Common Questions for Physicians

As a resource for practitioners and to promote continuous survey readiness

2011

University of Mississippi Health Care
COMMON TJC QUESTIONS FOR PHYSICIANS - 2011

Introduction

This “Common Questions” booklet has been developed to serve as a resource for you in the course of your work at UHHS and to promote our goal of always being “survey ready”.

What to Expect

Joint Commission surveys are unannounced. We are notified of the survey through The Joint Commission extranet site at 0730 on the morning of the survey. Surveyors focus on how services are perceived from the patient’s point of view and on how well departments and caregivers work together to coordinate care. The survey team will usually consist of at least four surveyors representing administration, physicians, nurses and life safety engineer. A survey for UHHS typically lasts 5 days. Each surveyor will select a number of patients to trace through our various services and settings. Surveyors may also interview patients and families. Surveyors will be escorted by Performance Improvement Department staff at all times.

Staff Tips for TJC Survey

The following tips can help staff feel more comfortable when interacting with surveyors:

- **Review records closely.** Remember that surveyors will conduct open-chart reviews during their visit. Staff must document completely and legibly – sign, date and time all medical record entries.

- **Exhibit displays.** Surveyors look for visuals such as PI displays, patient safety posters, etc. Look at your bulletin board to see what’s posted.

- **Be positive.** Answer questions with, “Yes, we do that. Let me tell you about our approach.” You may know your shortcomings, but focus on how you meet the standards.

- **Remember the three-second rule.** Try to answer the surveyor’s questions within three seconds. If you don’t know the answer, there are three responses:
  - Ask the surveyor to repeat the question
  - Ask for clarification if you don’t understand the question
  - Redirect the question to someone who can answer it

- **Answer only the question asked.** Do not elaborate or provide extraneous details about a process or procedure unless the surveyor asks. The surveyor will ask a follow-up question if he needs to know more.

- **Participate.** Help each other respond to questions. If you are in a group interview and the surveyor directs a question to you but you’re unsure of the answer, redirect the question to someone who can answer it.

- **Listen to surveyors.** If the surveyor goes into teaching mode, listen patiently and thank him for the information. Surveyors can have helpful solutions to complex issues that plague hospitals.

- **Answer in clear, simple language.** Be polite and respectful. Do not interrupt the surveyors or others. Describe what you do by giving an example. Do not argue with the surveyor. If the surveyor seeks information beyond the standards requirements, explain that you don’t understand and ask for the standard he is referencing.

- **Prepare to answer questions multiple times.** Repeat visits by surveyors may be stressful for staff or managers. Be constantly ready and remain calm and friendly while maintaining daily operational and patient activities.

- **Focus on the excellent service or care you provide.** The surveyors will observe staff but don’t worry about performing for surveyors. Concentrate on the tasks you do every day (e.g., washing your hands, identifying patients before administering meds, responding to clinical alarms, reading back orders).

- **Conduct a last-minute readiness assessment.** Do a quick sweep of your unit when the survey begins. Ask each other questions to prepare for the real survey. Share your findings with each other. The more you do this, the more comfortable you will be during the survey.
Q. How do you report safety concerns?
A. There are several reporting mechanisms available. The preferred method is the online occurrence report for any safety concerns including near-misses, errors, or other occurrences. This can be accomplished by going to the intranet - Hot Spots>Occurrence report, Desktop>Occurrence report, Dial 5-1157 and leave a voicemail. You do not have to leave your name, just information! Other options include notifying the nurse manager, the administrator on call, risk management, or the patient safety officer. Anyone may report safety concerns directly to The Joint Commission.

Q. What is a sentinel event?
A. 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.

- Such events are called "sentinel" because they signal the need for immediate investigation and response.
- Adverse Event is any untoward incident, therapeutic misadventure, iatrogenic injury, unexpected outcome or other undesired occurrence associated directly with care or services provided within the jurisdiction of the hospital, outpatient clinics, or other UMMC facility.
- Near Miss is any process variation that did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome.

Refer to Hospital Administrative Sentinel Event Policy –

Q. What process do you have in place for handling medical errors and what do you tell the family?
A. When a health care injury occurs, the patient and the family or representative are entitled to a prompt explanation by the attending physician of record, of how the injury occurred and its short- and long-term effects. When an error contributed to the injury, the patient and the family or representative should receive a truthful and compassionate explanation for the error and the remedies available for the patient. They should be informed that the factors involved in the injury will be investigated so that steps can be taken to reduce the likelihood of similar injury to other patients. Errors of any type should be reported via the incident/occurrence reporting system. Incidents are reviewed by risk management for the potential of sentinel event designation, and the need for a root cause analysis is assessed.

Refer to Hospital Administrative Disclosure of Adverse Events to Patients Policy –

Q. What are UHHS’s two Patient Identifiers?
A. For those patients with armbands, the patient name and Medical Record Number are the two identifiers. For those without armbands, the two identifiers are the patient’s name and date of birth. In the pediatric psychiatry area, the patient is identified by using name, photograph, and date of birth.

Refer to Hospital Administrative Patient Identification Policy –

Q. What is the “Universal Protocol”?
A. TJC’s Universal Protocol outlines steps taken before an invasive procedure to ensure patient safety. UHHS's policy on Pre-procedure Verification Process designates specific requirements for verification, site marking, and time out. Refer to Hospital Administrative Pre-Procedural Verification Policy -

Q. Are there exceptions to marking the surgical site?
A. Yes. The few exceptions to marking are listed in the policy, such as (but not limited to) life threatening emergencies, single organ cases, premature infants, cardiac caths, and cases where the person performing the procedure remains with the patient from the time the decision is made, consent is accomplished, and the procedure is done. See policy link in previous question.
Q. What procedures at UHHS require “Time Out?”
A. UHHS’s policy states “Certain routine minor procedures such as venipuncture, peripheral IV line placement, insertion of NG tube or Foley catheter insertion is not within the scope of the Universal Protocol. However, most other procedures that involve puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, and endoscopies are within the scope of this Protocol”.

Q. How does UHHS document “Time Out” to verify correct patient, correct site, and correct procedure?
A. UHHS uses a hot pink “Time Out” sticker. The RN assisting with the procedure completes the sticker and places it in the Progress Notes on the chart. Documentation includes:
- Correct patient identity
- Correct side and site
- Agreement on the procedure to be done
- Correct patient position
- Availability of implants
- Availability of special equipment or special requirements

Q. What if you need to perform a bedside procedure alone?
A. The physician should include the patient’s nurse, who will assist with the procedure and the “Time Out.” “Time Out” is expected and should be documented by the nurse with a pink “Time Out” sticker placed in the medical record.

Q. What are the requirements for verbal and telephone orders?
A. Verbal orders are not permitted except in the event of an emergency. Verbal orders will not be accepted in non-emergency situations. All verbal and telephone orders must be written down and read back to the practitioner. The responsible licensed practitioner must authenticate including dating and timing of all verbal and telephone orders within 48 hours upon receipt of order and all verbal and telephone restraint/seclusion orders according to the hospital restraint and seclusion policy.

Q. What is meant by the term "critical test results?"
A. Critical test results or values are those finds from diagnostic tests (even if from routine tests) which will always require rapid communication of the values/results to the patient’s responsible licensed caregiver. These should be communicated within 30-60 minutes from the time the critical results are discovered. This notification requires a verification read back.

Q. What is medication reconciliation?
A. It is a process for obtaining and documenting a complete list of the patient’s current medications upon admission to the organization with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list. The process continues with each transfer throughout the hospitalization and at the time of discharge. Orders such as “continue home meds” or “resume pre-op meds” are unacceptable.

Q. What abbreviations and symbols are on the “Do Not Use” list?
A. U, u, IU, Q.D., QD, q.d., qd, Q.O.D., QOD, q.o.d., qod, trailing zero after decimal point(X.0mg), lack of leading zero prior to decimal point(.Xmg), MS, MSO₄, MgSO₄. “Do Not Use” abbreviations are unacceptable in ALL orders, All preprinted forms and ALL medication-related documentation. No abbreviations, acronyms, or symbols may be used in the final diagnosis recorded in the medical record. Physicians not in compliance will be notified by Health Information Services for correction.
Q. Where can you find the “Do Not Use” list of Abbreviations?
A. The list is available online via Net Access. (See Administrative P&P Manual HADM/A-11.) Also, the list can be found within the UMC Yellow Pages, under “P”—Pharmacy Resource Center, “Drug Safety Information.”

Q. What about illegible handwriting?
A. Physician orders must be legible. Illegible orders require clarification with the person who wrote the order. Patient safety is the priority; therefore, “guessing” the intent of an order is not acceptable. Clarification and verification is expected. A new order must be written. For illegible medication orders, a Medication Error Report will be completed and submitted to Risk Management/Patient Safety.

Q. What is the best way to prevent the transmission of disease?
A. Hand hygiene remains the most effective method for preventing the transmission of disease. All surfaces of the hands and beneath the nails should either be vigorously washed with soap and water for at least 15 seconds or cleaned with an alcohol based solution. UHHS’s hand hygiene policy is based on CDC guidelines and may be found on the Infection Control website under the Manual tab.

Q. Are physicians monitored for appropriate “hand hygiene”?
A. All employees involved in direct patient care are monitored for compliance with hand hygiene on a regular basis.

Q. Where can the isolation guidelines be found?
A. The Infection Control website contains an alphabetical listing of all organisms and diseases requiring isolation with proper instructions as to the type of isolation, duration, and the protective equipment needed.

Q. What is the policy for administering procedural sedation?
A. Procedural refers to safe and effective sedation for diagnostic, therapeutic and invasive procedures. Patient safety and comfort are top priorities, and a high level of readiness for emergency situations is necessary in all cases and in all areas of the hospital where sedation is used. Regardless of the expected level of sedation or administration route, the sedation of a patient represents a continuum with general anesthesia. Sedation and monitoring of patients is practiced according to hospital policies. All patients receiving procedural sedation will be appropriately monitored by a qualified professional (RN, physician, or dentist) from the time of administration of sedation until predetermined discharge criteria are met. The person monitoring the patient shall have no other responsibilities during the sedation period other than the observation and monitoring of the patient and the necessary documentation. Refer to Hospital Administrative Policy and Procedure Manual – (http://uhc.umc.edu/intranet/manuals/HospAdmPolicies/(HADM.S-6)Sedation-Procedural.pdf).

Q. What are the requirements for resident supervision?
A. All residents function under the supervision of the attending physician/dentist. A responsible staff practitioner must be immediately available to the resident in all patient care settings, either in person or by phone, and must be able to present within a reasonable period of time, if needed. Each resident is evaluated at timely intervals on the basis of clinical experience, knowledge, technical skills, and overall ability to manage the care of the patient. The resident staff shall be subject to the medical staff bylaws, rules and regulations, with the exception that matters relating to clinical privileges, corrective action and hearing and appellate review procedures shall lie with the individual training program director and departmental procedures within the School of Medicine and/or Dentistry. The clinical duties, expectations and requirements for supervision are listed online for each level of training by department. This information is available through the campus intranet.

Q. How do you address:
A. obtaining “informed consent?” The physician performing the procedure (or treatment) is responsible for obtaining informed consent and documenting it in the patient’s medical record
prior to the procedure. To the extent possible, this will be based on a clear, concise explanation
of the patient’s condition and of all proposed technical procedures, risks and benefits of
 treatment, potential problems related to recuperation, possible result of nontreatment, likelihood
 of success, alternatives for treatment, risks and benefits of alternative treatment, and
 notification of the physician who is responsible for performing the procedure(s).

The patient has the right to know if UHHS proposes to engage in or perform any form of human
 experimentations affecting his or her case treatment and to refuse to participate in such research
 projects without jeopardizing his or her care.

**involving family and/or a surrogate decision maker(s) in care decisions?** Families are
 encouraged to participate in care decisions, based upon the patients’ wishes. Should the patient
 be incapable of making his or her treatment wishes known, identify designation of healthcare
 surrogate. In the absence of a designation, or if the designee is not reasonably available, any
 member of the following classes of the patient’s family who is reasonably available, in descending
 order of priority, may act as surrogate: 1) the spouse, unless legally separated; 2) an adult child;
 3) a parent; or 4) an adult brother or sister. Refer to Hospital Administrative Consent, Surgical,

**involuntary treatment?** The patient will not be subjected to any procedure without his or
 her voluntary and competent consent or the consent of his or her legally authorized
 representative, except in a medical emergency when the patient is unable to make an informed
 consent and a legally authorized representative is unavailable.

**honoring advance directives?** Patients are informed, as evidenced in the Patient Right’s
 Handout, that they should discuss their advance directive with their primary physician. UHHS's
 administrative policy and procedure is to resuscitate the patient during the surgical procedure
 unless a documented discussion and understanding takes places between the patient and the
 physician beforehand.

**formulating advance directives?** The attending physician or designee has the responsibility
 to provide all necessary medical information to the patient and answer any medical questions.
 The Department of Social Work has staff to assist patients and families with advance health care
 directives.

**decisions to withhold or withdraw life-sustaining treatment?** The attending physician is
 responsible for the withholding or withdrawal of life-sustaining treatment according to the
 patient’s or surrogate’s wishes and must write all orders to that effect. If the patient directs the
 physician to withhold or withdraw treatment, the doctor must document in the progress notes
 the patient’s diagnosis and prognosis, the patient’s intact decision making ability, the discussion
 of treatment options, and the patient’s decision to withhold and withdraw treatment. An
 advanced health care directive shall be honored when the patient suffers a terminal physical
 condition causing severe distress or unconsciousness and the patient’s physician determines that
 there is no expectation that the declarant will regain consciousness or a state of health that is
 meaningful to the patient, and that but for the use of life-sustaining mechanisms, the patient
 would die.

If the attending physician does not wish to participate in a request to withdraw life support
 systems, the physician must cooperate in transferring the patient to another physician who will
 honor the request. The hospital attorney shall be contacted for any questions or concerns.

**decisions to withhold resuscitative services?** The attending physician or designee, after
 discussion with the patient, if competent, and with family members, must write the Do Not
 Resuscitate Order (without abbreviations) and document the discussion/ decision in the patient’s
 chart. If the patient is a minor or in other applicable situations, this discussion will take place
 with the next of kin or legal guardian. If the patient has an advance directive, the documented
 wishes should be followed.

**dealing with patients'/families' decisions to forgo or withhold life-sustaining
 treatment?** The attending physician or his designee will consult with the patient’s family or
 surrogate decision maker to determine appropriate action if the patient cannot speak for himself
 or herself and does not have an advance directive. In cases where no surrogate decision maker
 or family member can be found, consent to life treatment will be implied until a surrogate
decision maker is available.
dealing with patients'/families' decisions pertaining to care and treatment at the end of life? The dying patient has the right to optimal comfort and dignity through the treatment of primary and secondary symptoms that respond to treatment as desired by the patient or the legally authorized representative. This should include: managing pain aggressively and effectively; providing appropriate treatment for primary and secondary symptoms; respecting the patient's values, religion, and philosophy; and sensitively addressing issues such as autopsy and organ donation. When a patient is diagnosed as being terminally ill, the physician talks with the patient and his or her family (unless otherwise directed by the patient’s wishes). Hospice or home health care may be offered as an option. We will work with the patient and his or her family in achieving the patient’s desires toward death with dignity and responding to his or her psychological, social, emotional, spiritual, and cultural concerns.

confidentiality of information? Disclosure of patient information may be made on a need-to-know basis, for treatment, payment and various healthcare operations, consistent with good medical ethical practices. For all other releases, the patient will sign a release of information form before any part of his or her record can be released. Release of information staff will screen for proper use of consent forms and that appropriate information is released. Charts are not kept where they are easily accessible to visitors rather they are kept in specific areas at the nursing desk. Staff is cognizant of those who access patients’ charts by checking for facility badges.

privacy and security? To address privacy certain safeguards are in place including: 1) Privacy curtains, which are available and should be used when a patient is receiving direct care. Avoid hallway and cafeteria conversations about patients. 2) Patient doors should be closed when delivering care. 3) Only the patient’s last name may be posted on the patient’s door; no other confidential information such as vital signs, intakes and outputs, etc. should be posted in view of the public. 4) Federal law prohibits staff from acknowledging a psychiatric patients’ admission to the general public; specific arrangements are made with family/significant other based upon the patients’ consent. We have restricted access to certain areas of the hospital. 5) UMMC has established various HIPAA privacy policies and procedures to follow that help ensure patient confidentiality.

To address security concerns the following safeguards are taken: 1) We distribute safety brochures to patients upon admission. 2) We conduct Code Pink, fire, and disaster drills. 3) Patient information maintained electronically is made secure through the use of passwords and automatic system log off.

communication needs? Any UHHS staff member can call the Department of Social Work or call the Language Line for assistance with any and all interpretation services. Refer to Hospital Administrative Interpreter and Other Assistance with Communication Policy – (http://uhc.umc.edu/intranet/manuals/HospAdmPolicies/(HADM.C-17)Communication-InterpreterandOtherAssist.pdf).

resolution of complaints? Patients and their families have the right to make complaints regarding hospital services, have these complaints analyzed, and be notified of corrective action when indicated. Patients are informed of this upon admission. Complaints should be made through the Customer Care Connection or to any member of their healthcare team. Concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission. E-Mail: complaint@jointcommission.org. Fax: Office of Quality Monitoring (630)792-5636.

pastoral services? An assessment of a patient’s spiritual needs is made upon admission so the information can be shared among the caregivers. When a patient requests pastoral services, staff should call 5-2112 in the hospital between 8am and 5:00pm or page the chaplain on call. Additionally, the patient may ask for her/his own minister; employees should contact requested clergy promptly. All staff is urged to document the ways in which the patients’ spiritual needs are addressed.

Q. Where is the Hospital Formulary located? What is the process when a non-formulary medication is ordered? What is the process for adding a medication to the formulary?
A. The formulary is available on the Pharmacy website (http://pharmacy.umc.edu). For non-formulary medication orders, the Pharmacist will contact the physician and offer an alternative formulary
medication. If the alternative is not acceptable to the physician, he must complete a non-formulary form. This form must be signed by an attending staff member. An exception to this process occurs when the patient is admitted on a non-formulary home medication and a formulary substitute does not exist. In this situation the non-formulary form does not need to be completed. (Refer to Pharmacy Policy D-009)

To add a medication to the formulary, a “Request for Formulary Addition” form is sent to the P&T Committee. This committee reviews the medication requested based on safety, efficacy, cost, and other information specific for that medication. After reviewing this information, the committee votes to accept or deny the request.

Q. How do you assess the learning needs, readiness and capabilities of the patient/family?
A. Learning needs, including barriers to communication, are assessed on every patient at the time of admission. Education of patients is begun at the time of admission. Although documentation is sometimes found in the nurses notes or other summary information, patient and family education is found on the Patient Education Record, the physician’s progress notes, the informed consent forms, consult sheets, Clinical Pathways, and/or the “Instructions to Avoid Food-Drug Interactions” Form.

Q. Are all relevant inpatient, ambulatory care, and emergency care records assembled when the patient is receiving care?
A. Yes. All treatment records, including inpatient, ambulatory care and emergent, are initiated, maintained, processed, and consolidated for every individual assessed or treated.

Q. What are the requirements for documentation and timing of the physician History and Physical?
A. A specialty appropriate history and physical examination shall be recorded within thirty days prior to a scheduled outpatient invasive or surgical procedure. An interval note shall be recorded no more than 24 hours prior to the procedure. The interval note will document pertinent interval changes in the patient’s condition that have occurred between the original history and physical and the procedure. If there is no interval change in the patient’s condition, “no interval change” shall be recorded. If the patient requires conversion to hospital admission status, then an updated history and physical will be required within twenty-four hours if the pre-history and physical is dated seven days prior to the current date.

An attending shall authenticate the history and physical examination when it has been recorded by a person other than the attending physician.

Q. When is a physician’s order necessary for restraint?
A. A non-violent restraint is necessary to temporarily limit the patient’s mobility or to maintain a medical device to prevent its accidental removal. Non-violent restraints cannot extend a time period greater than 24 hours. If greater than 24 hours a new order must be obtained daily.

A violent restraint is necessary when an unanticipated outburst of violent, severely aggressive or destructive behavior poses an imminent danger to the patient and/or others. Violent restraints are time limited according to the patient’s age: (a) up to 4 hours for adults 18 years old or older (b) up to 2 hours for children and adolescents age 9-17 years and (c) up to 1 hour for children under age 9 years. The physician must assess the patient in-person within one hour of initiation. He/she must sign verbal orders and document face-to-face evaluation. The physician must reevaluate face-to-face and document for continued need every 8 hours.

Q. How are Physician Privileges accessed?
A. Physicians can access their privileges via the UMC Intranet > Healthcare > Physician Privileges. Refer to UHHS intranet site - (http://ntecho1/echonet/privportal/msldir.htm?id=uhch)

Q. How are resident privileges accessed?
A. Resident privileges can also be accessed via the UMC Intranet > Healthcare > Resident and Fellow procedures. Refer to UHHS intranet site - (http://paws.umsmed.edu/RFPROCS/login.jsp)

Q. What are the proper reporting procedures to follow if you notice a physician is impaired?
A. If any individual working in The University Hospitals and Health System/UMMC suspects that a Medical Staff member is impaired, but is not thought to be an imminent danger to patients, he/she
should complete a “report of observed behavior” form and submit it to the Chief of Staff or his/her designee. The report must be factual and shall include a description of the incident(s) that led to the belief that the physician might be impaired. The individual making the report does not need to have proof of the impairment, but must state the facts that led to the suspicions. The Chief of Staff or designee will investigate including interviewing the physician and make a determination regarding the allegation as outlined in the Physician Health Assistance Policy. Refer to Hospital Administrative Physician Health Assistance Policy – (http://uhc.umc.edu/intranet/manuals/HospAdmPolicies/(HADM.I-3)Physician%20Health%20Assistance%20Policy.pdf).

If an observer suspects that a medical staff member may be practicing in an impaired state, which may reasonably be thought to be an imminent risk to patients, the following procedures will be followed: a. Observer will notify his/her immediate supervisor, or Department Head; b. Supervisor or Department Head will make an assessment of whether there is imminent danger to patients. If there is, the supervisor or Department Head will call the Chief of Staff and Administrator on Call; c. The Chief of Staff or his/her physician designee will follow the process as outlined in the Physician Health Assistance Policy.

**Q. What is a PRA?**

**A.** PRA stands for proactive risk assessment. PRA was previously known as FMEA - failure modes and effects analysis. PRA is the method used to investigate a high-risk process which if not planned or implemented correctly, has a significant potential for impacting the safety of the patient. The intent of a PRA is to prevent adverse events rather than simply reacting when they occur. We are required as an organization to conduct at least one PRA per year.

**Q. What PRA’s have been conducted here and how have you been involved in changes based on the recommendations?**

**A.** PRA’s completed so far include: Medication errors, Infant Abduction, Missed Medication Doses, Falls Prevention, Patient Identification, Duplicate Medical Records, and Suicide Prevention, Infant Security, Procedural Sedation, Medication Reconciliation, and Pediatric Security in Adult Service Areas. Universal Protocol: Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery is currently being reviewed through the PRA process. Staff should demonstrate an awareness of the PRA’s and be able to describe their involvement in any changes that were made in their area as a result of the analysis and recommendations.

**Q. What has been improved in regards to the care and service for your patients?**

**A.** We strive to continuously improve the care to our patients. Performance improvement (PI) activities are carried out throughout the organization. Our PI activities influence the way we deliver care and services to our patients daily. You will need to communicate to the surveyor specific improvements (in terms of percentage or rates) in processes and outcomes that your service has accomplished.

**Q. Do you have ORYX Core Measures for your service area?**

**A.** There are currently four ORYX Core Measures selected for data submission to TJC – Acute Myocardial Infarction (AMI); Perinatal Care (PC); Heart Failure (HF); and Children’s Asthma Care (CAC). These data results are reported quarterly to the Quality Boards.

**Q. What other clinical focus groups measures are collected?**

**A.** Data for five clinical focus groups are being collected and submitted monthly to the CMS. They include Acute Myocardial Infarction (AMI), Heart Failure (HF), Community Acquired Pneumonia (CAP), and Surgical Care Improvement Project (SCIP) inpatients – includes Coronary Artery Bypass Graft (CABG), Hip Replacement, Knee Replacement, Other Cardiac Surgery, Colon Surgery, Abdominal/Vaginal Hysterectomy, Vascular Surgery, and Major Surgery. The outpatient Surgical Care Improvement Project (SCIP) measures antibiotic timing and antibiotic selection. These data results are reported quarterly to the Quality Boards and monthly to the medical services. The measure results are publicly reported at the Hospital Compare website. (http://www.hospitalcompare.hhs.gov/Hospital/Home2.asp?version=alternate&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home)
Q. Do those who need it have access to poison-control information?
A. Yes. The poison control information is posted in the Emergency Department. The telephone number to reach the poison control specialist is 984-1675, and anyone can call for poison control information. Physicians can request at no charge a consult by a poison control physician. The physician will call the requesting physician and discuss his or her case with him or her.

Q. How would you respond in the case of a fire?
A. In our organization, the R.A.C.E. Procedure (rescue, alert, confine, extinguish) is used to respond to situations where fire threatens the safety of patients, visitors, or staff. Surveyors may ask staff to describe the last time they were involved in a fire drill.

Q. What is a MSDS? Where is it located?
A. The Material Safety Data Sheets (MSDS) that outline the hazardous materials present in particular areas should be readily accessible to all staff. Each department should designate an area for the MSDS and orient all employees to the location and use of the sheets. Refer to the UMC Intranet, Hot Spots, MSDS ONLINE, or the Environmental Health and Safety web page (http://ehs.umc.edu), Manuals, Chemical Safety, “Right to Know” Section 4.2.

Q. What would you do in the event of a chemical spill?
A. If you witness or discover a chemical spill, immediately call 4-1981 or 4-1420, and receive further instructions from the Chemical Safety Officer.

Q. Does the hospital have an Emergency Operations Plan (EOP)? How were you made aware of the plan?
A. Yes, there is an Emergency Operations Plan for the University of Mississippi Medical Center. The plan is located on the UMC intranet under Hot Spots or (http://disasterplan.umc.edu/plan.html). Employees are informed about the plan during new employee orientation, ongoing competencies and updated information about the plan is available from your supervisor.

Q. What would you do if the electricity, water, medical gas, or other utility system failed?
A. For all utility failures, please call 4-1420 immediately.

Q. What personal protective equipment is available to you?
A. Among the protective equipment available to employees are face shields, gowns, masks, shoe covers, safety glasses, gloves, and hair covers.

Q. How do you handle sharps and other hazardous materials?
A. Staff members should be able to describe the process specific to the unit or department.

Q. Is smoking allowed on campus?
A. UMC is a tobacco-free campus.

Q. Where is the fire alarm pull for your area? Where is the closest fire extinguisher?
A. All employees should be able to locate the fire alarm pulls and fire extinguishers in their work area.

Q. What is a Code Pink? What is your role during a Code Pink?
A. A Code Pink is an Infant/Child Abduction. All employees should be able to verbalize their role during a Code Pink depending upon their job and where they are located in the hospital. Procedures are outlined in Hospital Administration Policy and Procedure Manual. Refer to Hospital Administrative Infant/Child Abduction Response Procedures Policy – (http://uhc.umc.edu/intranet/manuals/HospAdmPolicies/(HADM.A-17)Abduction-Infant-Child.pdf)
Q. How do you ensure that the clinical alarms on your equipment are audible?
A. When the equipment is turned on it should go through a self-test and make sounds, this ensures you the speaker works. Also ensure that any alarm ports are not covered up. The actual alarms are tested when the Biomedical department does repairs and PM's on the equipment.

Q. How do you know that your equipment is up to date and safe for use on patients and its inspections?
A. By looking for the green inspection sticker and checking the date, it should show a date with in the last 12 months. Also by inspecting the housing and power cord to make sure they are not broken.

Q. How often do you inspect lead aprons, and how are they tracked?
A. Lead aprons are inspected annually by the Department of Radiology. The inspection date is noted on each apron. Aprons must be hung on racks or hooks to prevent cracks. Do not fold or crease the aprons.

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<tr>
<th>Disaster Type</th>
<th># To Call</th>
<th>Coded Over PA System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>911 or 4-6666</td>
<td>Dr. Red</td>
</tr>
<tr>
<td>Campus Police</td>
<td>911 or 5-7777</td>
<td></td>
</tr>
<tr>
<td>Violent Patient</td>
<td>4-1111</td>
<td>Code White</td>
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<tr>
<td>Cardiac Arrest (Adult)</td>
<td>4-1111</td>
<td>Code Blue</td>
</tr>
<tr>
<td>Cardiac Arrest (Pediatric)</td>
<td>4-1111</td>
<td>Code 13</td>
</tr>
<tr>
<td>Infant Abduction</td>
<td>911 &amp; 4-111</td>
<td>Code Pink</td>
</tr>
<tr>
<td>Rapid-Response (Family-Activated)</td>
<td>4-HELP (4-4357)</td>
<td></td>
</tr>
<tr>
<td>Chemical Spills (with fire potential)</td>
<td>911 or 4-6666</td>
<td></td>
</tr>
<tr>
<td>Chemical Spills</td>
<td>4-1981 or 4-1420</td>
<td></td>
</tr>
<tr>
<td>Poison Control</td>
<td>4-1675</td>
<td></td>
</tr>
</tbody>
</table>

For all emergencies at the Medical Mall call 981-4199.