- X-Rays

38 -75 m REM / Year

Activity on our Sun (and other stars) and the Earth’s magnetic fields cause the upper atmosphere to be bombarded with high speed particles and photons. While the Earth’s atmosphere shields us from much of this direct radiation, we are still exposed to some of this “primary” radiation. Interactions in the upper atmosphere release “secondary radiation” which is the source of most of the cosmic radiation which reaches the earth.

Consumer Products

- TV Sets
- Luminous Watches
- Smoke Detectors
- Airport X-rays
- Natural Gas
- Incandescent Mantles

The consumer products listed above either contain small amounts of radioactive materials or generate high speed particles or photons in the course of their operation.

General U.S. Population

- Natural Background: 500 m REM / Year
- Man-Made Sources: 100 m REM / Year
- Average = 600 m REM / Year

The average U.S. citizen receives a total annual dose of about 600 m REM as a result of naturally-occurring and man-made radiation.
Compute Your Own Radiation Dose

<table>
<thead>
<tr>
<th>Common Source of Radiation</th>
<th>Your annual inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: Cosmic radiation at sea level</td>
<td>26</td>
</tr>
<tr>
<td>For your elevation (in feet), add this number of m REM</td>
<td></td>
</tr>
<tr>
<td>Elevation – m REM</td>
<td>1000-2</td>
</tr>
<tr>
<td>Elevation of some U.S. cities (in feet): Atlanta = 1050, Chicago = 595, Dallas = 435, Denver = 5280, Las Vegas = 2000, Minneapolis = 815, Pittsburgh = 1200, St. Louis = 455, Salt Lake City = 4400, Spokane = 1890.</td>
<td></td>
</tr>
<tr>
<td>Ground: U.S. average</td>
<td>400</td>
</tr>
<tr>
<td>House construction – add 7 for stone, concrete, or masonry</td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>U.S. average</td>
</tr>
<tr>
<td>Water</td>
<td></td>
</tr>
<tr>
<td>Air</td>
<td></td>
</tr>
<tr>
<td>Weapons test fallout</td>
<td>4</td>
</tr>
<tr>
<td>X-ray and radio pharmaceutical diagnosis:</td>
<td></td>
</tr>
<tr>
<td>Number of CXRs ______ x 10</td>
<td></td>
</tr>
<tr>
<td>Number of lower GI X-rays ______ x 500</td>
<td></td>
</tr>
<tr>
<td>Number of radiopharmaceutical exams ______ x 300</td>
<td></td>
</tr>
<tr>
<td>(Average dose to total U.S. population = 92 m REM)</td>
<td></td>
</tr>
<tr>
<td>Jet plane travel: for each 2500 miles, add 1 m REM</td>
<td></td>
</tr>
<tr>
<td>TV viewing: for each hour per day ______ x 0.15</td>
<td></td>
</tr>
<tr>
<td>My annual dose in m REM =</td>
<td></td>
</tr>
</tbody>
</table>

One m REM per year is equal to: moving to an elevation of 100 feet or higher; increasing your diet by 4%; taking a 4-5 day vacation in the Sierra Nevada Mountains.
CAUTION

RADIATION AREA

- Used to identify an area where radiation is present.
- Primary user: Diagnostic Radiology and CT Scan.
- Located on any exposure room door.
CAUTION

RADIOACTIVE MATERIAL

TEMPORARY IMPLANT

Radionuclide________________ mCi_________
Inserted ____________________________
   (DATE)
Initial Exposure Rate at 1 Meter__________ mR/h
   (SIGNATURE)
To be removed________________________
   (DATE)

INSTRUCTIONS:
Patient must remain in hospital until implant is removed.
When implant is removed, “Radioactivity Precautions Tags” may also be removed.

For further information call Radiation Protection Office (ext. ________). In case of emergency, the telephone operator has a call List for use when the Radiation Protection Office Is not open.

DATE ___________   SIGNATURE ____________________
Radiation Protection Supervisor

Used radioactive source implants
Primary user: Radiation therapy
Located on the patient’s chart
**You may see one or both of these examples**

P A T I E N T  C O N T A I N S  R A D I O A C T I V E  M A T E R I A L
DO NOT REMOVE THIS LABEL UNTIL
1. Radioactive material is removed from patient, or
2. Removal is authorized by radiation Protection Supervisor (ext. ________)
VISITORS MUST CHECK IN WITH NURSING BEFORE GOING TO PATIENT.
Date ________   Signature________________
Performance Improvement – YOU Make the Difference!!!

- **Who is involved in this process?**
  - Patients
  - Families
  - Co-workers
  - Physicians

- **How can you be involved?**
  - Look for ways to improve processes in your area!
  - Identify interdisciplinary problems on an “Opportunity Statement” (located in the Forms section on the Intranet) and submit to your supervisor or the Executive Director of Organizational Excellence (Sherrill Rhodes, ext. 1175).
    - The Opportunity Statement goes to Quality & Patient Safety Council for approval.
  - The Quality & Patient Safety Council oversees, coordinates, and directs performance improvement activities. Membership includes members of Administration, Medical Staff, Management, and Quality Advisors.
    - Quality Advisors serve as team facilitators to keep the team on focus, ensure group participation, and suggest appropriate tools for data collection.

- **Volunteer to serve on performance improvement teams!**

- **Advantages of Teamwork:**
  - Teams improve your skills – more talent, expertise, and technical competence
  - Teams improve your communication – vertical and lateral, cross-departmental
  - Teams improve participation – boosts morale, job satisfaction
  - Teams improve effectiveness – solutions are more likely to be implemented

**Hospital-Wide Measurements:**
Patient satisfaction data (unit-specific), infection control data, fall rates, medication error rates, restraint rates, code blue data, length of stay/cost, patient safety data, and more!

**Joint Commission on Accreditation of Healthcare Organizations Chapters**
- Environment of Care
- Emergency Management
- Human Resources
- Infection Prevention and Control
- Information Management
- Leadership
- Life Safety
- Medication Management
- Medical Staff
- National Patient Safety Goals
- Nursing
- Provision of Care, Treatment, and Services
- Performance Improvement
- Record of Care, Treatment, and Services
- Rights, and Responsibilities of the Individual
- Transplant Safety
- Waived Testing
Reporting Safety or Quality Concerns

Patient safety and quality is a priority for Medical Center Health System. Please report any concerns you might have directly to your supervisor and complete an ORTS report. MCH is committed to reviewing your concern and intervening on behalf of the patient.

You may also report your patient safety and/or quality concerns directly to our accrediting agency, The Joint Commission (TJC). You may contact them via e-mail at complaint@jointcommission.org or by phone at 1-800-994-6610.

Our mission is to provide safe, compassionate care. No disciplinary action will be taken against you for reporting your concerns.
# 2017 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patients correctly</td>
<td>Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment. Make sure that the correct patient gets the correct blood when they get a blood transfusion.</td>
</tr>
<tr>
<td>Improve staff communication</td>
<td>Get important test results to the right staff person on time.</td>
</tr>
<tr>
<td>Use medicines safely</td>
<td>Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up. Take extra care with patients who take medicines to thin their blood.</td>
</tr>
<tr>
<td>Use alarms safely</td>
<td>Make improvements to ensure that alarms on medical equipment are heard and responded to on time.</td>
</tr>
<tr>
<td>Prevent infection</td>
<td>Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning. Use proven guidelines to prevent infections that are difficult to treat. Use proven guidelines to prevent infection of the blood from central lines. Use proven guidelines to prevent infection after surgery. Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.</td>
</tr>
<tr>
<td>Identify patient safety risks</td>
<td>Find out which patients are most likely to try to commit suicide.</td>
</tr>
<tr>
<td>Prevent mistakes in surgery</td>
<td>Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body. Mark the correct place on the patient’s body where the surgery is to be done. Pause before the surgery to make sure that a mistake is not being made.</td>
</tr>
</tbody>
</table>

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.
PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights and Responsibilities

“Medical Center Health System believes that patients have certain rights and responsibilities while under our care and service. These rights and responsibilities are codified in State and Federal regulations, as well as accreditation standards.” MCH-2087 Policy Statement

PATIENT RIGHTS:

The Joint Commission (TJC)

- Patients have the right to:
  - Reasonable access to care;
  - Care that is considerate and respectful of his or her cultural, psychological, spiritual, and personal values, beliefs, preferences, and personal dignity;
  - Pastoral and other spiritual services;
  - Be informed about and participate in decisions regarding his or her care;
  - Designating a decision maker in case the patient is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care;
  - Participate in ethical questions that arise in the course of his or her care, including issues of conflict resolution, withholding of resuscitative services, forgoing or withdrawal of life sustaining treatment, and participation in investigational studies or clinical trials;
  - Receive adequate information about the person(s) responsible for the delivery of their care, treatment, and services;
  - Refuse care, treatment, and services in accordance with law and regulation
  - Be informed of outcomes of care they must be knowledgeable about to participate in current and future care decisions, including when the results of care significantly differ from expected results
  - Effective communication as appropriate to age, understanding and language;
  - Resolution of complaints and the right to file a complaint with the state authority;
  - Security and personal privacy and confidentiality of information;
  - An environment that preserves dignity and contributes to a positive self image;
  - Be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation;
  - Be free from restraints and/or seclusion in any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff;
  - An assessment and management of pain;
  - Access protective and advocacy services;
  - Prompt resolution of grievances.

Center for Medicare/Medicaid Services (CMS)

- The patient has the right to:
  - Participate in the development and implementation of his or her plan of care;
  - Make informed decisions regarding his or her care, this includes being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right does not include the ability to demand the provision of treatment or services deemed to be medically unnecessary or inappropriate;
  - Formulate advance directives (inpatients only) and have hospital staff and practitioners who provide care comply with these directives;
Patient Rights and Responsibilities, cont

- Designate a representative to make decisions to exercise the patient’s right to participate in the development and implementation of the patient’s plan of care;
- Have a family member or representative of his or her choice, and his or her own physician notified promptly of his or her admission to the hospital;
- The right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time, and to be informed of any clinical restriction or limitation on such rights.
- Designate a support person to be present throughout the stay unless restricted by policy and to make decisions regarding visitation;
- Personal privacy. This right does not include the right to a private room;
- Receive care in a safe setting;
- Be free from all forms of abuse and harassment;
- Confidentiality of his or her clinical records;
- Access information contained in his or her clinical records within a reasonable period of time;
- Be free from restraints and/or seclusion in any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff;
- Prompt resolution of grievances.
- Effective management of pain

PATIENT RESPONSIBILITIES

The Joint Commission (TJC)

- The Patient/Family are responsible for:
  - Providing, to the best of their knowledge, accurate and complete information about presenting complaints, past illnesses, hospitalizations, medications, and other matters relating to the patient’s health. They are responsible for reporting unexpected changes in the patient's condition to the responsible practitioner;
  - Asking questions when they do not understand what has been told about the patient’s care or what they are expected to do;
  - Following the treatment plan developed with the practitioner. They should express any concerns they have about their ability to follow the proposed course of treatment;
  - Accepting the consequences of failing to follow the recommended course of treatment or using other treatments;
  - The outcomes of refusing treatment or failing to follow practitioner instructions;
  - Following the hospital’s rules and regulations concerning patient care and conduct;
  - Being considerate of other patients and hospital personnel by not making unnecessary noise, smoking, or causing distractions;
  - Respecting the property of other persons and that of the hospital;
  - Promptly meeting financial commitments agreed to with the organization.
  - Collaboration to ensure appropriate care after discharge
ORTS/MORTS
(Occurrence Report Trending System/Medication Occurrence Report Trending System) Policy MCH-4012

- To be completed for any Adverse Occurrence involving a patient, visitor, or other person who are not hospital employees.
- An adverse occurrence is any event which would not normally be expected to happen to any person(s) on or about the premises of Medical Center Hospital or any of its facilities.
- It is a non-disclosable document.
- It is NOT part of the Medical Record. DO document facts of the occurrence in the Medical Record, but DO NOT make any mention of the occurrence report.
- DO NOT COPY.
- The hospital employee most closely associated with the occurrence, or the employee who witnessed the occurrence or the employee who discovers the occurrence should complete the report. Report FACTS ONLY, no opinions.
- Immediately submit the completed form to your immediate supervisor or directly to Performance Improvement Department, within 24 hours of the occurrence or discovery of the occurrence.

What to Report:
Adverse Drug Reaction Airway Management AMA
Blood Products Care/Service Coordination Diagnosis/Treatment
Diagnostic Test (Radiology Issues) Environment Fall
ID/Documentation/Consent Infection Control Lab Specimen/Test
Line/Tube Maternal/Childbirth Med/Fluid Error
Restraint/Support Devices Safety/Security/Conduct Skin/Tissue
Surgical Site Infection Surgery/Procedure Vascular Access Devices

When to Report
Within 24 Hours of the Incident

Why Do you Need to Report?
To Improve Processes To Comply with The Joint Commission (TJC) Standards
To Track Trends To Bring Issues to Management’s Attention

SENTINEL EVENTS
Policy MCH-4024

- A “Sentinel Event” is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- Complete an ORTS report.
- Immediately notify the supervisor of the involved department and/or the Risk Manager or Administrative Coordinator after regular business hours.
- Sentinel Event Teams will be convened under the direction of the Risk Manager at the discretion of the hospital administrative staff. Sentinel Event Teams will consist of staff at all levels involved in the event and persons with authority to make necessary and appropriate decisions.
- A thorough and credible Root Cause Analysis will be conducted to identify basic and causal factors underlying the occurrence.
- The Root Cause Analysis will be focused on hospital processes, policies and procedures, rather than individual performance. If the analysis reveals opportunities with individual performance, appropriate coaching, training and/or peer review referrals will be made.
- Root Cause Analysis findings are used to develop an Action Plan for Improvement to facilitate changes that will help to prevent future similar occurrences.
PATIENT COMPLAINTS & FORMAL GRIEVANCES
Policy MCH-2049

- Complaints
  - Our goal is that all patient’s verbal complaints be handled promptly and courteously immediately upon receipt of the complaint, by the employee receiving the complaint or as soon as possible by the appropriate department supervisory staff.

- Formal Grievances
  - Any verbal complaint that cannot be resolved “immediately” by the staff present becomes a formal grievance. (MCH has defined “immediately” as within 24 hours).
  - Any written complaint received, including but not limited to US postal delivery, facsimile machine, or e-mail.
  - Written comments received on the Patient Satisfaction Survey when they have requested to be contacted by a hospital representative.
  - Whenever a patient or their representative requests that their complaint is handled as a formal grievance.
  - A legal Notice of Claim is not considered a formal patient grievance.
  - All formal patient grievances require a written response from the hospital, within seven (7) days of receipt.
    - The Quality & Service Excellence Division is responsible for tracking these grievances for feedback and compliance with the seven (7) day response requirement.
    - Involved Departments will be expected to complete the investigation and follow-up with the complainant, and to provide feedback to the Quality & Service Excellence Division in a timely fashion in order to facilitate the formulation of the written response in accordance with the actual findings.

Chain of Command to follow in dealing with patient complaints/grievances:

- Staff member that receives complaint
- Charge Nurse/ Shift Supervisor
- Department Director of involved Department
- Service Excellence Director (Administrative Coordinator after regular business hours)
- Risk Manager (Administrative Coordinator after regular business hours)
- Executive staff representative
- Governing Board member(s)

If a patient or patient’s representative threatens to bring a legal action against the hospital, DO NOT engage in a conversation regarding their specific threat or the appropriateness of their concerns. Simply continue to provide the best care possible to them as appropriate to their needs and offer to have someone else visit with them about their concerns.
FALL REDUCTION PROGRAM

PURPOSE: To decrease the occurrence of patient related falls and related injuries through accurate assessment, identification of patients at risk, and implementation of effective interventions.

Inpatient Fall Prevention Program

If a patient is identified at risk for falling, this risk should be included in the patient’s plan of care and communication with the interdisciplinary team should occur by placement of the yellow armband on the patient, yellow non-skid socks on the patient, and yellow fall symbol on/outside the door to the patient’s room.

Note in change-of-shift reports that the patient is on Fall Precautions.

Interventions:

- Place at-risk patients in rooms near the nurses station, if possible.

- All healthcare providers, with each patient visit, are to check for the following:
  - bed in low position, wheels locked, brakes on
  - top two siderails are up, all four if indicated
  - bed alarm activated – zero bed prior to placing a patient in the bed for the first time
  - reorient patient to room / environment
  - toileting needs
  - call light, water, phone, glasses, hearing aid, cane, walker, etc. within reach
  - night light is on at dark
  - bedside table is on the opposite side of the exit side of bed to avoid using the table as a support for transfer
  - floor is clean and dry
  - pathway to bathroom is clear of clutter
  - patient and family/significant other understanding to call for assistance when getting out of bed
  - the possibility of the least restrictive restraint
  - utilize minimal lift equipment or assistive device appropriate for the patient

- Educate the patient and/or family/visitors on fall prevention strategies.

- Review medications which place patients at greater risk for falls: sleeping pills, B/P and heart meds, pain meds, etc.

- If a patient falls, complete an Occurrence Report Trending System (ORTS) Report and review plan of care to assure interventions are implemented appropriately.

- Always notify the attending physician, the House Supervisor, the Charge Nurse, and the next of kin or emergency contact when a patient falls with or without injury. Document this in the ORTS.

- All MCH inpatients are assessed on admission and reassessed, at a minimum, daily for fall risk per MCH Policy 2071.
Outpatient Fall Prevention Program:

All outpatients of Medical Center Healthcare System (MCHS) who present with an obvious unsteady gait, use of an assistive device (e.g. cane, walker, wheelchair) or who complains of unsteadiness, will be identified as a fall risk and basic fall precautions/interventions will be implemented.

All MCHS outpatient areas will complete an annual environmental risk assessment that will determine the level of individual patient assessment and interventions required by the specific outpatient area.

Requirements for patient assessment and interventions are as follows:

Level 1 Area: No patient specific fall risk assessment for this care setting is required. Environmental risk assessment shall be performed. Basic fall interventions implemented when warranted.
Areas included: Clinical Laboratory, MCH Main Lab, Radiology (non-sedated patients), Diabetes Center, FHC, FHC Dental Clinic, Pre-Op Express, and all Urgent and Pro Care Clinics excluding the Pro Care clinics located in Walmart.

Level 2 Area: All patients in this care setting should be considered a fall risk. No patient-specific risk assessment is required. Basic fall prevention interventions should be implemented for all patients.
Areas included: GI Lab, Bronch Lab, Same Day Surgery, Interventional Cardiology, Sleep Lab, Pulmonary Function Lab, Radiology (sedated patients), and the Emergency Department.

Level 3 Area: Patients in this care setting shall be assessed for fall risk upon admission or establishment of care, but no ongoing assessment is required unless there is a significant change in the patient's condition. Fall prevention interventions shall be implemented for at-risk patients.
Areas included: Cardiac Rehab, Infusion Services

Level 4 Area: Patients in this care setting shall be assessed for fall risk upon admission or establishment of care, and will receive ongoing reassessment of fall risk at least once a day at each visit or episode of care for diagnostic/procedural and outpatient/ambulatory settings. Fall prevention interventions shall be implemented for at-risk patients.
Areas included: Wound Care, HBO, Rehab (PT, OT, ST) Clinic, Center for Health and Wellness, PT/Sports Medicine

Fall Prevention Interventions

Any patient assessed/reassessed or pre-determined to be at risk of fall shall have a basic set of interventions deployed to prevent a fall. These interventions include, but are not necessarily limited to, the following:

- Gurneys will have side rails in the raised position when the patient is unattended.
- Patients will not be left unattended on exam or procedural tables without postural safety devices employed.
- A call bell or other staff notification device will be made available to the patient to call for assistance.
- Should the patient need to ambulate, staff will assist the patient and/or utilize assistive devices as warranted.
- Communicating fall risk to other members of the team as required

In all areas, the patient and/or family will be informed of the patient's fall risk status.

References: The Joint Commission 2011 Standard PC.01.02.08
Updated 08/2015
The mission statement of the Interpreter Services Program (ISP) is to promote equal access to health care, facilitate effective communication with non-English speaking, LEP (Limited English Proficient), deaf, hard of hearing and visually impaired patients. The ISP also helps facilitate cross-cultural understanding, create trust and rapport, increase quality of care, reduce costs, enhance satisfaction, and pursue excellence.

- **What kind of Interpreter Services do we have?**
  - Language Access Network: Video Interpretation Services (MARTTI)
  - Certified Languages International (CLI): Telephonic Services
  - Highland Council for the Deaf, Big Spring Texas: On-site Sign Language
  - Authorized Medical Center Interpreters

- **How do we identify those that need Interpreter Services?**
  - Upon admission the organization shall identify whether or not the patient is in need of translation or interpretive services.
  - This is accomplished by determining the patient’s primary language and whether or not there is any language barrier to effective communication.

- **Interpreter Services are available 24/7.**
  - During office hours:
    - Monday through Friday 8:00 p.m. - 4:30 p.m. contact 640-1240
    - Staff interpreters are available for Spanish, Arabic, French, Chinese, Japanese, German, Filipino (Tagalog) and Yuruba.
    - Interpreters for all other languages are available from the use of certified telephonic interpretation: Certified Languages International (CLI).
  - After office hours and weekends:
    - Medical Center Hospital contracts telephonic interpretation with CLI.
    - Interpreter Services 24-hour/7-day phone number 432-640-1138 or pager number 432-742-2677.

- **When do we need Interpreter Services?**
  - The significant care needs of the patient including but limited to:
    - Determination of a patient’s medical history or description of ailment or injury
    - Diagnosis or prognosis of ailments or injuries
    - Provision of information concerning patient’s rights and advanced directives, informed consent or permission for treatment
    - Explanations regarding follow-up treatments, therapies, test results, or recovery
    - Explanation of medication prescribed (instructions regarding dosage, how and when medication is to be taken and side effects)

- **When Interpreter Services are not needed?**
  - Family may be used for non-medical related interpretive services (e.g. explaining visiting hours, orientation to the room environment, basic demographics, etc.)

Medical Center Hospital also provides services to the Hearing Impaired/Deaf. Please let us know as soon as possible if you will need the assistance of a sign language interpreter so that we can provide you the professional sign language interpreter in a timely manner. Medical Center Hospital contracts hearing impaired services with Highland Council for the Deaf, Big Spring, Texas.
Locations of MARTTI®

- ED, Cath Lab, CPC – located in ED Triage
- Center for Women & Infants – located across from Room 4138
- Wheatley Stewart Medical Pavilion – located in the Main Admitting break room
- Radiology/Registration – located in the linen alcove behind registration
- 4C – located across from the 4C nurses’ station
- ICU 4 – located outside Bed #20 (south end nurses’ station)
- 6C – located across from the 6C nurses’ station
- 6W – located 6C nurse’s station
- 3W – located behind the 3W nurses’ station
- 5C, 5W – located across from the 5C nurses’ station
- Main Operating Room – located by isolation room main PACU
- ICU2 – located in the south end nurses’ station
- 8C – located across from 8C nurses’ station
- 9C – located across from 9C nurses’ station
- Center for Health & Wellness
- Loaner units – contact Carolyn Bickerstaff in the Quality & Service Excellence Division at ext. 1174.

Helpful Hints

- **DO NOT TURN MARTTI OFF!!!** (unless told by IT)
- If you are having problems connecting, or experiencing a long wait time, hang up and try calling back again.
- If you continue to have problems, call the 1-800 number on the back of the MARTTI® unit.
- If you have any questions, please contact Meghan Pry at ext. 2298 or Carolyn Bickerstaff at ext. 1174.
SERVICES PROVIDED:
☐ Laparoscopic gastric bypass surgery
☐ Laparoscopic sleeve gastrectomy surgery
☐ Laparoscopic adjustable gastric band surgery
☐ FitChoice weight loss management program

REMEMBER:
☐ Obesity is a disease leading to many other physical and psychological problems
  ☐ Diabetes
  ☐ Hypertension
  ☐ Sleep apnea
  ☐ Depression
  ☐ Heart disease
  ☐ High cholesterol and triglycerides
  ☐ Osteoarthritis

☐ Obesity Sensitivity
  ☐ Provide chairs without arms or alternative seating
  ☐ Provide assistance with ambulation if needed
  ☐ Utilize minimal lift equipment
  ☐ Choose words wisely
  ☐ Be aware of verbal and nonverbal communication

*Walk a mile in their shoes...*
**EARLY HEART ATTACK CARE**

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**EHAC: Early Heart Attack Care**

**Why is it important?**

- Heart disease is the number one killer in the United States and has been since the 1900s.
- 1.2 million Americans suffer from a heart attack every year.
- 785,000 Americans will have a first-time heart attack.
- 470,000 will have a repeat heart attack.
- Results in 800,000 deaths per year.
- Every 25 seconds someone dies from heart disease.
- According to the World Health Organization (WHO) 17.3 million people die from heart disease worldwide.
- WHO estimates that by the year 2030 that number will climb to 23.6 million deaths per year.

**What are the signs of a heart attack?**

- Uncomfortable pressure, squeezing, fullness, burning sensation or pain in the center of the chest.
- Discomfort may last more than a few minutes, or goes away and comes back.
- Pain or discomfort in one or both arms, your back, neck, jaw, or stomach.
- Shortness of breath with or without chest discomfort.
- Nausea, vomiting, cold sweats, or lightheadedness.

**Men and Women is there a difference?**

Men often display the typical signs and symptoms of a heart attack.

- Chest discomfort
- Cold sweats
- Pain radiating to left arm
- Shortness of breath

Women however display atypical signs and symptoms of a heart attack.

- Generalized achiness or fatigue
- Shortness of breath
- Nausea/vomiting
- Back, shoulder, neck or jaw pain
- Abdominal pain

**Why do people Wait?**

**Denial and Procrastination = Our Heart’s Enemy**

- It’s nothing really serious (I’ll just rest a bit)
- I’m too busy right now (I don’t have time to be sick)
- I don’t want to be a problem (If it turns out to be nothing, I’ll be embarrassed by the fuss made)
- It’s probably heart burn or indigestion (I’ll take something for it)
- I’m strong (Just walk it off, grin and bear it)
- I’m healthy (I have no serious medical problems... I exercise)
- I’ll just wait it out (Everything will be okay)
INFECTION PREVENTION

Infection Prevention is the universal practice of all healthcare workers (HCW’s). The single most important activity in the prevention and control of infection is **HAND HYGIENE**. MCH adheres to CDC Guideline for Hand Hygiene in Healthcare Settings, 2002. When hands are visibly soiled, wash with soap and water. When hands are not visibly soiled, use an alcohol based hand rinse or hand rub. Hand hygiene will be performed before and after using gloves for contact with the patient or her environment.

Of special concern to healthcare workers are Bloodborne Pathogens which are infectious particles contained in blood that can cause disease. The Occupational Safety and Health Administration (OSHA) has issued a standard that if followed, is designed to protect you. This law, OSHA’s Bloodborne Pathogen Standard: Final Rule provides guidelines for the safety of the healthcare workers related to blood and body fluids. You are covered by the standard if it is reasonably anticipated that you could be exposed to Bloodborne Pathogens as result of performing your job duties. On-the-job safety for healthcare workers is provided by engineering controls, training in safe work practices, and equipment.

About 95% of Bloodborne Pathogen acquisition is not work related. In the remaining 5%, is occupational exposure.

Bloodborne Pathogens may be found in:

<table>
<thead>
<tr>
<th>Blood</th>
<th>Joint fluid</th>
<th>Tissue cultures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semen</td>
<td>Amniotic fluid</td>
<td>Any visibly bloody</td>
</tr>
<tr>
<td>Vaginal secretions</td>
<td>Saliva (in dental procedures)</td>
<td>fluid or fluids in which differentiating</td>
</tr>
<tr>
<td>Chest fluid</td>
<td>Human organs or tissues</td>
<td>blood is not possible</td>
</tr>
<tr>
<td>Abdominal fluid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal fluid</td>
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</tbody>
</table>

The most prevalent infections that are transmitted in the blood are Human Immune Deficiency (HIV), Hepatitis B (HBV), and Hepatitis C (HCV). There is no cure for HBV. Employee Health and Wellness offers free immunization for HBV to all employees. If you decline the HBV immunization, you must do so in writing. If you have declined HBV immunization in the past and would now like to receive it, contact Employee Health and Wellness. There is no cure and no immunization for HIV. There is no cure and no immunization for HCV. The practice of Universal Precautions is an effective way of preventing infection by Bloodborne Pathogens.

Universal Precautions are the use of impervious barriers (esp. Personal Protective Equipment, PPE) every time contact with blood or body fluids can be expected.

PPE is provided to you by your employer, MCH, but YOU must make the decision and act to use it whenever contact with blood or body fluids can be expected. Choose PPE according to the task to be performed. Gloves, gowns, masks, and eye protection are commonly used PPE. For resuscitation use a mouth barrier.

Handle all contaminated materials and equipment according to MCH policy. Blood contaminated products are disposed of in red bags, red containers, or containers with the biohazard symbol. All disposable sharps shall be disposed of in puncture resistant color coded or marked containers promptly after use. Use safety engineered devices to prevent accidental sharps injury. Do not deactivate or alter a safety engineered device.
In the event of an on-the-job exposure to blood or blood contaminated fluids, do the following:

a. Wash the area immediately with soap and water.

2. Report the incident to your Supervisor and state your need to proceed to the Emergency Department.

3. Obtain an Employee Accident Report. This form may be completed while you are in the Emergency Department.

3. Follow-up with the Emergency Department within 30 minutes of the exposure incident.

In the case of certain types of exposures, the Centers for Disease Control recommend drug treatment for the prevention of HIV and AIDS. Studies show that to achieve maximum benefit, these medications should be first taken within 2 hours of the exposure occurrence. Testing and counseling for HIV and HBV will be available as appropriate to employees from Employee and Wellness at no charge. The result of these tests will be made available to the employee. Results are communicated in person and all records are confidential.

Links are available to the MCH Exposure Control Plan #2043 and to the complete text of The OSHA Bloodborne Pathogens Standard.

Infection Prevention is Everybody’s Business.

If you have questions or concerns, please do not hesitate to contact the Infection Prevention Coordinator at 640-1862.
Medical Center Health System’s Notice of Privacy Practices
(Includes Texas Privacy Law)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Purpose: The Hospital and its professional staff, employees, and volunteers and all of its affiliated entities including the Family Health Clinic, and MCHS Professional Care (referred to collectively as Hospital) follow the privacy practices described in this Notice. The Hospital maintains your personal health information in records that will be maintained in a confidential manner, as required by law. This health information may include photographs obtained by authorized personnel at the Hospital for treatment purposes. The Hospital must use and disclose your health information to the extent necessary to provide you with quality health care. To do this, the Hospital must share your health information as necessary for treatment, payment and health care operations.

2. What Are Treatment, Payment, and Health Care Operations? Treatment includes sharing information among health care providers involved in your care. For example, your physician may share information about your condition with the pharmacist to discuss appropriate medications or with radiologists or other consultants in order to make a diagnosis. The Hospital may use your health information as required by your insurer or HMO to obtain payment for your treatment and hospital stay. We also may use and disclose your health information to improve the quality of care, e.g., for review and training purposes. It is also determined that patient safety activities of patient safety organizations (PSOs) are deemed to be healthcare operations under the Privacy Rule.

3. How Will the Hospital Use My Health Information? Your health information may be used for the purposes listed below, unless you ask for restrictions on a specific use or disclosure:
   - To share with your healthcare provider(s) and PSOs as needed for follow-up care. This would include Texas Tech University Health Science Center (TTUHSC), the Permian Basin Healthcare Network (PBHN), ProCare and other physicians and healthcare providers with staff privileges at MCHS.
   - Hospital Directory, which may include your name, general condition, and your room number.
   - Religious affiliation to a hospital chaplain or member of the clergy.
   - Authorized family members who may consent to your treatment or who are involved in the payment for your treatment.
   - Workers’ Compensation. (Your health information regarding benefits for work-related illnesses may be released as appropriate.)
   - To carry out health care treatment, payment, and operations functions through business associates, e.g., to install a new computer system.
   - American Red Cross (or a government disaster relief agency) if you are involved in a disaster relief effort.
   - Appointment reminders.
   - To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)
   - Used (or disclosed to a business associate) for fundraising, but such information will be limited to your name, address, phone number, and the dates you received services at the Hospital. (You will have an opportunity to opt-out from receiving any fundraising communications after the initial notification required by law.)
   - Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law).
   - Health oversight activities, e.g., audits, inspections, investigations, and licensure.
   - Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)
   - Law enforcement (e.g., in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on the Hospital’s premises; and in emergency circumstances relating to reporting information about a crime.)
   - To coroners and medical examiners.
• Organ and tissue donation.
• Certain research projects approved by an Institutional Review Board.
• To prevent a serious threat to health or safety.
• To military command authorities if you are a member of the armed forces.
• National security and intelligence activities.
• Protection of the President or other authorized persons from foreign heads of state, or to conduct special investigations.
• Inmates. (Medical information about inmates of correctional institutions may be released to the institution.)
• Alcohol and drug abuse information has special privacy protections. The Hospital will not disclose any information identifying an individual as being a patient or provide any medical information relating to the patient’s substance abuse treatment unless: (i) the patient consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

Certain types of information will be subject to additional restrictions on disclosure, such as AIDS test results and psychotherapy notes.

4. Your Authorization Is Required for Other Disclosures. Except as described above, we will not use or disclose your health information unless you authorize (permit) the Hospital in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

5. You Have Rights Regarding Your Medical Information. You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by the Hospital:

• **Right to request restriction.** You may request limitations on your health information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. However, you may request to restrict certain disclosures of your health information if the services were paid in full and out of pocket has been met, at which time we will comply with your request.

• **Right to confidential communications.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.

• **Right to inspect and copy.** You have the right to inspect and request copies of your health information regarding decisions about your care. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by the Hospital. The Hospital will comply with the outcome of the review.

• **Right to request amendment.** If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the Hospital, which requires certain specific information. The Hospital is not required to accept the amendment.

• **Right to accounting of disclosures.** You may request a list of the disclosures of your health information that have been made to persons or entities other than for health care treatment payment or operations in the past six (6) years, but not prior to April 14, 2003. After the first request, there may be a charge.

• **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site at [www.MCHodessa.com](http://www.MCHodessa.com).

• **Right of notification of breach.** The Hospital will notify you in the event a breach of your protected health information has occurred and you were affected.

• **Right of notification of genetic information.** You may prohibit the Hospital from using or disclosing your genetic health information for underwriting.

6. Requirements Regarding This Notice. The Hospital is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. The Hospital may change this Notice and these changes will be effective for health information we have about you as well as any information we receive in the future. Each time you register at the Hospital for health care services as an inpatient or outpatient, you will receive a copy of the Notice in effect at the time. The Hospital will prominently post any revision made to this Notice at our web site listed herein.

7. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Hospital or with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint to the Hospital or the Department of Health and Human Services.

**MCHS Contact:** You may call The MCHS Privacy Officer at 640-1106 if:

• you have a complaint;
• you have any questions about this Notice;
• you wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
• you wish to obtain a form to exercise your individual rights described in paragraph 5.
ETHICAL DILEMMA: Occurs in situations where a choice must be made between two or more relevant, but contradictory ethical directions or when every alternative results in an undesirable outcome for one or more persons.

ETHICAL PRINCIPLES:

- **Autonomy:** The right of a competent individual to make informed choices concerning medical treatment and care; the right to have control over one’s personal destiny through self-determination.

- **Beneficence:** The obligation to do that which is good.

- **Nonmaleficence:** Exercising care to do no harm.

- **Justice:** Equitable and reasonable distribution of care, goods, and services.

CLINICAL ETHICS COMMITTEE:

- **Purpose:**
  *To provide education to Committee members, hospital staff and physicians about how to do good decision-making related to ethical dilemmas;*
  
  *To be a forum to address specific patient situations when there are ethical concerns related to the care of a patient;*
  
  *To provide support to all care providers, which includes assuring that appropriate policies and procedures are in place to deal with various ethical dilemmas.*

- **Membership:** The Committee includes persons of different backgrounds and specialties, such as physicians, nursing staff, chaplain, social worker, other ancillary hospital staff, administration, and community representatives.

- **Referral Process:** Anyone can make a referral to the Committee and they can remain anonymous. To contact the Committee, call 640-3844.
The Condolence Cart

The Condolence Cart is to provide care and resources to the family and friends of patients who are actively dying (expected to die within 72 hours). This allows them to stay with their loved one as much as possible in their final hours.

The Condolence Cart includes items such as hot coffee & hot water, bottled water, snacks, Kleenex, a memory book, a Bible and an information book. Also included are games, crayons and coloring books for younger children.

The nursing staff at MCH has access to a Condolence Cart whenever one is needed. Use of the cart should be discussed between the nursing staff and the patient’s family before ordering it for a particular room.

When the Condolence Cart is ordered, a card with a picture of a Sunset (shown above) will be placed on, or near, the patient’s room. This picture will also be on the cart itself.

The picture of the Sunset silently lets the MCH staff know that a patient is near death and appropriate behavior and care should be shown by all.

If you have any questions, please contact Chaplain Farrell Ard at ext. 1400 or Chaplain Doug Herget at ext. 1914.
Workplace diversity is a people issue, focused on the differences and similarities that people bring to an organization. It is usually defined broadly to include dimensions beyond those specified legally in equal opportunity and affirmative action non-discrimination statues. Diversity is often interpreted to include dimension which influence the identities and perspectives that people bring, such as profession, education, parental status and geographic location.

As a concept, diversity is considered to be inclusive to everyone. In many ways, diversity initiatives complement non-discrimination compliance programs by creating the workplace environment and organizational culture for making differences work. Diversity is about learning from others who are not the same, about dignity and respect for all, and about creating workplace environments and practices that encourage learning from others and capture the advantage of diverse perspectives.

Refer to MCH Administrative Policy-2044.
UTILIZATIONS AND OUTCOMES MANAGEMENT

Medical Center Hospital provides a variety of assessment and resource services through our Utilization & Outcomes Management (UOM) Department. This dedicated group of social workers, nurses and support staff work in conjunction with patients, families, physicians, other hospital staff and community providers. Their primary goal is to assure that appropriate care is delivered at the appropriate time by the appropriate provider at the most reasonable cost.

The health, social situation and discharge needs of our patients are assessed to help identify any potential needs and develop an appropriate plan of care. Patients and families can utilize the UOM Department to help identify community resources to provide service after discharge from the hospital. This can help ensure that the patient's needs are adequately and safely met, even when they are no longer under the care of Medical Center Hospital.

The UOM Department also assists patients and families with information and paperwork referencing Advance Directives, long-term care placement and/or end of life care options. For more information, please call the department at (432) 640-2830.

- What is an Advanced Directive?
  - Also known as a Living Will, an Advanced Directive allows you to document your wishes concerning medical treatments at the end of life.
  - An Advanced Directive becomes effective when the patient’s attending physician certifies that:
    - The patient has a terminal or irreversible condition
    - The patient is unable to make their own medical decisions, unable to communicate and/or non-responsive.

- What is a Medical Power of Attorney (MPoA)?
  - An MPoA allows a patient to name an adult, known as the “Agent”, to make decisions about your medical care – including decisions about life-sustaining treatments – if the patient can no longer speak for themselves.
  - The MPoA is especially useful because it appoints someone to speak for you any time you are unable to make your own decisions, not only at the end of life.
  - The MPoA becomes effective when the attending physician determines that you are no longer able to understand and appreciate the nature and consequences of a treatment decision.

- Additional Terms:
  - **Terminal Condition**
    - An incurable condition caused by injury, disease or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.
  - **Irreversible Condition**
    - A condition, injury or illness:
      - That may be treated but is never cured or eliminated
      - That leaves a person unable to care for themselves or make decisions on their own behalf
      - That, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.
  - **Life-sustaining Treatment**
    - Treatment that, based on reasonable medical judgment, sustains the life of a patient and, without which, the patient will die. This includes both life-sustaining medications and artificial life support.
    - This term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care or any other medical care provided to alleviate a patient's pain.

- The Advance Directive and Medical Power of Attorney documents can be found on:
  - Every unit in the nursing resource box
  - Utilization & Outcomes Management (UOM) Intranet Home Page
  - Performance Improvement (PI) Intranet Home Page
  - Service Excellence Intranet Home Page
o Ask a social worker or transition nurse for them
o Call the Patient Relations Hotline at ext. 2273

• Completing These Documents
  o Patient must be competent and able to make informed decisions in order to execute these documents.
  o Two people must witness the signing of these documents. These documents DO NOT have to be notarized.
  o Witness #1 may not be:
    ▪ Designated to make a treatment decision for the patient
    ▪ Related by blood or marriage
    ▪ Entitled to any part of your estate or have a claim against your estate
    ▪ Your attending physician or an employee of your attending physician
    ▪ Involved in providing direct patient care to the patient
    ▪ Be an officer, director, partner or business office employee of the health care facility the patient is being cared for or of any parent organization of the health care facility
  o Witness #2 may be any competent adult.

• Abuse and Neglect (See Policy MCH – 1060)
  o **Physical Abuse** – Any intentional and unwanted contract with you or something close to your body. Sometimes physically abusive behavior does not cause pain or even leave a bruise, but it’s still unhealthy.
  o **Examples of physical abuse include:**
    ▪ Scratching, punching, biting, strangling or kicking
    ▪ Throwing something at you such as a phone, book, shoe or plate.
    ▪ Pulling your hair.
    ▪ Pushing or pulling you.
    ▪ Grabbing your clothing.
    ▪ Using a gun, knife, box cutter, bat, mace or other weapon.
    ▪ Smacking your bottom.
    ▪ Forcing you to have sex or perform a sexual act.
    ▪ Grabbing your face to make you look at them.
    ▪ Grabbing you to prevent you from leaving or to force you to go somewhere.
  o **Signs of physical abuse:**
    ▪ Has unexplained burns, bites, bruises, or black eyes
    ▪ Bone fractures, broken bones and skull fractures
    ▪ Seems frightened of the parents or caretaker
    ▪ Favoring or avoiding contact with a body part
    ▪ Covering or hiding certain body parts
    ▪ Limping that was not noticed before
    ▪ Open wounds, cuts, punctures especially those looking similar to items found around the house. (i.e. puncture wounds from a hair brush)
    ▪ Untreated injuries in various stages of healing
    ▪ Sprains, dislocations
    ▪ Reports someone physically is hurting them
    ▪ Aggressive, disruptive and/or destructive behavior
    ▪ Passive, withdrawn and/or emotionless behavior
  o **Emotional/Verbal Abuse** – Includes non-physical behaviors such as threats, insults, constant monitoring or “checking in”, excessive texting, humiliation, intimidation, isolation or stalking.
  o **Examples of emotional/verbal abuse include:**
    ▪ Calling you names and putting you down.
    ▪ Yelling and screaming at you.
    ▪ Intentionally embarrassing you in public.
    ▪ Preventing you from seeing or talking with friends and family.
    ▪ Telling you what to do and wear.
    ▪ Using online communities or cell phones to control, intimidate or humiliate you.
    ▪ Blaming your actions for their abusive or unhealthy behavior.
    ▪ Stalking you.
    ▪ Threatening to commit suicide to keep you from breaking up with them.
- Threatening to harm you, your pet or people you care about.
- Making you feel guilty or immature when you don’t consent to sexual activity.
- Threatening to expose your secrets such as your sexual orientation or immigration status.
- Starting rumors about you.
- Threatening to have your children taken away.

**Signs of emotional or verbal abuse:**
- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
- Being extremely withdrawn and non-communicative or not-responsive
- Over/under use of eye contact
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent or caretaker or others important in the life of the child/vulnerable adult
- Child or adult reports the abuse

**Sexual Abuse** – Refers to any action that pressures or coerces someone to do something sexually they don’t want to do. It can also refer to behavior that impacts a person’s ability to control their sexual activity or the circumstances in which sexual activity occurs, including oral sex, rape or restricting access to birth control and condoms.

**Examples of sexual assault/abuse include:**
- Unwanted kissing or touching.
- Unwanted rough or violent sexual activity.
- Rape or attempted rape.
- Refusing to use condoms or restricting someone’s access to birth control.
- Keeping someone from protecting themselves from sexually transmitted infections (STIs).
- Sexual contact with someone who is very drunk, drugged, unconscious or otherwise unable to give a clear and informed “yes” or “no.”
- Threatening someone into unwanted sexual activity.
- Repeatedly pressuring someone to have sex or perform sexual acts.
- Repeatedly using sexual insults toward someone.

**Signs of sexual assault/abuse:**
- Has difficulty walking or sitting
- Signs and Symptoms of Abuse and Neglect
- Bruises or other injuries around the breast or genital area
- Suddenly refuses to change clothing or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a venereal disease
- Runs away
- Torn, stained or bloody clothing
- Reports inappropriate touching
- Reports sexual abuse
- Inappropriately touches others in a sexual way
- Fear of being alone with adults, especially if of a particular gender

**Exploitation** – The illegal or improper use of a person’s funds, property or assets.

**Examples of exploitation:**
- Cashing someone’s check without permission
- Forging signatures
- Misusing or stealing a person’s money or possessions
- The improper use of conservatorship, guardianship or power of attorney.

**Signs of exploitation:**
- Unusual bank activity
- Missing social security or SSI checks
- Recent new friends residing with and/or expressing affection or interest (adults/elders)
- Missing property such as money, jewelry etc.
- Checks or documents bearing the signature of an elder or vulnerable adult who cannot write
- Missing mail or mail re-directed to a different address
- Social Security and or SSI monies not being spent on the needs of the child or adult

- **Neglect** – This is a passive form of abuse in which a perpetrator is responsible to provide care for a victim who is unable to care for himself or herself, but fails to provide adequate care.

- **Examples of neglect:**
  - Acts of omission
  - Ignoring physical or medical care needs
  - Failure to provide access to appropriate health, social care or educational services
  - Withholding necessities of life (i.e. medications, nutrition, heating)
  - Failure to provide sufficient supervision
  - Preventing client to have access to services

- **Signs of neglect**
  - Cuts, lacerations, puncture wounds, bruises or welts
  - Absence of hair or hemorrhaging below scalp
  - Dehydration and/or malnourishment without illness-related cause
  - Burns
  - Unexplained injuries or injuries of unknown origin
  - Absence of food, heat, hygiene, clothing, comfort
  - Isolation
  - Absence of prescribed medication

- **What do I do when I witness in-hospital abuse? (Policy MCH-1034)**
  - Take immediate action to protect, comfort, and assure the safety and treatment of the patient.
  - Verbally notify your supervisor and/or the appropriate unit director.
  - Complete an ORTS report and give to your unit director.
  - Unit director will initiate an investigation.
  - **NOTE:** APS does not investigate abuse that occurs in a health care facility.

- **Who should make the report?**
  - Anyone can make a report but if the abused is a patient, the preference is the healthcare provider with the primary knowledge of the identified concern must initiate the call to the hotline.

- **How to Make a Report**
  - Call the state-wide hotline at 1-800-252-5400 or
  - You can also complete a report on-line at [www.txabusehotline.org](http://www.txabusehotline.org)
  - Provide the intake worker with as much information as possible about the incident that occurred or what the patient has told you as well as contact information for the hospital.
  - Contact social services for further management of the incident (640-2830).
  - If the Hotline intake worker determines that the patient is in immediate danger, the intake worker will advise the caller to contact the local law enforcement agency.
  - APS or CPS will be involved in doing the related investigation.
  - In cases in which there is suspected sexual assault, the Sexual Assault Nurse Examiner (SANE) Program at MCH should be contacted through the operator.
  - Notify the family of the need to make a report based on concern for the patient’s safety.
  - If patient’s safety continues to be a concern notify security.
  - If the abuse or neglect occurred in a long-term care facility or a skilled nursing facility, call the Texas Dept. of Human Services at 1-800-458-9858.
  - Reports may also be submitted verbally or in writing to the Health Facility Compliance Division, Texas Dept. of Health, 1100 West 49th St., Austin, Texas 78756-3199
  - 1-800-228-1570
• **About Domestic Violence**
  o Domestic Violence is abusive behavior that occurs within a family setting. That abuse often involves emotional, psychological and/or sexual abuse, as well as physical injury.
  o APS does not investigate domestic violence cases unless the abused partner is determined to be disabled.
  o A CPS report must be completed if in discovering domestic violence you discover that the abuser is also abusing their children.
  o What do I do when I learn of domestic violence involving a patient?
    o Immediately provide the patient with information regarding the nearest family violence shelter.
    o Give patient the written notice, “Notice to Adult Victims of Family Violence” located on the intranet (MCH Administrative Policy No. 2040).
  o Document in the record that the patient has been given this information.
  o Consult social services for further management of the issue.

• **Things to Remember When Reporting Abuse and Neglect**
  o A person is given immunity from civil and criminal liability in an action arising from an investigation if the person was acting in good faith and in the scope of the person’s responsibilities.
  o MCH is permitted to disclose PHI without prior written authorization for certain public health activities and purposes in accordance with the policy HIPAA-5026.
  o All suspected or actual abuse and neglect must be reported within 48 hours to the Texas Dept. of Protective and Regulatory Services.

• **Family Violence Resources**
  o Safe Place
    • Midland (432) 570-1465
    • Odessa (432) 580-5970
  o Angel House (432) 333-2527
  o Police Department (432) 333-3641
  o APS/CPS 1-800-252-5400
  o Questions or Comments?
  o All policies can be found in the new employee orientation manual or on the intranet. Policies discussed: MCH 1060, MCH 2045, MCH 1034, and MCH 2040.
The Physician Staff Health & Wellness Committee at Medical Center Hospital is charged with overseeing, in an organized and responsible manner, matters of physician health, wellness and impairment whether the impairment is due to physical, mental or addictive processes. To assist the Committee in the process, the Medical Staff has implemented a Medical Staff Health and Rehabilitation Policy. The Policy provides for a non-punitive approach to addressing physician impairment. The emphasis is on assistance and rehabilitation to aid members of the medical staff to retain optimal professional skills and functioning, consistent with protection of patients.

The concern of Medical Center Hospital and its medical staff is always for quality patient care. At the same time, however, there must be sensitivity to and compassion for members whose abilities may possibly be diminished or compromised through impairment.

An impaired medical staff member is one who is unable to practice his or her profession with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.

Often a medical staff member, friend, colleague, or other hospital staff such as Nursing staff are in a position to see problems before they become an impairment to the physician’s ability to practice. Reports will be dealt with total confidentiality to the full extent permitted by law.

Confidentiality

The Physician Staff Health & Wellness Committee is a Peer Review Committee. Referrals to, proceedings of, and actions taken by the Committee are confidential and privileged. Vernon’s Texas Codes Annotated, Occupational Code §160.007 provides that each proceeding or record of a medical peer review committee is privileged. Furthermore, unless disclosure is required or authorized by law, a record or determination of, or a communication to, a medical peer review committee is not subject to subpoena or discovery and is not admissible as evidence in any civil or administrative proceeding without waiver of the privilege of confidentiality executed in writing by the committee.

State Statutes provide civil immunity for a person who in good faith reports or furnishes information to a medical peer review committee or the board (Texas State Board of Medical Examiners). Avoid speculation, conclusions, gossip and discussion of committee matters with anyone outside those described in the Medical Staff Health and Rehabilitation Policy.

The purpose of the Medical Staff Health and Rehabilitation Policy is to provide a process for assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients.
Key components

- Identification
- Investigation
- Intervention
- Refer for Evaluation
- Aftercare
- Monitoring

Report of Impairment
An individual who suspects that a member of the Medical Staff is impaired shall give a written report to one of the following staff:

- The Administrator/CEO
- Chief of Staff
- Chief Medical Officer
- Chairperson or any member of the Physician Staff Health & Wellness Committee

Physician Staff Health & Wellness Committee
For the current list of Physician Staff Health & Wellness Committee members, please contact the Medical Staff Office at 640-1058. Also, the list can be located on the hospital intranet by clicking on:

- “Depts”
- “Med Staff”
- “Physician Health & Wellness”

The report should be factual and include a brief description of the incidents or activities which led to the suspicion that the medical staff member might be impaired. The individual making the report does not need to have proof of impairment.

A medical staff member who believes he or she is impaired may refer himself or herself to any member of the committee. A voluntary entrance into a rehabilitation program is not reportable to the Data Bank if no professional review action was taken and the practitioner did not relinquish clinical privileges.

The Committee is available to help the physician find sources of evaluation and/or treatment so that the physician may continue to practice medicine safely. The Physician Staff Health & Wellness Committee also works closely with the Texas Medical Association (TMA) Committee on Physician Health and Rehabilitation (PHR). For information from TMA about the PHR, call their Hotline at 800/880-1640.

Please refer questions about this document to the Medical Staff Office @ 640-1116.
BODY MECHANICS

Body Mechanics and Transfer Training

Back Pain
Low back pain affects approximately 60-80% of Americans at some time in their lives. Among health care workers (nurses), this prevalence has been found to be slightly higher. The most frequent cause of musculoskeletal injury amongst healthcare workers involves the manual handling of patients. Often it is not the result of one incident, but cumulative damage over a long period of time. While there is no way you can completely eliminate the chances of injury in healthcare, you can certainly reduce the chances through a combination of preventative measures.

General Prevention of Back Pain
Overall physical fitness correlates favorably with a reduction of back pain and recovery from injury. Regular exercise, a healthy diet, and other healthy lifestyle choices will lessen your chances of injury. On the other hand, obesity and smoking correlate unfavorably with low back pain. Finally, the use of mechanical patient lifts has been shown to reduce back injuries and other musculoskeletal injuries.

Posture and Back Pain
Excessive and prolonged poor posture can cause cumulative damage to your back and other musculoskeletal joints. Correct posture is not something that comes natural. It is a learned behavior that requires continuous conscious awareness. Maintenance of the proper spinal curvature along with the avoidance of any single posture for prolonged periods of time can lessen your chances of cumulative damage.

Body Mechanics
The strain on your low back is decreased when you lift in the following manner:
- Stand as close as possible to the load you are lifting.
- Bend mainly at your knees rather than solely at your hips or low back.
- Lift mainly with your legs while maintaining your back in a straight or slightly lordotic position.
- Avoid twisting your trunk while you are lifting.

Pivot Transfers
In addition to the above mentioned tips, observe the following when transferring a patient from the bed to a chair:
- Make sure the patient is wearing shoes or slip-resistant socks.
- Have the patient scoot forward to the edge of the bed.
- Assist the patient at the waist (preferably with a gait belt) rather than pulling under the arms. Unless the patient can use a walker, stand in front of the patient to give assist.
- Assist the patient to move his or her center of gravity forward while coming to stand (nose over toes).
- Have the patient take small steps or pivot with small steps to the chair rather than twisting to transfer.
EMPLOYEE DRESS CODE

ADMINISTRATION

POLICY MEMORANDUM

<table>
<thead>
<tr>
<th>POLICY TITLE:</th>
<th>Employee Dress Code</th>
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<tr>
<td>POLICY NUMBER:</td>
<td>MCH-1027</td>
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<tr>
<td>TJC FUNCTION AREA:</td>
<td>Leadership</td>
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<tr>
<td>POLICY APPLICABLE TO:</td>
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POLICY STATEMENT:

The uniform or clothing worn by employees, as well as personal appearance and hygiene, reflects pride in Medical Center Health System (MCHS) and the service given to the patient. Each employee is responsible for maintaining high standards by presenting a neat, clean, well-groomed appearance, at all times. It is the Department Directors’ and/or the Supervisors’ responsibility to enforce the dress code uniformly throughout MCHS and to initiate corrective action for non-compliance with the dress code.

MCHS recognizes the importance of individually held religious beliefs to persons within its workforce. MCHS will reasonably accommodate a staff member’s religious beliefs in terms of workplace attire unless the accommodation creates an undue hardship. Accommodation of religious beliefs in terms of attire may be difficult in light of safety issues for staff members. Those requesting a workplace attire accommodation based on religious beliefs should be referred to the Human Resource (HR) Department.

PROCEDURE:

The following standards represent the minimal dress code. Departments may have more specific dress code policies which are subject to the written approval of the Department Director, the Dress Code Committee and the Chief Executive Officer.

1) All employees are required to wear their photo-identification badge provided by the hospital while on duty. Refer to policy MCH-3000 Identification Badges for further detailed information.
a) The badge must be worn **above the waist** with the picture and name visible at all times.

b) Due to the proximity care capability, no items such as pins or decorations may be placed on the badges as they will interfere with the card function.

c) Identification badges may be affixed to a lanyard rather than pinned or clipped to clothing. Such lanyards must not promote other organizations, events or businesses. Approved MCHS lanyards may be worn. All other lanyards may be worn only if approved by the Chief Executive Officer.

2) Special commemorative or recognition pins may be worn only with the approval of the Department Director and the Executive Team member. Professional/commemorative pins may only be worn for the calendar month of the event. These items may not be placed on employee’s identification badges.

3) Hair

a) Hair styles which have a shocking effect are unacceptable.

b) Non-traditional hair color are prohibited. Examples of hair colors that are non-traditional include, but are not limited to: blue, purple, green, orange, and pink. A single non-traditional color hair extension is acceptable to support awareness in a nationally designated observation month with written approval.

c) Hair must be clean and neatly groomed in such a manner that it does not create a safety hazard.

d) Facial hair must be trimmed, clean and well groomed.

e) Hats/caps (with the exception of professional nursing caps) may only be worn in-house with the written approval of the Dress Code Committee and Chief Executive Officer.

4) Jewelry should be conservative and in good taste. Employee and patient safety should be considered when wearing jewelry. Dangling earrings, necklaces or bracelets for employees giving patient treatment are not allowed.

5) Body art

a) Piercings are only permitted in the ear.

b) Tongue rings, nose rings, gauge earrings (spacers), barbells, plugs (unless flesh in color) or any other kind of facial piercing will not be permitted. Flesh color plugs must be worn in place of gauge earrings.

6) Body art or Tattoos should be tasteful or else covered up. Examples of body art that are not allowed include but are not limited to: Tattoos that advocates gang representation, sexual, racial, or religious discrimination or inappropriate for the workplace are not acceptable and are required to be covered.
7) **Uniforms**

   a) Nursing staff involved with direct patient care will have pre-selected specific colors that will be used by nursing staff and maternal ward only.

   b) Basic colors of pants – navy and black can be worn by other departments that do not have direct contact with patients.

   c) Employees in other departments cannot wear the same solid color tops that nursing staff have designated.

8) **Hospital issued scrubs:**

   a) Hospital issued scrubs will be worn ONLY by the following departments:

   i) Recovery Room

   ii) Operating Room

   iii) Labor and Delivery

   iv) Sterile Processing

   v) Cath Lab

   vi) Special Procedures

   b) Hospital issued scrubs should be changed if contaminated before re-entering a sterile environment. Employees from other departments assigned to work in the above mentioned areas are allowed to wear the same type of scrub for that area at the time they are in the area.

   c) Hospital issued scrubs cannot be worn home.

9) **Uniforms, scrubs, and/or lab coats must be clean, pressed and must fit properly.**

10) **Footwear restrictions** will be determined by individual department directors with the approval of the Dress Code Committee. These restrictions will be made only for safety and practicality reasons.

   a) All shoes must be clean and in good condition.

   b) For non-clinical departments, opened toed shoes may be worn at the discretion of the department director. Opened toed shoes excludes the wearing of flip-flops. Flip flops are defined as a light sandal with a thong between the big and second toe and or make a flopping noise while walking.

   c) For clinical departments, a closed toe shoe is required.

11) Employees may not wear shoe covers or disposable gowns out of the work area.

12) If an employee is not required to wear a uniform or lab coat, neat, clean, pressed clothing must be worn. The following must be professional in appearance and appropriate for the job duties of the employee:
a) Skirt or dress length must touch the top of the knee cap.
b) Slits in skirts/dresses (must be modest)
c) Appropriate denim clothing (no Jeans)
d) MCHS approved team T-shirts are allowed to be worn. Each department will be required to have written approval from the dress code committee and the Chief Executive Officer prior to wearing the team t-shirts.

13) The following CANNOT be worn while on duty, with or without a lab coat:
   a) Shorts
   b) Overalls
   c) Sleeveless dresses/blouses, strapless dresses/blouses or sun dresses/blouses
   d) T-shirts (excludes team T-shirts on Fridays with written approval, see 12. d.), sweatshirts or shirt with logos or writing on the front and/or back, except approved logos on special occasions.
   e) Jeans (or jean cut) pants, regardless of color unless written approval for special occasions. Jeans worn on special occasions must be in good repair and cannot have holes, rips or cuts that show skin.
   f) Faded or acid-washed clothing
   g) Sheer clothing that allows under-garments to be seen
   h) Jogging Suits
   i) Tight pants, or pants shorter than mid-calf
   j) Clothing with plunging necklines or exposing midriffs.
   k) Leggings, jeggings or any other tight trendy pant can be worn with skirts and dresses as long as the length of the skirt or dress touches the top of the knee cap. Leggings cannot be worn with an oversized top or sweater. Leggings can be worn as an undergarment but not a pant.

14) It is imperative that employees exhibit a standard of professionalism that portrays cleanliness. Special attention is given to personal and oral hygiene.
   a) A SMILE is a must.
   b) Fingernails must be clean and a reasonable length to comply with departmental safety and sanitary requirements. Nail polish is allowed. However, chipped nail polish is prohibited.
   c) Health care personnel having direct patient care contact ("hands on" patient care) will not wear artificial nails. Gel nails used for nail extensions are
considered artificial nails. Natural nails will be less than one quarter (1/4) of an inch long above the ridge of the nail per CDC Guidelines.

d) Make-up must be professional in appearance.

e) Perfume or cologne must be used in moderation. Perfumes and colognes are prohibited if performing direct patient care.

15) Failure to comply with the MCHS employee dress code will result in disciplinary action, up to and including termination. The employee will be required to clock out and sent home to change.

16) Enforcement:

Any employee who notices another employee violating the dress code should inform their immediate supervisor who should then take appropriate action.

<table>
<thead>
<tr>
<th>AUTHOR’S SIGNATURE</th>
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<tbody>
<tr>
<td>Robbi Banks, Vice President, Human Resources</td>
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<tr>
<th>AUTHORIZING SIGNATURE(S)</th>
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<tr>
<td>William W. Webster President, Chief Executive Officer</td>
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END OF POLICY
ADMINISTRATION

POLICY MEMORANDUM

<table>
<thead>
<tr>
<th>POLICY TITLE:</th>
<th>Electronic Computing Devices and Media Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY NUMBER:</td>
<td>MCH-1100 (Replaces MCH-1037, MCH-1045, MCH-1067 and MCH-1095)</td>
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<tr>
<td>TJC FUNCTION AREA:</td>
<td>Leadership</td>
</tr>
<tr>
<td>POLICY APPLICABLE TO:</td>
<td>Employees, medical staff, volunteers, contractors, consultants, temporaries, those affiliated with third parties and any others who access the MCHS network of information.</td>
</tr>
<tr>
<td>POLICY EFFECTIVE DATE:</td>
<td></td>
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<tr>
<td>POLICY REVIEWED:</td>
<td>02/01/2006</td>
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<tr>
<td>POLICY REVISED:</td>
<td>06/02/2011; 11/2013; 9/8/2016; 2/16/2017</td>
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ALTERNATE WORD SEARCH: Electronic computing devices; encryption; personal computers; laptop computers; tablets; smartphones; cell phones; removable memory devices; flash drives; USB drives; thumb drive; electronic media; devices; ePHI; HIPAA; 6019; iPad; iPhone; CD; DVD; software; proprietary software; employee developed software; software use.

POLICY STATEMENT:

Medical Center Health System (MCHS) shall implement reasonable and appropriate controls to govern the receipt, use and removal of hardware and software that could possibly contain electronic protected health information (ePHI) in any form. Devices are to be used as a means to access data on the MCHS network. Any email, short message service (SMS) texting or instant messaging (IM) of ePHI must use I.T. approved encryption software.

In this document the word device will pertain to any device capable of recording and/or storing ePHI. This policy also establishes procedures for obtaining and using MCHS devices that are owned, leased and/or maintained by MCHS or personal devices that are used for MCHS business. Because technology continues to evolve, this policy is considered to cover any future storage technology.

SUMMARY:

- Devices are anything that can access ePHI data on the MCHS network.
  - Must be password protected.
  - Subject to audits.
  - Must report if stolen or lost so the device can be wiped.
- User may use only MCHS authorized software.
- Unauthorized software may be removed without notification.
To use a Smartphone, Smartphone Request Form must be submitted.
  o MCHS eMail is allowed on smartphones using I.T. approved email software
• All eMail, Short Message Service (SMS), and Texting (IM) must use I.T. approved encryption.
• eMail containing ePHI must be encrypted by I.T. approved encryption software.
• SMS Texting in any form concerning work related information or used in any way to accomplish work related tasks will be considered ePHI and must be done using IT approved texting software.

PROCEDURE

1. Use of Electronic Storage Devices:

The following standards and requirements must be met by all individuals using storage devices for MCHS business purposes:

A. All devices shall be password protected.

B. Any device containing electronic protected health information (ePHI) must use I.T. approved encryption software to use email, short message service (SMS) texting or instant messaging (IM).

C. Users may not install connectivity hardware or software to the computing resources at MCHS; this includes, but is not limited to, internet browsers. MCHS uses only Microsoft Internet Explorer (IE). Support of, and updates to, IE are only to be made by Information Technology (IT).

D. Any device containing confidential or patient information must not be left unattended or in an unsecured location.

E. Devices used in the course of corporate business are subject to audits, even if employee-owned.

F. Users will not permit anyone else, including (but not limited to) user's family and/or associates, patients, patient families, or unauthorized employees, to use the device containing ePHI for any purpose.

G. Users will immediately report to IT if their device is lost or stolen by calling the Computer Support Center at extension 1385 so the CIO and Security Department can be notified. Lost or stolen devices with the capability to be remotely wiped will be cleared of data remotely at that time of the report.

H. MCHS reserves the right to inspect both MCHS owned and employee owned devices of personnel to ensure that ePHI is not present on the device.

I. Only specified, authorized programs from the suite of software currently supported by the IT Department will be allowed on MCHS owned devices. If the employee loads
other software or data, MCHS will not be responsible for loss of data nor will MCHS attempt to recover the data if the device fails.

J. MCHS does not condone, allow or accept responsibility for unauthorized, unlicensed or pirated software.

K. Users choosing to store information on local storage of a computing device are required to backup individual program data files on their system on a weekly basis. MCHS assumes no responsibility for any loss. MCHS policy 1046 states that all data should reside on the network where it can be backed up and stored safely.

2. Personal Computers

A. All hardware and software must be used in compliance with applicable licenses, notices, contracts and agreements.

B. Personal computers (PCs) installed in any department of Medical Center Hospital (MCHS) are the property of the IT Department. It allows IT the ability to use equipment in the most effective manner to accomplish the mission of the hospital.

C. Use of a computer at MCHS means the user assumes personal responsibility for appropriate use and agrees to comply with IT policy, other applicable MCHS policies as well as city, state and federal laws and regulations.

D. Records, files, reports, and programs installed on or entered into any PC owned, leased, etc. by MCHS, automatically becomes the property of MCHS.

E. Hospital personnel, contractors, consultants, temporaries and other users including those affiliated with a third party who access the MCHS network are not authorized to add, delete, modify or duplicate programs installed on any PC without the direct authorization of IT.

F. Unauthorized software may be removed without notification to the user.

G. Private programs brought from any outside source are not allowed to be loaded on MCHS Computers. Use and installation of private programs on any computer in MCHS without the express permission of the IT or the IT Steering Committee is prohibited.

H. Prior to being loaded, all software will be inspected by IT Computer Support Personnel or an IT designee to ensure the software is virus-free and compatible with the system in which it will be installed.

3. Software Use

A. Commercial Software is software written by third parties. All employees will:
1. Use only Commercial Software which has been properly licensed to or purchased by the District, the Hospital, or other District Facility.

2. Ensure that copies of Commercial Software are not created for their personal use or for the personal use of any other employee or other person, from software licensed to or purchased by the District, the Hospital, or other District Facility.

3. Ensure that copies of Commercial Software created for use in the normal course of business have been confirmed as authorized copies by the IT Steering Committee.

B. Proprietary Software is software written by employees of the District, the Hospital, or other District Facility or by external consultants or software developers engaged to create or develop software.

1. The Ector County Hospital District (ECHD) retains the entire rights to Proprietary Software, even after any employee who may have developed the software has left the employment of the District, the Hospital, or other District Facility.

2. All Proprietary Software is confidential and is intended solely for the use of employees in the normal course of business. As such, working copies and back-up of Proprietary Software may be made for use within the District, the Hospital, or other District Facility. The District has protection from unauthorized duplication of proprietary Software. Accordingly, employees must ensure that copies of Proprietary Software are not distributed to other parties nor should employees retain copies of Proprietary Software for personal use or distribute same for the personal use of any other employee or other person.

C. Employees will not store personally owned software on computers owned, leased or utilized by the District, the Hospital, or other District Facility without the written approval of the IT Steering Committee.

D. Employees will be required to sign a “Software Use” policy annually at the time of their employment evaluation. The policy will become part of the employee’s personnel file.

4. Smartphones

A. Due to the increasing popularity of smartphones, some users of the MCHS computing environment may choose to buy a smartphone of their own and wish to synchronize it with the MCHS computer system. This must be requested using the Smartphone Request Form located on the Forms section of the Intranet. The Smartphone Accountability Statement must also be submitted with the Smartphone Request Form.

B. Synchronization with the MCHS computer system is only available to exempt/salaried employees.

C. Employees are asked to keep their phones on silent or vibrate mode while on the MCHS campus.
D. While at work, employees are expected to exercise discretion in using smartphones. Excessive personal calls during the work day can interfere with employee productivity and be distracting to others.

E. Employees using MCHS owned smartphones will limit the phone to business use. If the phone must be used for personal calls, these calls should be short in duration.

F. Misuse of a smartphone includes, but is not limited to:
   - Making calls or text of a threatening or inappropriate nature
   - Making excessive personal calls
   - Inappropriate use of smartphone internet access or email

G. When driving a vehicle and using a smartphone to conduct hospital business, employees are encouraged to pull off the road and be parked before making or answering a call.

H. MCHS owned smartphones must be returned to MCHS upon termination of employment in order for the termination of employment to be considered "in good standing".

I. Owners of a smartphone must adhere to the following criteria for compatibility with the MCHS computing environment:
   - Have an existing account on the MCHS network and use IT approved email software that supports encryption as their email client.
   - Have an existing account on the MCHS network and use IT approved texting software that supports encryption as their texting client.
   - Purchase a data plan along with the voice plan provided by the phone carrier
   - Encryption must be turned on
   - Even if it requires an additional cost, the ability for the service provider to "wipe it clean" if lost or stolen is required

J. Abuse of this policy through personal use or use in violation of the law or MCHS policies will result in disciplinary action, up to and including termination of employment and for non-employees, severance of the business association.

5. Movement of Hardware and/or electronic media

A. ePHI in all states is to be encrypted.

B. SMS Texting in any form concerning work information will be considered ePHI and must be done using IT approved texting software that supports encryption and the wiping of the device in case of loss. Standard text messaging of any kind concerning work related information or to accomplish work related tasks are strictly prohibited.

C. MCHS email is allowed on smartphones using IT approved email software that supports encryption and the wiping of the device in case of loss.

D. MCHS workforce members shall not remove from MCHS's facilities hardware or electronic media containing ePHI without the approval of the Health Information Management (HIM) Department. Such approval shall only be granted if the hardware or electronic media is necessary for the performance of a job-related function on MCHS's behalf. Proper authorization from HIM is required.
6. Equipment Responsibility
   A. Administrators and Department Directors must request a device through the appropriate form on intranet. The request must contain the following information:
      a. The type of device and the coverage needed; e.g. local, national
      b. The name of the responsible party
      c. The department code for any charges associated with the device
      d. A contact phone number
      e. If the user is not an employee of MCHS the user’s driver’s licenses number must be included
      f. IT will maintain a database of MCHS device customers

7. Transfers
   A. Devices may not be transferred between employees and/or departments.

8. Loan Equipment
   A. IT does not maintain a pool of "loaner" devices for telecommunication type devices.

9. Repairs due to physical damage
   A. If a MCHS device malfunctions, it must be returned to IT. The department in which the employee is assigned is responsible for all replacement and repairs of all devices damaged by departmental employees.

   B. Any user who loads software on a device will be solely responsible for the repair of the device if it becomes infected by a virus.

10. Lost, Stolen, or Compromised Devices
    A. MCHS maintains software with the capability to track mobile devices. In case of loss or theft, the software will be used to attempt to locate and retrieve the MCHS device but MCHS takes no responsibility if the device is not recoverable.

    B. MCHS has the ability to remotely "wipe" a device and will do so at its sole discretion.

    C. If MCHS detects a data or policy breach, or virus or similar threat to the security of MCHS's data and technology infrastructure, the device will be wiped.

    D. If a device is lost or stolen, it should be reported to IT immediately so the Telecommunications Manager and CIO can be notified. If a missing device is not located in a timely manner, the responsible party may be required to reimburse MCHS for its replacement.

       a. When the loss is reported, a replacement unit will not be issued until the Security Department is notified and a police report is completed. A written statement detailing the circumstances of loss, a copy of the Security Departments report and the police report must be submitted to the IT Department and must accompany the replacement
request. If the responsible party is found to be liable, a payroll deduction form must be completed before a replacement unit will be issued.

11. Device Returns

A. When an employee or department no longer requires a device it must be returned IT at which time all ePHI and MCHS data will be removed from the device.

12. Final Disposal of a Device with/without ePHI

A. Removal Standard. The IT Department shall ensure that ePHI subject to final disposition by MCHS is disposed of using a method that reasonably ensures ePHI cannot be recovered or reconstructed.

B. Retrievable Copy. The IT Department shall ensure that a retrievable back-up copy is made before disposal of ePHI if the hardware or electronic media contains the only copy of the electronic ePHI that is required or needed by MCHS.

C. Hardware. The IT Department shall be responsible for the final disposal of hardware that contains ePHI or the final disposal of ePHI on hardware using the following methods:

   a. If MCHS is deleting ePHI and retaining the hardware, the IT Department shall use all known and reasonable methods to permanently remove ePHI from memory locations

   b. If hardware or hardware component containing ePHI is being disposed of, IT shall destroy the information by reformatting, overwriting, and/or degaussing the hardware using all practical and appropriate methods; then the hardware is put into a locked receptacle provided by a secure disposal company, to await pickup and destruction

   c. Media forms should be degaussed, cut up or scored with a scissor before being discarded.

13. Risks/Liabilities/Disclaimers

A. While MCHS will take every precaution to prevent the employee’s personal data from being lost in the event it must remote wipe a device, it is the employee’s responsibility to take additional precautions, such as backing up email, contacts, etc.

B. MCHS reserves the right to disconnect devices or disable services without notification.

C. Lost or stolen devices must be reported to the company within 24 hours. Employees are responsible for notifying their mobile carrier immediately upon loss of a device.

D. The employee is expected to use his or her devices in an ethical manner at all times and adhere to the company’s acceptable use policy as outlined above.

E. The employee is personally liable for all costs associated with his or her device.
F. The employee assumes full liability for risks including, but not limited to, the partial or complete loss of company and personal data due to an operating system crash, errors, bugs, viruses, malware, and/or other software or hardware failures, or programming errors that render the device unusable.

G. MCHS reserves the right to take appropriate disciplinary action up to and including termination for noncompliance with this policy.

14. Enforcement

Any employee found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

REFERENCES:

- International Standards Organization (ISO 27002).
- NIST 800 Series
- (The HITECH Act begins at H.R. 1-112 through 1-165 (pp. 112 through 165 in the document). The security and privacy provisions are found at Subtitle D Privacy, beginning H.R. 1-144 (p. 144)).

REVISION HISTORY:

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Responsible</th>
<th>Summary of Change</th>
</tr>
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<tbody>
<tr>
<td>Feb 2017</td>
<td>I.T. Security</td>
<td>Removed - Employees with cameras on their smartphones are prohibited from taking pictures of patients, employees or visitors.</td>
</tr>
<tr>
<td>Feb 2017</td>
<td>I.T. Security</td>
<td>Added – HIPAA References</td>
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</tbody>
</table>
| AUTHOR'S SIGNATURE | Brad Dummer  
Computer Security Officer |
|-------------------|--------------------------------|
| AUTHORIZING SIGNATURE(S) | Gary Barnes, C.I.O.  
Vice President, Information Technology |
| AUTHORIZING SIGNATURE(S) | William Webster  
President, Chief Executive Officer |
| END OF POLICY | |
Quality
It's part of everything we do.

Quality is priority one at Medical Center Health System. It's the foundation of every decision we make as we strive to provide outstanding care to every patient, every time.

We're proud to share the many quality accreditations, certifications and achievements awarded to Medical Center Health System by the nation’s leading healthcare experts. We couldn't achieve these results without the hard-working and dedicated employees and physicians who provide care at Medical Center Health System. They work as a team to provide the best care possible to you and your family.

Medical Center Health System • 500 West 4th Street • Odessa, Texas 79761 • (432) 640-6000 • mchodessa.com